BROOKS/COLE
CENGAGE Learning

Issues and Ethics in the Helping Professions, 9th Edition
Gerald Corey, Marianne Schneider Corey, Cindy Corey, Patrick Callanan

Product Director: Jon-David Hague

Content Developer: Julie Martinez

Content Coordinator: Sean Cronin

Associate Media Developer: Audrey Espey

Product Assistant: Kyra Kane

Brand Manager: Molly Felz

Market Development Manager: Kara Kindstrom

Content Project Manager: Rita Jaramillo

Art Director: Caryl Gorska

Manufacturing Planner: Judy Inouye

Rights Acquisitions Specialist: Roberta Broyer

Production Service & Compositor: Cenveo

Photo & Text Researcher: PMG

Copy Editor: Kay Mikel

Text Design: Kseniya Makarova

Text Design: Ingalls Design

Cover Design: Ingalls Design

Cover Image: The Sun (woodcut on paper), Rothenstein, Michael (1908-93)/ Private Collection / Photo © Peter Nahum at The Leicester Galleries, London / The Bridgeman Art Library

Library of Congress Control Number: 2013943674

Student Edition:

ISBN-13: 978-1-305-38945-8

ISBN-10: 1-305-38945-X

Cengage Learning
200 First Stamford Place, 4th Floor
Stamford, CT 06902
USA

Cengage Learning is a leading provider of customized learning solutions with office locations around the globe, including Singapore, the United Kingdom, Australia, Mexico, Brazil, and Japan. Locate your local office at **www.cengage.com/global.**

Cengage Learning products are represented in Canada by Nelson Education, Ltd.

To learn more about Cengage Learning Solutions, visit **www.cengage.com.** Purchase any of our products at your local college store or at our preferred online store **www.cengagebrain.com.**

Printed in the United States of America
1 2 3 4 5 6 7 18 17 16 15 14

INTRODUCTION

In this chapter we examine the cultural values, beliefs, and assumptions of helping professionals and their clients and discuss how these values may influence therapeutic outcomes. We emphasize the ethical dimensions of becoming aware of our own values and potential biases, as well as understanding the client's worldview and tailoring the therapeutic process to the client's cultural context. Our cultural experiences, values, and assumptions are the basis of our worldview and possible biases, so it is important to be aware of how they influence our practice. We also discuss sexual orientation and gender identity, and the values surrounding these topics.

One of the major challenges facing mental health professionals is understanding the complex role cultural diversity and similarity play in therapeutic work. Clients and counselors bring a wide variety of attitudes, values, culturally learned assumptions, biases, beliefs, and behaviors to the therapeutic relationship. Some counselors may deny the importance of these cultural variables in counseling; others might overemphasize the importance of cultural differences, lose their spontaneity, and thus may lose contact with their clients. Working effectively with cultural diversity in the therapeutic process is a requirement of good ethical practice. Pack-Brown, Thomas, and Seymour (2008) emphasize the ethical responsibility of counselors to provide professional services that demonstrate respect for the cultural worldviews, values, and traditions of culturally diverse clients. They contend that "cultural issues affect all aspects of the counseling process, including ethical considerations that emerge from the time the counselor first meets a client to termination of the helping endeavor" (p. 297). Because each of us comes from a unique blend of cultures and identities, all counseling interactions can be seen as multicultural events.

Duran, Firehammer, and Gonzalez (2008) assert that culture is part of the soul: "When the soul or culture of some persons are oppressed, we are all oppressed and wounded in ways that require healing if we are to become liberated from such oppression. When discussing these issues, it is important to realize that we have all been on both sides of the oppression/oppressor coin at different points in our lives" (p. 288). Mental health practitioners must avoid using their own group as the standard by which to assess appropriate behavior in others. In addition, greater differences may exist within the same cultural group than between different cultural groups, and we need to be intraculturally sensitive as well as multiculturally sensitive. Cultural sensitivity is not limited to one group but applies to all cultures. There is no sanctuary from cultural bias.

Cultural diversity, as well as cultural prejudice, is a fact of life in our world. Yet it is only within the past couple of decades that helping professionals have realized that they can no longer ignore the pressing issues involved in serving culturally diverse populations. To the extent that counselors are focused on the values of the dominant culture and insensitive to variations among groups and individuals, they are at risk for practicing unethically (Barnett & Johnson, 2010). It is essential to be mindful of diversity if we are to practice ethically and effectively.

In this chapter we focus on the ethical implications of a multicultural perspective or lack thereof in the helping professions. To ensure that the terms we use in this chapter have a clear meaning, we have provided specific definitions in the box titled "Multicultural Terminology."

MULTICULTURAL TERMINOLOGY

Culture The word *culture*, interpreted broadly, is associated with a racial or ethnic group as well as with gender, religion, economic status, nationality, physical capacity or disability, and affectional or sexual orientation. Pedersen (2000) describes culture as including demographic variables such as age, gender, and place of residence; status variables such as social, educational, and economic background; formal and informal affiliations; and the ethnographic variables of nationality, ethnicity, language, and religion. Considering culture from this broad perspective provides a context for understanding that each of us is a member of many different cultures. Culture can be considered as a lens through which life is perceived. Each culture, through its differences and similarities, generates a phenomenologically different experience of reality (Diller, 2011). Choudhuri, Santiago-Rivera, and Garrett (2012) define culture as a "total way of life held in common by a group of people who share similarities in speech, behavior, ideology, livelihood, technology, values, and social customs" (p. 34).

Ethnicity is a sense of identity that stems from common ancestry, history, nationality, religion, and race. This unique social and cultural heritage provides cohesion and strength. It is a powerful unifying force that offers a sense of belonging and sharing based on commonality (Lum, 2004; Markus, 2008).

An **oppressed group** refers to a group of people who have been singled out for differential and unequal treatment and who regard themselves as objects of collective discrimination. These groups have been characterized as subordinate, dominated, and powerless.

Multiculturalism is a generic term that indicates any relationship between and within two or more diverse groups. A multicultural perspective takes into consideration the specific values, beliefs, and actions influenced by a client's ethnicity, gender, religion, socioeconomic status, political views, sexual orientation, physical and mental/cognitive abilities, geographic region, and historical experiences with the dominant culture. Multiculturalism provides a conceptual framework that recognizes the complex diversity of a pluralistic society, while at the same time suggesting bridges of shared concern that bind culturally different individuals to one another (Pedersen, 1991, 2000).

Multicultural counseling "can be operationally defined as the working alliance between counselor and client that takes the personal dynamics of the counselor and client into consideration alongside the dynamics of the cultures of both of these individuals" (Lee & Park, 2013, p. 5). From this perspective, counseling is a helping intervention and process that defines contextual goals consistent with the life experiences and cultural values of clients, balancing the importance of individualism versus collectivism in assessment, diagnosis, and treatment (Sue & Sue, 2013).

Cultural diversity refers to the spectrum of differences that exists among groups of people with definable and unique cultural backgrounds (Diller, 2011).

Diversity refers to individual differences on a number of variables that place clients at risk for discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic

continued on next page

status (Welfel, 2013). Both multiculturalism and diversity have been politicized in the United States in ways that have often been divisive, but these terms can equally represent positive assets in a pluralistic society.

Cultural pluralism is a perspective that recognizes the complexity of cultures and values the diversity of beliefs and values. Lee and Park (2013) add that "counselors must provide services that help people to solve problems or make decisions in the midst of such sweeping demographic and sociological change" (p. 5).

Cultural diversity competence refers to a practitioner's level of awareness, knowledge, and interpersonal skills needed to function effectively in a pluralistic society and to intervene on behalf of clients from diverse backgrounds (Sue & Sue, 2013).

Cultural empathy pertains to therapists' awareness of clients' worldviews, which are acknowledged in relation to therapists' awareness of their own personal biases (Pedersen, Crethar, & Carlson, 2008).

Culture-centered counseling is a three-stage developmental sequence, from multicultural awareness to knowledge and comprehension to skills and applications. The individual's or group's culture plays a central role in understanding their behavior in context (Pedersen, 2000).

Cultural awareness includes a compassionate and accepting orientation that is based on an understanding of oneself and others within one's culture and context (Crethar & Winterowd, 2012).

Social justice work in counseling involves the empowerment of individuals and family systems to better express their needs as well as to advocate on their behalf to address inequities and injustices they encounter in their community and in society at large (Toporek, Lewis, & Crethar, 2009). Social advocacy addresses issues of equity for members of society who have been marginalized (Ratts, 2009).

Cultural tunnel vision is a perception of reality based on a very limited set of cultural experiences. *Culturally encapsulated counselors* define reality according to a narrow set of cultural assumptions and fail to evaluate other viewpoints, making little attempt to understand and accept the behavior of others.

Globally literate counselors display a cultural curiosity that is characterized by an openness to engaging in new cultural experiences. Global literacy goes beyond tolerance of diverse cultures and worldviews; it promotes mutual respect and understanding (Lee, 2013b).

Stereotypes are oversimplified and uncritical generalizations about individuals who are identified as belonging to a specific group. Such learned expectations can influence how counselors see the client.

Racism is any pattern of behavior that, solely because of race or culture, denies access to opportunities or privileges to members of one racial or cultural group while perpetuating access to opportunities and privileges to members of another racial or cultural group (Ridley, 2005). Racism can operate on individual, interpersonal, and institutional levels, and it can occur intentionally or unintentionally.

Unintentional racism is often subtle, indirect, and outside our conscious awareness; this can be the most damaging and insidious form of racism (Sue, 2005). Practitioners who presume that they are free of any traces of racism seriously underestimate the impact of their own socialization. Whether these biased attitudes are intentional or unintentional, the result is harmful for both individuals and society.

Cultural racism is the belief that one group's history, way of life, religion, values, and traditions are superior to others. This allows for an unequal distribution of power to be justified a priori (Sue, 2005).

Microaggressions are persistent verbal, behavioral, and environmental assaults, insults, and invalidations that often occur subtly and are difficult to identify (Choudhuri et al., 2012). They usually involve demeaning implications and may be perpetrated against others on the basis of their race, gender, sexual orientation, or ability status.

There is some concern about how to refer appropriately to certain racial and ethnic groups as preferred names tend to change. For instance, some alternate names for one group are Hispanic, Latino (Latina), Mexican American, or Chicana (Chicano). Practitioners can show sensitivity to the fact that a name is important by asking their clients how they would like to be identified and by listening for the words clients themselves use.

In our discussions as coauthors and in our classrooms with students, we have debated the pros and cons of including cases that identify specific cultures and issues of difference. Although it is useful to challenge readers to wrestle with cultural specifics, we share a concern with our students that we not perpetuate stereotypes of any specific cultural group. We hope that the benefits of including specific cultural identities in this textbook and case examples helps to facilitate meaningful reflection on complex ethical, legal, clinical, and cultural issues.

On a related note, simply using terms such as *culture, diversity*, and *multicultural* does not mean that we are culturally aware and sensitive. Some are able to use language but find it difficult to put into practice concepts pertaining to diversity. Thoughtful reflection as you examine the issues presented in this chapter may reveal some personal areas for improvement.

THE PROBLEM OF CULTURAL TUNNEL VISION

LO2 Most students come into training knowing only their own culture and may assume that all cultures are basically the same. This can lead to **cultural tunnel vision**, a perception of reality based on a very limited set of cultural experiences. Trainees could unwittingly impose their values on unsuspecting clients by assuming that everyone shares these values. It is essential that students explore their attitudes and fears about people who are different from them. At times, student helpers from privileged backgrounds have expressed the attitude, explicitly or implicitly, that clients from other racial and ethnic groups are unresponsive to professional psychological intervention and lack the motivation to change, which

these student helpers label as "resistance." Students may never stop to think that what they call resistance may be a healthy response on the part of the client to the helper's cultural and theoretical bias.

Students are not alone in their susceptibility to cultural tunnel vision. Ridley (2005) points out that racism has been present in mental health delivery systems for quite some time. Studies from the 1950s to the present have documented enduring patterns of racism in mental health care delivery systems. The impact of racism on various racial groups and the existence of racism in a variety of treatment settings is well documented.

Although some instances of racism in therapeutic settings are overt or blatant, many more instances may be subtle, yet damaging to clients. For instance, some helping professionals fall into the trap of making statements that reveal their reluctance to acknowledge a client's ethnicity. Sue and Sue (2013) regard **color blindness** as a racial microaggression. When a client reports feeling alienated in the workplace because she is the only person of color employed there, a color-blind counselor might minimize her concerns and say, "I think you are being too paranoid. We should emphasize similarities not people's differences" (Sue & Sue, 2013, p. 170). This statement conveys the message that race is not a critical variable that affects people's lives and that it has no sociopolitical relevance. People who say they are color-blind usually are trying to communicate that they do not discriminate and that they treat others equally; however, in doing so, they are ignoring a vital part of that person's identity. The statement "I don't see color" can be interpreted as "I don't see *your* color." The statement gives the impression that those who benefit from racial privilege are closing their eyes to the experiences of others. This notion of color blindness can be extended to dimensions of culture other than race. Whether the result is overlooking a client's gender, sexual orientation, ethnicity, or any other important dimension of their lives, *cultural blindness* will surely detract from one's effectiveness as a helper.

Sue, Capodilupo, Nadal, and Torino (2008) suggest that many White Americans have difficulty acknowledging race-related issues because they stir up guilt feelings about their privileged status and threaten their self-image as moral, fair, and decent human beings. As they point out, "to accept the racial reality of [People of Color] inevitably means confronting one's own unintentional complicity in the perpetuation of racism" (p. 277). Similarly, an American person of color may assume that all White Americans view the world through a privileged status. We need to examine any generalization that rules out differences among groups.

In the 1960s Gilbert Wrenn (1962), one of the pioneers in the counseling profession, characterized a **culturally encapsulated counselor** as having some of the following traits:

- Defines reality according to one set of cultural assumptions
- Shows insensitivity to cultural variations among individuals
- Accepts unreasoned assumptions without proof or ignores proof because that might disconfirm one's assumptions
- Fails to evaluate other viewpoints and makes little attempt to accommodate the behavior of others
- Is trapped in one way of thinking that resists adaptation and rejects alternatives

Years later Wrenn (1985) maintained that cultural encapsulation continues to be a problem for counseling professionals. A good way to begin to develop a multicultural perspective is by becoming more aware of your own culturally learned assumptions, some of which may be culturally biased (Pedersen, 2003). This provides a context for understanding how diverse cultures share common ground and also how to recognize areas of similarity and uniqueness. Pedersen reminds us that the complexity of culture can be viewed as friend rather than foe because it helps us avoid searching for easy answers to hard questions. Pedersen (2008) believes that it is no longer possible for effective counselors to ignore their own cultures or the cultures of their clients through encapsulation. Whether we are aware of it or not, culture controls our lives and defines reality for each of us. Pedersen asserts that cultural factors are an integral part of the helping process and influence the interventions we make with our clients. "Until the multicultural perspective is understood as having positive consequences toward making psychology more rather than less relevant and increasing rather than decreasing the quality of psychology, little real change is likely to occur" (p. 15).

Learning to Address Cultural Pluralism

Cultural pluralism is a perspective that recognizes the complexity of cultures and values the diversity of beliefs and values. To operate as if all our clients are the same is not in accord with reality, and can result in unethical and ineffective practice.

Roysircar (2004) emphasizes the importance of cultural self-awareness, which is captured in the motto, "Therapist, know thy cultural self." Roysircar asserts that therapists' cultural self-awareness is essential for effective and culturally relevant therapy. Chao (2012) adds that counselors who are multiculturally aware but who lack knowledge may have limited knowledge about the cultural context of racially and ethnically diverse clients. On the other hand, she acknowledges that "the converse also holds. Counselors with multicultural knowledge but not awareness may be unaware of their own cultural biases, thus lacking cross-cultural counseling competence" (p. 35)

Lum (2011) maintains that the route to cultural competence begins with an understanding of your own personal and professional cultural awareness. It is critical to develop an understanding of your personal and cultural values and beliefs and to examine your personal assumptions, biases, and values. This awareness can have a direct influence on your practice and your relationships with clients. For example, if you value autonomy and independence, yet have never reflected on or examined your own values, assumptions, and biases, you may inadvertently impose this value on a client who prizes interdependence and collectivism. From Lum's perspective, cultural awareness alone is not sufficient; it is the first step leading to cultural sensitivity and to achieving cultural competence.

Social justice moves beyond cultural awareness and focuses on active support and advocacy, including promoting equality and justice for underserved and oppressed groups of people (Crethar & Winterowd, 2012). Cultural competence involves having an understanding of how social systems operate with respect to the treatment of culturally diverse groups. This entails understanding the impact of systemic forces such as racism, sexism, heterosexism, classism, and ableism on the psychosocial development of individuals (Lee & Park, 2013).

Lee (2013b) makes a case for becoming a globally literate person, "a lifelong process that is rooted in a commitment to living one's life in a manner that makes cultural diversity a core principle.... Embracing a globally literate lifestyle also involves a commitment to social justice and social responsibility" (p. 311). Globally literate counselors are committed to expanding their comfort zone throughout their careers. Lee emphasizes that global literacy is not mainly learned in the classroom; rather, it is "the result of one's attempt to become a lifelong student of cultural diversity and a true citizen of the world" (p. 312). This concept is in stark contrast to counselors who are culturally encapsulated and believe that their culture represents the "best way" to live.

THE CHALLENGES OF REACHING DIVERSE CLIENT POPULATIONS

The multicultural counseling competencies developed by the Association for Multicultural Counseling and Development (Roysircar et al., 2003) provide a framework for the effective delivery of services to diverse client populations. Another useful resource is the APA's (1993) "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations." The APA's guidelines challenge practitioners to respect the roles of family members and the community structures, hierarchies, values, and beliefs that are an integral part of the client's culture. Providers should identify resources in the client's family and the larger community and use them in delivering culturally sensitive services. For example, an entire Native American family may come to a clinic to provide support for an individual in distress because many of the healing practices found in Native American communities are centered on the family and the community.

Psychology has traditionally been based on Western assumptions, which have not always considered the influence and impact of racial and cultural socialization (APA, 2003a). Many clients have come to distrust helpers associated with the establishment or with social service agencies because of a history of unequal treatment. Clients from oppressed groups may be slow to form trusting relationships with counselors, and mental health professionals may have difficulty identifying with these clients if they ignore the history behind this distrust. Helpers from all cultural groups need to honestly examine their own assumptions, expectations, and attitudes about the helping process.

The medical model of clinical counseling often is not a good fit for people of lower socioeconomic status. Child care and transportation difficulties are insurmountable economic barriers for many. In addition, taking time off from work for medical appointments may mean loss of pay. Therapists must be willing to go outside of the office to deliver services in the community. Home-based therapy has been used extensively with ethnic minority clients and families, mainly because many people in the community do not trust traditional mental health professionals (Zur, 2008). Zur comments that making a home visit with these clients can be a way to get a firsthand view of their home, rituals, neighborhood, community, and support system. Going outside the office can decrease suspicion and enhance trust. Delivering helping services in nontraditional ways is discussed in detail in Chapter 13.

Sometimes cultural traditions contribute to the underutilization of traditional psychotherapeutic services by clients from diverse groups. Cultural beliefs and norms may stop some people from seeking professional help when faced with a problem. Consider Kenji's experience of being torn between marrying a person selected by his parents and marrying a woman of his choice. He might first look for a solution within himself through contemplation. If he were unable to resolve his dilemma, he might seek assistance from a family member or from a religious or spiritual adviser. Then he might look to some of his friends for advice and support in making the best decision. If none of these approaches resulted in a satisfactory resolution of his problem, Kenji might then reach outside his cultural community for an "outside expert" as a last resort. The fact that he did not seek counseling services sooner has little to do with resistance or with insensitivity on the part of counselors; Kenji was following a route congruent with his cultural background.

Some argue that ethnic minority clients who use counseling resources may lose their cultural values in the process. Some culturally encapsulated helpers mistakenly assume that a lack of assertiveness is a sign of dysfunctional behavior that should be changed. Labeling this behavior dysfunctional reflects the counselor's value orientation, and may also result in microaggressions. Practitioners need to consider whether passivity is a problem from the client's culturally learned perspective and whether assertiveness is a useful behavior that the client hopes to acquire.

ETHICS CODES FROM A DIVERSITY PERSPECTIVE

LO3

Most ethics codes mention the practitioner's responsibility to recognize the special needs of diverse client populations. Gallardo, Johnson, Parham, and Carter (2009) develop the theme that integrating culturally responsive practices with more traditional models of therapy is of major importance when we consider the diverse client populations that mental health professionals serve. They add that it is not enough for therapists to simply practice within the framework of the ethics codes. Gallardo and colleagues take the position "that if we begin with a cultural framework at the outset, the lens by which we view our ethics codes, and minimum standards, also evolves to more accurately reflect the cultural realities inherent in our services" (p. 427). Culture influences every facet of our existence, so it is essential that culturally responsive practice be central in all that we do. "It is important that as a profession we recognize that our ethics code requires us to be competent with all those with whom we work therapeutically and that it is our professional responsibility to maintain the competencies and knowledge needed to do so. In failing to meet this standard, we are failing to meet our ethical and cultural responsibility as practitioners" (p. 429).

Take the time to review the ethics codes of one or more professional organizations to determine for yourself the degree to which such codes take multicultural dimensions into account. Then consider how you could increase your multicultural competencies beyond what is suggested by these codes. The Ethics Codes box titled "Addressing Diversity" provides an overview of how the various codes address these issues.

Addressing Diversity

The **Canadian Counselling and Psychotherapy Association's** (2007) code of ethics calls for members to respect diversity.

> Counselors actively work to understand the diverse cultural background of the clients with whom they work, and do not condone or engage in discrimination based on age, color, culture, ethnicity, disability, gender, religion, sexual orientation, marital, or socio-economic status. (B.9.)

In the Preamble of the **Code of Professional Ethics for Rehabilitation Counselors** (CRCC, 2010), the following statement recognizes the value of diversity:

> Rehabilitation counselors are committed to facilitating the personal, social, and economic independence of individuals with disabilities. In fulfilling this commitment, rehabilitation counselors recognize diversity and embrace a cultural approach in support of the worth, dignity, potential, and uniqueness of individuals with disabilities within their social and cultural context. They look to professional values as an important way of living out an ethical commitment.

The **Ethical Standards for School Counselors** (ASCA, 2010) offers the following guideline regarding the social justice mandate:

> Professional school counselors monitor and expand personal multicultural and social justice advocacy awareness, knowledge and skills. School counselors strive for exemplary cultural competence by ensuring personal beliefs or values are not imposed on students or other stakeholders. (E.2.a.)

School counselors are also expected to possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and professionally.

In the **NASW *Code of Ethics*** (2008), cultural competence and recognition of social diversity are clearly linked to ethical practice. Here are two relevant guidelines:

> Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups. (1.05.b.)

> Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. (1.05.c.)

The **APA** (2010) ethics code indicates that part of competence implies understanding diversity:

> 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. (2.01.b.)

The ACA (2014) ethics code infuses issues of multiculturalism and diversity throughout the document, including sections dealing with the counseling relationship, informed consent, bartering, accepting gifts, confidentiality and privacy, professional responsibility, assessment and diagnosis, supervision, and education and training programs.

> Multicultural/Diversity Considerations: Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared. (B.1.a.)

CULTURAL VALUES AND ASSUMPTIONS IN THERAPY

LO4 Cultural conflicts sometimes occur between the values inherent in traditional approaches to counseling and the values of culturally diverse groups. Counselors who operate from culturally biased views of mental health and who use intervention strategies that are not congruent with the values of culturally diverse people perpetuate forms of injustice and institutional racism (Duran et al., 2008).

Chung and Bemak (2012) believe clinicians must be willing to redefine their professional roles and adapt their practices to better suit the client's worldview, life experiences, and cultural identity. "Western skills, techniques, interventions, models, and theories need to be aligned to be culturally sensitive" (p. 72). Chung and Bemak also contend that counselors cannot ignore the impact of racism, sexism, and other forms of discrimination and oppression on the well-being of their clients, nor the negative impact these "isms" may have on families and communities. Ivey, D'Andrea, and Ivey (2012) state that traditional approaches to counseling theory and skills may be inappropriate and ineffective with some groups. Special attention must be given to how socioeconomic factors, sexism, heterosexism, and racism influence a client's worldview. Ivey and colleagues note that traditional counseling strategies are being adapted for use in a more culturally respectful manner. In working with diverse clients, mental health professionals need to expand their perception of mental health practices to include support systems such as family, friends, community, self-help programs, and occupational networks.

Cultural differences are real, and they influence all human interactions (Lee & Park, 2013). Clinicians may misunderstand clients of a different sex, race, ethnicity, age, social class, or sexual orientation. If practitioners fail to integrate these diversity factors into their practice, they are infringing on the client's cultural autonomy and basic human rights. Without awareness, the counselor's ability to be helpful is impaired. For instance, a clinician may misinterpret a client's close relationships with extended family members to be indicative of enmeshment and pathologize her behavior as being overly dependent. Ethical practice requires that practitioners be trained to address diversity factors when they become relevant in the therapy process. In the cases that follow, the therapists impose their values in ways that significantly detracted from the value of therapy and may have resulted in significant harm to the clients. The imposition of values can be transparent—as in these cases—or more subtle, but in both cases it is unethical.

The case of Hanh

Stacy is a high school counselor. A Vietnamese student, Hanh, is assigned to her because of academic difficulties. Stacy observes that Hanh is slow and deliberate in his conversational style, and she immediately assigns him to a remedial speech class. In the course of their conversations, Hanh discloses to Stacy that his father wants him to apply to college and major in pre-med. Hanh is not sure that he even wants to attend college. Stacy gives Hanh a homework assignment, asking him to tell his father that he no longer wants to pursue college plans and wants to follow a direction that appeals to him.

- Was the fact that Hanh spoke slowly and deliberately an indication that he needed a remedial speech class? Can you offer other explanations for Hanh's slow and deliberate speech?
- If you were Hanh's therapist, how would you deal with the conflict between Hanh's goals and his father's expectations?
- Was Stacy culturally sensitive when asking Hanh to directly confront his father? What other alternatives were available?
- Was Stacy too quick in making her assessments, considering that Hanh was sent to the school counselor by a teacher? Would it have made a difference if he had come voluntarily for guidance?
- Would you recommend family counseling? If so, how would you present this to Hanh and his parents?
- How would the ethics code guidelines on diversity influence your approach to working with Hanh?

Commentary. When there is a cultural difference between the counselor and client, counselors must familiarize themselves with how the client approaches counseling and avoid imposing their worldview on the client. Although we hope the counselor would explore with Hanh his choice of a major in college and the conflict with his father over his educational and career plans, it is inappropriate for the counselor to tell Hanh what to do. Suggesting that Hanh directly confront his father has serious implications; Hanh's father may never speak to him again if Hanh is confrontational. Our assessment skills need to encompass the cultural context and the consequences of proposed interventions on the client's life.

The case of Cynthia

Sage has recently set up a private practice in a culturally mixed neighborhood. Cynthia comes to Sage for counseling. Cynthia is depressed, feels that life has little meaning, and feels enslaved by the needs of her husband and small children. When Sage asks about any recent events that could be contributing to her depression, she tells him that she has discussed with her husband her desire to return to school and pursue a career of her choosing. Her husband threatened a divorce if she followed through with her plans. Cynthia then consulted with her pastor, who pointed out her obligations to her family. Sage is aware of his own cultural biases, which include a strong commitment to family and to the role of the man as the head of the household. Although he feels empathy for Cynthia's struggle, he persuades her to postpone her own aspirations until her children have grown up. She agrees to this because she feels guilty about asserting her own needs, and she is also fearful of being left alone. Sage then works with her to find other ways to add meaning to her life that would not have such a dramatic impact on the family.

- List the potential gender and cultural issues in this case. How might you have addressed each of them?
- Sage did not explore the lack of meaning in Cynthia's life until after he persuaded her to give up her aspirations. What ethical issue does this raise?
- If Cynthia had shared Sage's family values, would his approach have been appropriate?
- How would the ethics code guidelines on diversity influence your approach to working with Cynthia?

Commentary. Cynthia spoke with two significant people regarding her aspirations, and both of them rejected her goals. The therapist also ignored her aspirations. A more ethical approach would be to provide a supportive environment in which Cynthia could explore her struggles without the therapist imposing his agenda on her. Cynthia should not feel pressured to adopt the therapist's value system, nor let her actions be determined by her need to please the therapist. Sage's ethical duty is to listen to Cynthia's aspirations without judgment and to respect her struggle in her journey toward finding her own answers.

Individualistic Versus Collectivistic Cultural Values

Writers in the field of multicultural counseling allege that most contemporary theories of therapy and therapeutic practices are grounded in individualistic assumptions frequently associated with the values of mainstream U.S. culture (Duran et al., 2008; Sue & Sue, 2013). These values include autonomy, self-determination, and becoming your own person. According to Johnson, Barnett, Elman, Forrest, and Kaslow (2012), Western cultures tend to promote independent models of the self that emphasize personal control and the preeminence of individual rights and responsibilities. Feminist and multicultural scholars are critical of this model and emphasize the salience of mutual interdependence, connection to others, communal responsibilities, and emotional responsiveness in leading a moral life. The broader social contexts of families, groups, and communities are often important to clients who value the interdependent self more than the independent self. Duran and colleagues (2008) claim that Western (individualistic) counseling interventions have at times been used to promote social control and conformity rather than the psychological well-being of people in diverse groups: "The counseling profession has not had the humility to critically assess the depths of the culturally biased nature of its helping methods nor the negative outcomes that commonly ensue from imposing Western helping theories and practices among clients from diverse groups and backgrounds" (p. 290).

Practitioners who draw from any of the contemporary therapeutic models would do well to reflect on the underlying values of their theoretical orientation. Many of the therapy systems reflect core value orientations of mainstream American culture. Hogan (2013) characterizes these underlying values as emphasizing the patriarchal

nuclear family; keeping busy; measurable and visible accomplishments; individual choice, responsibility, and achievement; self-reliance and self-motivation; change and novel ideas; competition; direct communication; materialism; and equality, informality, and fair play. The degree to which these value orientations fit clients from other cultures needs to be carefully considered by practitioners.

Challenging Stereotypical Beliefs and Cultural Bias

Counselors may think they are not culturally biased, yet may continue to hold stereotypical beliefs and cultural biases that could affect their practice. Some examples include these statements: "Failure to change stems from a lack of motivation." "People have choices, and it is up to them to change their lives." To assume that what people lack is motivation is simplistic and judgmental and does not encourage exploration of their struggles. Furthermore, many people do not have a wide range of choices due to environmental factors beyond their control.

Practitioners who counsel persons in diverse groups without an awareness of their own stereotypical beliefs, cultural biases, and faulty assumptions can cause harm to their clients. Therapists not trained in addiction treatment can bring harm to their clients dealing with substance abuse due to the therapists' faulty assumptions and misconceptions. One of these assumptions is that willpower alone is sufficient to change a person's life. Cross-culturally competent practice requires that mental health practitioners be aware of the unique cultural realities of their clients. Culturally competent counselors are engaged in an aspirational practice, and they realize that they can never say that they have arrived at a final state of competency. Ethical practice implies that counselors actively deal with attitudinal barriers. The *Code of Professional Ethics for Rehabilitation Counselors* (CRCC, 2010) identifies advocacy as a part of ethical practice:

> In direct service with the client, rehabilitation counselors address attitudinal barriers, including stereotyping and discrimination, toward individuals with disabilities. They increase their own awareness and sensitivity to individuals with disabilities. (C.1.a.)

Reflect on these issues as you consider the following case example.

The case of Claudine

Claudine takes over as director of a clinic that has a large percentage of Latin American immigrants as clients. At a staff meeting she sums up her philosophy of counseling in this fashion: "People come to counseling to begin change or because they are already in the process of change. Our purpose is to challenge them to continue their change. This holds true whether the client is Euro-American, Latin American, or from another cultural group. If clients are slow to speak, our job is to challenge them to speak, because the expectation in the dominant culture is that people deal with problems through talking. Silence may be appropriate in the Latin American culture, but it does not work in this culture. The sooner clients learn this, the better off they are."

- To what extent do you agree or disagree with Claudine's assumptions, and why?
- What biases or privileges do you think Claudine holds that might contribute to her point of view?
- What values are reflected in Claudine's statement?
- If you worked with Claudine, would you be inclined to challenge her statements? If so, what would you say to her?

Commentary. Pedersen (2000) would say that Claudine is a culturally encapsulated counselor because she is defining everyone's reality according to her own cultural assumptions and values. She is minimizing cultural differences by imposing her own standards as criteria for judging the behavior of others. In defense of Claudine, there is some truth in her premise regarding a counselor's role in challenging a client to change. However, the key point is that therapists need to first understand the worldview of their clients and then invite them to decide on change that is congruent with their own values and goals.

Examining Some Common Assumptions

Unexamined assumptions can be harmful to clients, especially assumptions based on one's own cultural biases. What is good for one is not good for all. Becoming a culturally competent clinician involves acknowledging that we bring our cultural biases, assumptions, stereotypes, and life experiences to our work with clients. When we are helped to recognize our cultural biases and assumptions, we are less likely to act against the best interests of clients from diverse groups and backgrounds. Crethar and Winterowd (2012) show how counselors with a *social justice orientation* are aware of their assumptions and how these views influence the therapeutic process:

> When counselors work from the assumption that their clients have the same needs, desires, values, and perspectives as they do, they are likely to make errors based on differences in culture and context. Counselors with multicultural competence take the time to co-develop goals with clients and their communities that prioritize the clients' values, culture, and context. Goals and therapeutic approaches that emerge as a result of such collaboration ultimately serve clients best. (pp. 5–6)

Ivey, D'Andrea, and Ivey (2012) state that it is crucial for counselors to become aware of and to examine how power and privilege operate in the counseling relationship. Certain groups have more privileges and entitlements than others; examples include White, male, and middle-class privilege. It is important to examine the economic privilege that we may have as counselors that can prevent us from fully understanding the everyday struggles and worldviews of clients who are from lower socioeconomic backgrounds. People who face homelessness, poverty, and extreme financial burdens are often filled with feelings of shame and are the recipients of judgment, ridicule, and blame in society. Counselors from more affluent segments of society may fail to account for these salient issues for clients struggling with severe economic conditions. A counselor's economic privilege might lead to misunderstanding in the following ways:

- Labeling clients as resistant or unmotivated if they are not able to arrive for appointments on time, are absent from sessions, or are unable to pay for sessions
- Challenging clients to take steps to improve their economic conditions without addressing or validating sociocultural restrictions that affect a client's disadvantaged position in society
- Assuming clients from lower socioeconomic status groups are less intelligent, less effective as parents, or less educated

Gerald Monk (2013), who works with counselor trainees in community settings, says "it is easy to overlook the constraining social factors that affect our clients pertaining to class and socioeconomic status" (p. 105). It is crucial that trainees acknowledge their privileged background, monitor how their own socioeconomic status differs from that of their clients, and become aware of how this difference affects the therapeutic relationship. Monk tells his economically privileged students that being privileged is not wrong. The key issue is not *being* privileged, but how this privilege is *used*. He states: "Our trainee therapists need to develop a consciousness of their own social class influences and refrain from imposing their own class-related assumptions on their clients' particular life challenges" (p. 105).

The following sections examine some commonly held beliefs and assumptions about the therapeutic environment that have implications for effectively working with clients from diverse cultural backgrounds.

ASSUMPTIONS ABOUT SELF-DISCLOSURE. Therapists may assume that clients will be ready to talk about their intimate personal issues, or that self-disclosure is essential for the therapeutic process to work. Sue and Sue (2013) point out that most forms of contemporary therapy place value on one's ability to self-disclose by sharing intimate personal material. The assumption is that self-disclosure is a characteristic of a healthy personality. The converse is that individuals who are reluctant to self-disclose in therapy possess negative traits such as being guarded and mistrustful. However, it is unacceptable in some cultures to reveal personal problems because it not only reflects on the person individually but also on the whole family. Some clients may view self-disclosure and interpersonal warmth as inappropriate in a professional relationship with an authority figure (Barnett & Johnson, 2010). There are strong pressures on many Asian American clients not to reveal personal concerns to strangers or outsiders. Similar pressures have been reported for Latino, American Indian, and African American clients, as well as those from various other cultures. Therapists need to realize that cultural forces may be operating when clients are slow to disclose personal details. Indeed, for many clients it seems strange, and even absurd, for them to talk about themselves personally to a professional therapist whom they do not know. This is illustrated in Alberto's case.

The case of Alberto

Alberto, a Latino client, comes to a community college counseling center on the recommendation of his physician, who found no organic basis for his symptoms of depression, chronic sleep disturbance, and the imminent threat of failing his classes. As you begin your initial session with Alberto, you recognize that he is extremely guarded, revealing little about himself or how he is feeling. You believe that self-disclosure and openness to the expression of feelings are necessary for change to occur. In trying to help Alberto, you challenge him to be more self-disclosing.

- To what areas of your client's sense of privacy and culture might you want to be sensitive?
- If you were to encourage Alberto to be more self-disclosing, what possible consequences might there be in his outside life? Explain.
- In reviewing your interventions, in what ways do they reflect, or not reflect, an understanding of the importance of extended family in Alberto's culture?
- Can you think of some reasons Alberto's cautiousness may be more adaptive than maladaptive?

Commentary. It is important not to pathologize a client who is cautious during the early phase of therapy. Be aware of and respect the differences that exist among different cultures and people in establishing trust, especially in the beginning of a therapeutic relationship. For some, it is very foreign to speak to a stranger without first developing a rapport with the person. Some clients have a greater need than others to develop a relationship with a therapist before they make themselves vulnerable. The fact that Alberto followed through on his physician's recommendation is a sign that he is open to help, and your task is to provide the structure that allows him to feel safe enough to express his concerns. It would be especially useful for you to explain to Alberto how the therapeutic process works. The case of Alberto reminds us that counselors must ensure their own competence—in this case cultural competence—before launching into therapy work with culturally different clients.

The case of Lily

Lily, a licensed counselor, has come to work in a family-life center that deals with many immigrant families. She often reacts impatiently with the pace of her clients' disclosures. Lily decides to teach her clients by modeling for them. With one of her reticent couples she says: "My husband and I fight and disagree a lot. We express our feelings openly and clear the air. In fact, several years ago my husband had an affair, which put our relationship into turmoil. I believe it was my ability to vent my anger and express my hurt that allowed me to work through this terrible event."

- How do you evaluate Lily's self-disclosure? Would such a disclosure be useful to you if you were her client?
- Would you be inclined to make a similar type of disclosure to your clients? Why or why not?
- In your opinion, is such a disclosure ever appropriate? Why or why not?
- What values are being imposed on Lily's clients? How might they react to or interpret her self-disclosure?

Commentary. Therapist self-disclosure can serve a therapeutic purpose, but the client's needs and concerns should guide such disclosures. Self-disclosure that is done for the benefit of the therapist, that burdens the client with unnecessary information, or that creates a role reversal where a client takes care of the therapist can be considered a boundary violation (Zur, 2009). Self-disclosure should never be used to meet the clinician's personal needs at the expense of the client's treatment needs. In this case, without taking the time to really know her clients, Lily burdened them with self-disclosures in her impatience and her rush to find a solution. Lily's disclosure seems designed to justify her own behavior rather than to help her culturally different client couple.

ASSUMPTIONS ABOUT DIRECTNESS AND RESPECT. Traditional therapeutic approaches tend to stress directness and assertiveness, yet in some cultures directness is perceived as rudeness and something to be avoided. Americans generally want to get to the "bottom line" and tend to get impatient when that does not happen. People from many cultures value less direct styles of communication. For example, Latinos engage in "plática" (small talk) before beginning to address their concerns. The counselor could assume that this lack of directness is evidence of pathology, or at least a lack of assertiveness, rather than a sign of respect. Many Asian Americans, Latinos, and Native Americans have been brought up not to speak until spoken to, especially when they are with the elderly or with authority figures. A counselor may interpret the client's hesitancy to speak as resistance when it is really a sign of respect.

If therapists cannot connect to clients using the techniques in which they were trained, it is incumbent on them to find other ways to connect with their clients. Simply put, when therapists have trouble understanding and working with a client, the client is not the problem. The problem rests with the therapist's inability to come up with a way to facilitate the client's exploration of his or her problem. Consulting with a colleague who is familiar with the client's culture may provide a new perspective on why the client is reticent to talk. The case of Miguel provides another example of a therapist's assumptions about directness.

The case of Miguel

Miguel, a Latino born in the United States, has completed his PhD and is working at a community clinic in family therapy. In his training he has learned about the concepts of directness, assertiveness, and triangulation (the tendency of two persons who are in conflict to involve a third person in their emotional system to reduce the stress). Miguel is watching for evidence of these tendencies. While he is counseling a Latino family, the father says to his son, "Your mother expects you to show her more respect than you do and to obey her." Miguel says to the mother, "Can you say this directly to your son rather than allowing your husband to speak for you?" The room falls silent, and there is great discomfort.

- What might account for the discomfort in the room?
- How could Miguel have handled this situation differently?
- What were Miguel's assumptions?

Commentary. As with many vignettes in this book, we cannot emphasize enough the need for cultural sensitivity. The "great discomfort in the room" was evidence that something had gone astray. To intervene in a respectful and helpful way, Miguel could have begun by acknowledging the patriarchal communication mode common to many Latino families. By asking the mother to directly address the son, Miguel reduced the father's role in a way that was culturally inappropriate. By focusing on the variables of directness and triangulation, Miguel missed other aspects of the moment. His intervention was ill timed because he had not established a strong connection with the family. Miguel's response to what occurred in this session could be the deciding factor in whether the family returns for another session.

Clinicians may assume that being assertive is better than being nonassertive and that clients are better off if they can tell people directly what they think and what they want. However, every culture deals with interpersonal situations in a unique way. It is critical to recognize that there are different perspectives on the value of being direct and assertive; therapists should avoid assuming that assertive behavior is the norm and is desirable for everyone.

ASSUMPTIONS ABOUT SELF-ACTUALIZATION AND TRUSTING RELATIONSHIPS. Many mental health professionals assume that it is important for the individual to become a self-actualizing person. Counselors may focus on self-actualization for the individual without regard for the impact of the individual's change on the significant people in that person's life or the impact of those significant people on the client. A creative synthesis between self-actualization and responsibility to the group may be a more realistic goal for many clients.

Another assumption pertains to the quality of the personal relationship between therapist and client. Americans tend to talk more readily about their personal lives than do those in other cultures. This characteristic is reflected in most therapeutic approaches. Although clinicians expect some resistance or reluctance, they assume that clients will eventually be willing to explore personal issues. In many cultures this kind of a relationship takes a long time to develop.

ASSUMPTIONS ABOUT NONVERBAL BEHAVIOR. Many cultural expressions are subject to misinterpretation, including appropriate personal space, eye contact, handshaking, dress, formality of greeting, perspective on time, and so forth. People from Western countries often feel uncomfortable with periods of silence and tend to talk to ease their tension. In some cultures silence may be a sign of respect and politeness rather than a lack of a desire to continue to speak. Silence may be a reflection of fear or confusion, or it may be a cautious expression and reluctance to do what the counselor is expecting of the client.

Students in the helping professions are often systematically trained in a range of microskills that include attending, open communication, observation, hearing clients accurately, noting and reflecting feelings, and selecting and structuring, to mention a few (Ivey, Ivey, & Zalaquett, 2014). Although these behaviors are aimed at creating a positive therapeutic relationship, individuals from certain ethnic groups may have difficulty responding positively or understanding the intent of the counselor's instructions and behavior. The counselor whose confrontational style involves direct eye contact, physical gestures, and probing personal questions could be seen as intrusive by clients from another culture.

As we mentioned earlier, in some cultures direct eye contact is considered a sign of interest and presence, and a lack thereof can be viewed as being evasive. However, in any culture an individual may maintain more eye contact while listening and less while talking. Research indicates that some African Americans may reverse this pattern by looking more when talking and looking slightly less when listening. Among some Native American and Latino groups, eye contact by the young is a sign of disrespect. Some cultural groups generally avoid eye contact when talking about serious subjects (Ivey & Ivey, 1999; Ivey et al., 2014). Clinicians need to acquire

sensitivity to cultural differences to reduce the probability of miscommunication, misdiagnosis, and misinterpretation of behavior.

A PERSONAL CASE HISTORY. Some time ago Marianne Corey and Jerry Corey conducted a training workshop with counselors from Mexico. Marianne was perceived by a male participant as being too direct and assertive. He had difficulty with Marianne's active leadership style and indicated that it was her place to defer to Jerry by letting him take the lead. Recognizing and respecting our cultural differences, we were able to arrive at a mutual understanding of different values.

Jerry had difficulty with the participants showing up after the scheduled time and had to accept the fact that we could not follow a strict time schedule. Typically we have thought that if people were late or missed a session, group cohesion would be difficult to maintain. Because the issue was openly discussed in this situation, however, the problem did not arise. We quickly learned that we had to adapt ourselves to the participants' view of time and they to us as well. To insist on interpreting such behavior as resistance would have been to ignore the cultural context.

ADDRESSING SEXUAL ORIENTATION

LO5 Most of the previous discussion on multiculturalism has focused on issues of culture and ethnicity. However, the concept of human diversity encompasses much more than racial and ethnic factors; it encompasses all forms of oppression, discrimination, and prejudice, including those directed toward age, gender, ability, religious affiliation, and sexual orientation. In 1973 the American Psychiatric Association stopped labeling **homosexuality**, a sexual orientation in which people seek emotional and sexual relationships with same-gendered individuals, as a form of mental illness. In 1975 the American Psychological Association endorsed this move by recommending that psychologists actively work to remove the stigma that had been attached to homosexuality. Along with these changes came the assumption that therapeutic practices would be modified to reflect this viewpoint: The mental health system had finally begun to treat the *problems* of gay, lesbian, bisexual, and transgender people rather than treating *them* as the problem.

The ethics codes of the ACA (2014), the APA (2010), the AAMFT (2012), the CAMFT (2011a), the CCPA (2007), the CRCC (2010), and the NASW (2008) clearly state that **discrimination**, or behaving differently and usually unfairly toward a specific group of people, is unethical and unacceptable. As an example of a nondiscrimination policy, consider this standard of the *Code of Professional Ethics for Rehabilitation Counselors* (CRCC, 2010):

> Rehabilitation counselors do not condone or engage in discrimination based on age, color, culture, disability, ethnicity, gender, gender identity, race, national origin, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law. (A.2.b.)

As more states enact laws that permit same-sex marriage, the voices of those critical of unions between same-sex couples are increasingly strident. Many gay and lesbian people internalize these negative societal messages and experience psychological pain and conflict because of this (Schreier, Davis, & Rodolfa, 2005). Therapists are faced with various clinical and ethical issues in working with **lesbian**, **gay**, **bisexual**, and **transgender** (LGBT) people, and this work needs to include a recognition of the societal factors that contribute to oppression and discrimination based on sexual orientation or gender identity.

One of these ethical issues involves therapists confronting their own values regarding same-sex or bisexual desire and behavior. Working with lesbian, gay, bisexual, and transgender individuals presents a challenge to mental health providers who hold strong personal values regarding sexual orientation and gender identity. According to Graham, Carney, and Kluck (2012), "the increased rate at which LGB clients use counseling services means that counselors will likely have LGB clients, whether they are aware of it or not" (p. 2). Given the current sociopolitical climate, some LGBT clients may not feel comfortable disclosing their sexual orientation. Mental health professionals who have negative reactions to gay, lesbian, bisexual, and transgender people may be inclined to impose their own values and attitudes, or at least to convey strong disapproval. Smith, Shin, and Officer (2012) note that mental health professionals may inadvertently perpetuate oppression, especially in the use of language. "The power in language to shape and produce phenomena means that counselors and counseling psychologists should continually scrutinize and deconstruct language that inhibits the health and wellness of our clients" (p. 400).

Schreier, Davis, and Rodolfa (2005) remind us that no one is exempt from the influence of societal negative stereotyping, prejudice, and even hatefulness toward LGBT people. Schreier and colleagues add that negative personal reactions, limited empathy, and lack of understanding are common characteristics in therapists who work with LGBT clients. Before clinical practitioners can change their therapeutic strategies, they must change their assumptions and attitudes toward the sexual orientation of others. Unless helpers become conscious of their own assumptions and possible countertransference, they may project their misconceptions and their fears onto their clients. Therapists are challenged to confront these personal prejudices, myths, fears, and stereotypes regarding sexual orientation. This is particularly important when a client discloses his or her sexual orientation well into an established therapeutic relationship. In such situations prejudicial, judgmental attitudes and behaviors on the part of the therapist can do serious damage to the client. We highlight this topic because it illustrates not only the ethical problems involved in imposing values but also the problems involved in effectively addressing the mental health concerns of gay, lesbian, bisexual, and transgender clients.

Heterosexism is a worldview and a value system that can undermine the healthy functioning of the sexual orientations, gender identities, and behaviors of lesbian, gay, bisexual, and transgender individuals. Practitioners need to understand that heterosexism pervades the social and cultural foundations of many institutions and often contributes to negative attitudes toward people who are not heterosexual or do not meet the socially accepted standards of stereotypical gender roles and behaviors.

The American Psychological Association's Division 44 (APA, 2000) has developed a set of specialty guidelines for psychotherapy with lesbian, gay, and bisexual clients that prohibit unfair discrimination based on sexual orientation. These guidelines affirm that a psychologist's role is to acknowledge how societal stigma affects clients and addresses four main areas of understanding: (1) attitudes toward LGB people

and sexual orientation issues, (2) relationships and family concerns, (3) the complex diversity within the LGB community, and (4) the training and education needed to work effectively with this client population.

A therapist who works with lesbian, gay, bisexual, and transgender people has a responsibility to understand the special concerns of these individuals and is ethically obligated to develop the knowledge and skills to competently deliver services to them. One study examined graduate counseling students' perceived competence in working with LGB clients (Graham et al., 2012). Among the 234 master's-level and doctoral-level participants who completed the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005), a pattern emerged revealing that participants felt most competent in the awareness domain and least competent in the skills domain. The results also demonstrated that "increased level of training (doctoral versus master's), number of LGB clients seen in practica, and attendance at LGB-focused workshops and conferences were associated with increased competence" (p. 2).

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC, 2008) has developed a set of competencies for counselors in training to help them examine their personal biases and values pertaining to sexual orientation. Competent counselors will develop appropriate intervention strategies that ensure effective service delivery. Among the specific competencies listed are the following:

- Competent counselors recognize the societal prejudice and discrimination experienced by LGBT individuals and assist them in overcoming internalized negative attitudes toward their sexual and gender identities.
- Counselors strive to understand how their own sexual orientation and gender identity influences the counseling process.
- Counselors seek consultation or supervision to ensure that their own biases or knowledge deficits do not negatively influence their relationships with LGBT clients.
- Counselors understand that attempting to change the sexual orientation or gender identity of LGBT clients may be detrimental, and further, such a practice is not supported by research and therefore should not be undertaken.

The ALGBTIC (2009) has also developed competencies geared toward counselors who work with transgender individuals, families, groups, or communities. These competencies are based on a wellness, resilience, and strength-based approach. The authors who developed the *Competencies for Counseling with Transgender Clients* believe counselors are in a unique position to make institutional change that can result in a safer environment for transgender people. This begins with counselors creating a welcoming and affirming environment for transgender individuals and their loved ones. Counselors must respect and attend to the whole individual, and should not simply focus on gender identity issues. Counselors who work with transgender people are expected to seek professional development opportunities to enhance their knowledge and skills related to their clients. For a complete list of the specific competencies in working with transgender individuals, see ALGBTIC (2009).

One way to increase your awareness of ethical and therapeutic considerations in working with LGBT clients is to take advantage of continuing education workshops sponsored by national, regional, state, and local professional organizations. By participating in such workshops, you can learn about specific interventions and strategies that are appropriate for LGBT clients. From an advocacy perspective, it is important to familiarize yourself with LGBT resources in your local community. You may not know the sexual orientation of a client until the therapeutic relationship develops, so even if you do not plan to work with an LGBT population, you need to have a clear idea of your own assumptions, attitudes, and values relative to this issue.

The ALGBTIC (2008) competencies have relevance to all mental health professionals. Consider these questions:

- Do you hold any specific attitudes, beliefs, assumptions, and values that could interfere with your ability to effectively counsel lesbian, gay, bisexual, and transgender clients?
- What competencies do you most need to develop in working effectively with sexual orientation and gender identity issues?
- How would you react, if after three months into the therapeutic relationship, you learned that your client was attracted to same-sex partners?
- How comfortable are you counseling a same-sex couple who want to explore their difficulties in the area of sexuality and intimacy?
- To what degree are you familiar with the specific issues of discrimination facing many LBGT persons?
- What steps can you take to learn more about the LGBT community and mental health issues that pertain to this group?

The Role of Counselor Educators and Therapists in Challenging "Isms"

In our profession it is not uncommon to have multiple professional identities, such as therapist, consultant, and educator. On occasion these roles are blended, and at other times we wear only one professional hat at a time. As agents of social change, we work hard to prevent and reduce prejudice in many forms. In our work as counselor educators, we take an active role in challenging students around their "isms" for the purpose of making them more effective counselors.

As clinicians, however, we encounter clients who express racist, sexist, and homophobic remarks, but we do not automatically challenge these statements. We have to ask ourselves whether it is within our role as counselors to challenge clients beliefs and to share our reactions of feeling offended. Is this a reflection of our own agenda and not that of our clients'? We do not aspire to always keep these roles completely separate, but as counselors we have a responsibility to examine with great thoughtfulness our intentions, our actions, and their consequences for our clients.

Sometimes it is beneficial to draw attention to a client's prejudicial beliefs in the context of the issues the client is working on in treatment. For example, when counseling a woman on her rigid thinking, we were able to connect her racist remarks to an all-or-nothing way of seeing the world and others. This connection helped the client increase her awareness of how this contributed to her relational difficulties. In another instance, when working with middle school children, we were able to use their discriminatory remarks as a catalyst for a discussion on difference, empathy, and

power. What roles or professional identities do you hold that you think would be difficult for you to lay aside in the face of a value clash?

Value Issues of Gay, Lesbian, Bisexual, and Transgender Clients

Like any other oppressed group, lesbians, gay men, bisexuals, and transgender individuals experience discrimination, prejudice, and oppression when they seek employment or a place of residence. But lesbian, gay, bisexual, and transgender clients also have special counseling needs that may raise ethical and social justice issues.

It is a mistake to assume that lesbians or gay men who come to counseling want to explore matters pertaining to their sexual orientation or that their depression is related to sexual orientation. An array of problems unrelated to sexual orientation may be of primary concern. In short, therapists need to listen carefully to their clients and be willing to explore whatever concerns they bring to the counseling relationship, as the following case shows.

The case of Myrna and Rose

Myrna and Rose seek relationship counseling because they are having communication problems. They have a number of conflicts that they want to work out. They clearly state that their sexual orientation is not a problem for them. They say they need help in learning how to communicate more effectively.

Counselor A. This counselor agrees to see Myrna and Rose, and during the first session he suggests that they ought to examine their sexual orientation. He questions their commitment to being only in relationship with women. He expresses concern about excluding any issues from exploration in determining what could be their problem.

- How do you react to the stance of this counselor? Explain.
- Would it have made a difference if in his informed consent he had stated that no issue would be excluded from possible exploration in therapy?
- Is it ethical for a counselor to insist that there could be a problem when a couple insists there is no problem?
- Would a counselor insist that a heterosexual couple examine their sexuality when discussing communication issues?
- What message is the counselor's desire to explore their sexual orientation giving to these clients?

Counselor B. This counselor agrees to see the couple. During the initial session he realizes that he has strong negative reactions toward them. These reactions are so much in the foreground that they interfere with his ability to effectively work with the couple's presenting problem. He tells the two women about his difficulties and suggests a referral. He lets them know that he had hoped he could be objective enough to work with them but that this is not the case.

- Was this counselor's behavior ethical? Is he violating any of the ethics codes in refusing to work with this couple because of their sexual orientation?
- Given his negative reactions, what steps could this counselor take to manage his personal beliefs and reactions?

Counselor C. This counselor agrees to see the two women and work with them much as she would with a heterosexual couple. The counselor adds that if at any time their sexual orientation causes them difficulties, it would be up to them to bring this up as an issue. She lets them know that if they are comfortable with their sexual orientation she has no need to explore it.

- What are your reactions to this counselor's approach?

In reviewing the approaches of these three counselors, which approach would be closest to yours? To clarify your thinking on the issue of counseling gay and lesbian clients, reflect on these questions:

- Therapists often find that the presenting problem clients bring to a session is not their major problem. Is the counselor justified in introducing sexual orientation as a therapeutic issue?
- Do you see any ethical issue in a heterosexually oriented therapist working with same-sex couples?
- What attitudes are necessary for therapists to be instrumental in helping clients with their sexual orientation?
- Can a counselor who is not comfortable with his or her own sexual identity possibly be effective in assisting clients who are struggling with their sexual identity?
- If Myrna and Rose stated they would like to get married, what ethical obligations do therapists have in supporting their gay and lesbian clients who seek a deeper commitment?

Commentary. Counselors sometimes mistakenly assume, as did Counselor A, that the sexual orientation of same-sex clients is a problem that needs to be addressed. When counselors feel that they *must* address sexual orientation with a gay or lesbian couple, we suspect they may lack competence with this client group. They may be operating according to a biased assumption that homosexual orientation is always linked to the presenting problem.

Recently the American Psychological Association (2013) filed amicus briefs in two same-sex marriage cases before the U.S. Supreme Court. APA stated that there is no scientific basis for prohibiting same-sex marriage. Scientific studies have demonstrated how the psychological and social aspects of committed relationships between same-sex partners mainly resemble those of heterosexual relationships. As well, heterosexual partnerships and same-sex partners encounter similar issues concerning intimacy, loyalty, and stability.

Generally, we would be inclined to explore the problems presented by the couple. During the course of therapy, if it becomes evident that there is a problem that was not identified initially, we would present our thoughts to the couple. As with individual clients, we want to be open to address concerns as they become relevant in their therapeutic work. As therapists we need to ask ourselves what motivates us to introduce a problem to a couple that they have not identified as one of their goals. Is this based on our clinical judgment, or does it reflect our personal biases? Recognizing when our countertransference or value bias could be having a negative effect on our professional work demands a great deal of honesty.

The case of Bernard

Bernard, a 45 year old male, is married to Rebecca, and they have two boys and two girls. He has a very successful career, and Rebecca is a stay-at-home mom. Bernard has been secretly visiting gay bars for the past 10 years. He has also been in a secret gay relationship for 5 years. Rebecca found out about Bernard's double life, and she confronted him.

Sara, his therapist, has traditional religious values and objects to gay relationships on moral grounds. Sara discloses this to Bernard during their first session as part of the informed consent process. Sara admits that she is not knowledgeable about gay relationships. She commits to researching the subject and consulting with her colleagues, who have more expertise in this area. Sara now believes that she is qualified to work with Bernard.

After the fifth therapeutic session, it is obvious that Bernard's psychological condition is deteriorating. Sara believes that to stop counseling Bernard or to terminate the therapeutic session before the final stage means that she has failed. Sara further believes that her existential approach and being a role model will teach Bernard acceptable societal values. Sara begins by taking Bernard to a popular restaurant where straight couples socialize. Sara also takes Bernard to her church, which emphasizes that marriage is a union between a man and woman. Bernard eventually appears to be receptive to the warm, empathic, and mentoring relationship Sara has established. Bernard expresses his gratitude, and Sara believes that counseling has been successful.

- What are the implications from a diversity perspective in this case?
- What are your thoughts about Sara's self-disclosure in this case?
- What ethical, legal, professional, and clinical issues does this case suggest?
- How would you counsel Bernard?

Commentary. Therapists ensure their competence to work with specific presenting problems and client types by undergoing appropriate education, training, and supervised practice. Sara was not competent to work with a gay or bisexual client. She blurred boundaries in her treatment plan for Bernard. It is both inappropriate and unprofessional to convey intolerance to gay, lesbian, bisexual, and transgender clients. In our view, general competence as a mental health practitioner requires the capacity to show a respectful attitude toward a gay person or same-sex couple without imposing one's personal views or values. Furthermore, Sara's self-disclosure can be experienced as rejection and have damaging psychological effects on Bernard.

A Court Case Involving a Therapist's Refusal to Counsel Homosexual Clients

In their article, "Legal and Ethical Issues in Counseling Homosexual Clients," Hermann and Herlihy (2006) describe the case of *Bruff v. North Mississippi Health Services, Inc.* (2001). This interesting case illustrates the complexity counselors confront when their value system and religious beliefs conflict with their client's issues. This section is based largely on Hermann and Herlihy's provocative article.

In 1996 Jane Doe initiated a counseling relationship with Sandra Bruff, a counselor employed at the North Mississippi Medical Center, an employee assistance program provider. After several sessions, Jane Doe informed Bruff that she was a lesbian and wanted to explore her relationship with her partner. Bruff refused on the basis of her religious beliefs, but offered to counsel her in other areas. The client (Jane Doe) discontinued counseling, and her employer filed a complaint with Bruff's agency. Bruff again repeated her reason for refusing to work with Jane Doe and added that she would be willing to work with clients on any areas that did not conflict with her religious beliefs.

Eventually, Bruff was dismissed by her employer. Bruff appealed to an administrator of the medical center who asked her to clarify the situations in which she could not work with a client. She reiterated that she would "not be willing to counsel anyone on any subject that went against her religion" (cited in Hermann & Herlihy, 2006). She was offered a transfer to a Christian counseling center, which she refused on the basis that the director of the center was too liberal. She was given another opportunity for a position in the agency, but lost to a more qualified candidate. Another position in the agency became available, but she did not apply, and eventually she was terminated. Bruff filed suit, and a jury trial in a federal court ruled in her favor. However, on appeal the court reversed the jury's findings and found that there was no violation of Bruff's rights. The court noted that the employer had made several attempts to accommodate Bruff but that Bruff remained inflexible.

Legal aspects of the case. Hermann and Herlihy (2006) summarize some of the legal aspects of the *Bruff* case:

- The court held that the employer did make reasonable attempts to accommodate Bruff's religious beliefs.
- Bruff's inflexibility and unwillingness to work with anyone who has conflicting beliefs is not protected by the law.
- A counselor who refuses to work with LGBT clients can cause harm to them. The refusal to work on a LGBT client's relationship issue constitutes discrimination, which is illegal.
- Counselors cannot use their religious beliefs to justify discrimination based on sexual orientation, and employers can terminate counselors who engage in this discrimination.

Hermann and Herlihy believe the *Bruff* case sets an important legal precedent. They assert that the appeals court decision is consistent with the Supreme Court's precedent interpreting employers' obligations to make reasonable accommodations for employees' religious beliefs. From a legal perspective, the court case clarifies that refusing to counsel homosexual clients on relationship matters can result in the loss of a therapist's job. A homosexual client who sues a counselor for refusing to work with the client on issues related to sexual orientation is also likely to prevail in a malpractice suit as the counselor could be found in violation of the standard of care in the community.

In discussing the ethical implications of the *Bruff* case, Hermann and Herlihy (2006) emphasize the importance for counselors to develop nonjudgmental and accepting attitudes, regardless of their own value system. In short, counselors who discriminate based on sexual orientation are violating ethical standards.

Consider these questions as you think about the issues involved in this case:

- How would you deal with client's issues that conflict with your moral beliefs?
- Is it possible to provide clients with services consistent with an ethical standard of care if counselors conceal their beliefs that homosexuality is wrong?
- If your moral beliefs are substantially different from your client, is this equivalent to your not being competent to work effectively with this client? Are referrals ever justified because of major value conflicts?
- How do you determine that your referral will benefit or harm your client?
- Do counselors have an ethical obligation to reveal their religious beliefs prior to the onset of a professional relationship?
- If you are fully disclosing of your limitations and owning them as your problem, are you behaving ethically and legally?
- To what degree does your informed consent document protect you from an ethical or legal violation?
- How would you apply the basic moral principles addressed in Chapter 1 to making ethical decisions in this case?

Commentary. We find this case very challenging as it exposes ethical issues that have no easy answers and that require a great deal of discussion. An inability to discuss the problem precludes finding a solution. The *Bruff* case illustrates both ethical and legal issues related to value imposition and conflict of values between counselor and client (see Chapter 3). In a counseling relationship, it is not the client's place to adjust to the therapist's values, yet this counselor maintained that she could not work with clients whose beliefs went against her religious views. Bruff demonstrates a lack of understanding that counseling is not about her but about the client's needs and values.

Although we do not question Bruff's right to possess her own personal values, we do have concerns about the manner in which she dealt with the client involved in this case. We do not believe that all counselors can work effectively with all clients, but we expect them to avoid using their personal value system as the criteria for how all clients should think and act. Counselors must develop the capacity to put their values aside and focus on the needs of the client, which is a mark of a true professional. If a referral is made, it should always be based on the client's needs and the competence of the counselor, not on the personal values of the counselor.

We also question whether it was appropriate for this counselor to have a position in a public counseling agency given her inexperience and ineffectiveness working with diverse client populations. Bruff showed inflexibility both in dealing with her clients and in her response to the agency's attempts to accommodate her values by transferring her to another position.

THE CULTURE OF DISABILITY*

LO6 People with chronic medical, physical, and mental disabilities represent the largest minority and disadvantaged group in the United States. Disability has become a natural and ordinary part of life (Smart & Smart, 2012). Yet people with disabilities are part of a misunderstood culture because they do not conform to the socially determined and accepted standards of normalization, beauty, physical attractiveness, and being able-bodied.

The number of people with disabilities across the life span is steadily growing. This can be seen in part by the rise of childhood disabilities such as autism, attention deficit and hyperactivity disorders, and by the cumulative lifestyle factors that lead to obesity, diabetes, heart disease, and cancers. Disabilities in U.S. society are even more prevalent as a result of prolonged and sustained military action in war zones around the world. This has resulted in catastrophic physical injuries (traumatic brain injury, spinal cord injury, and amputations) and serious mental health concerns (posttraumatic stress, substance abuse, and addictions) among men and women who have placed their lives in harm's way on our behalf (Jackson, Thoman, Suris, & North, 2012). To serve this growing population, counselors must acquire unique cultural attributes that are foundational in cultivating an ethical, competent, multicultural practice. Counselors must acquire a basic awareness and knowledge of working with those in the disability **community** and understand some of the ethical dilemmas and concerns that may arise with this unique and diverse group of individuals.

The Disability Community

Understanding the unique cultural attributes of the disability community is essential in gaining a therapeutic alliance with individuals who may or may not identify themselves as part of the disability community. Considering (a) the within-group differences, (b) the variety of disabilities that exist, and (c) the disabilities that are hidden versus those visible or physical in nature, it is difficult to acquire accurate statistical incidence and prevalence of all categories of disease, impairments, medical, physical, psychiatric, developmental, and mental health conditions.Generally, disability researchers accept that there are somewhere between 36 million and 54 million Americans with disabilities. So, who is included in this group we call the disability community?

First and foremost, diagnostic labels and classifications alone are not helpful to counselors in understanding their client's unique cultural differences; nor do they predict or describe the actual medical, psychological, or psychosocial functional capacity of the individual (Falvo, 2009). The foundational principle in counseling persons with disabilities is treat the person first rather than treat the disability. It is also foundational to understand the continuum model of disability, which illustrates that there is no superhuman or perfect earthly being. Rather, we are all made up of differing abilities along a theoretical continuum. At one end of the continuum is the theoretical superhuman, and at the other end is the person who is near death. Helping professionals should focus therapy on the person's current functional abilities and capabilities, which lie somewhere along the continuum of disability. Achieving optimal levels of psychosocial functioning with the individual based on his or her *abilities* defines best practices in working with persons with disabilities.

Stephen Hawking, a renowned British theoretical physicist, provides one example of a person with a disability (Amyotrophic lateral sclerosis; ALS) who transcends the typical course and prognosis of his disease and exhibits extraordinary *differing abilities*. The uninformed observer may look at this individual as a person in a wheel chair

*We are indebted to Mark A. Stebnicki, PhD, LPC, CRC, Professor in the graduate program in rehabilitation counseling at East Carolina University, for contributing this section on counseling people with disabilities.

who has severe physical and communication deficits, and some practitioners may feel compelled to "treat the disability," or the person's deficits. This would be considered working within the *biomedical model* of disease, disability, and illness. A culturally competent practitioner acting in an ethical manner would acknowledge and embrace Professor Hawking's *abilities*, as opposed to his *disabilities*. Working in new paradigms of disability such as the holistic and psychosocial models of *health and wellness* (Nosek, 2005) is a good starting point for approaching therapy embracing the client's unique and diverse cultural attributes. Understanding the individual's cultural identity and how the client perceives his or her abilities is key. Allowing clients to express and communicate their experience of disability and how it may (or may not) hinder their day-to-day functioning is also essential in establishing a strong rapport and working toward an optimal working alliance.

Understanding disability from the disability community's perspective has been the life work of Livneh (2012) as well as many others. Livneh's exhaustive work in psychosocial rehabilitation suggests that the disability community as a whole has historically been marginalized and segregated within multiple life areas (for example, schools, employment, housing, and transportation). It is important for counselors to understand this because they may be dealing with clients who have low self-esteem or perhaps have identified with a particular societal stereotype of disability created by their experience of discrimination. Indeed, there are distinct attitudinal differences in society between people with and without disabilities. Some of the major influences on the treatment and individual responses to disability include (a) our sociocultural conditioning; (b) our childhood influences; (c) various psychodynamic mechanisms that cultivate cultural tunnel vision; (d) the perception that disability is seen as a punishment for sin; (e) our existential anxiety and aesthetic aversion toward people who have disfigurement, physical limitations, and perceptions toward what "normal" is; and (f) other disability-specific related factors.

The ethical and cultural issues of disability are wide-reaching and are of paramount concern, especially for those who do not have a voice to express themselves due to cognitive or communication deficits and for those with severe psychiatric disabilities. Having a disability in the United States can lead to even more intense levels of social isolation, discrimination, stereotypes, poverty, and dependence on public/government assistance. People who lack the mental capacity to consent to their medical or mental health treatment, or those not capable of handling their financial affairs, are particularly vulnerable and are easily manipulated by others. People with disabilities often are not provided with equivalent services or are denied services or programs available to others. Historically, many individuals within the disability community comment that attitudinal barriers are more of a hindrance than the disability itself (Hahn & Belt, 2004; Nosek, 2005; Ragged Edge Online, 2012; Wright, 1983).

Ethical Concerns in the Role of Client Advocate

Given the decreased functional capacity and severity of some disabilities, many counselors take on the natural role of **client advocate**. Many times, counselors justify their actions by acting in a beneficent and nonmaleficent manner. In most cases, counselors truly believe they are working for their clients' best interests. Accordingly, our colleagues often observe us doing good work *for* rather than *with* our clients.

Some of us may enjoy the image of being *the expert* with all the knowledge and resources for our clients. However, the most helpful role of the counselor is to form a collaborative relationship with clients. Consider the following questions:

- How does our own worldview influence what we believe to be the best treatment practices for our clients with severe disabilities?
- What measures have we taken with our clients to ensure that we are working in a professional role to help protect our clients' autonomy?
- Do we treat clients with severe disabilities differently from those considered able-bodied?

Indeed, the role as client advocate raises potential ethical concerns because of the intense emotional nature of the work we do. This is especially relevant for clients who do not have a voice for themselves due to cognitive, communication, or psychiatric disabilities. The disability community more than other groups is prey to manipulation, wrong-doing, and human rights violations. Thus client advocate is a natural role for the counselor.

Acting as client advocate involves the integration of a variety of professional activities facilitating empowerment strategies critical to ensure client independence. Counselors who act in the role of client advocate engage in socially conscious, action-oriented behaviors considered to be ethically responsible. Some counselors may work to help remove institutional, attitudinal, and sociocultural barriers by raising awareness of certain risk factors for disease such as HIV/AIDS. Other counselors focus on prevention activities with high-risk populations such as adolescent substance abuse and addictions. Other counselors regularly utilize state or regional protection and advocacy services to help clients being discriminated against in a variety of employment, education, housing, public transportation, or independent living settings.

Competent and ethical counselors acting as client advocates know how to balance the multiple roles and responsibilities across a continuum of services offered to clients. Assisting clients to cultivate higher levels of independence will strengthen the therapeutic alliance and cultivate client-based skills of problem solving, healthy risk-taking, and other therapeutic tasks. Some in the disability community argue that counselors acting as client advocates can foster dependency. Indeed, there are multiple concerns surrounding this issue, and counselors must carefully monitor themselves or consult with a qualified and competent clinical supervisor. The ethical principles of beneficence and nonmalaficence, if not carefully monitored, can indeed compromise client autonomy.

Blending the roles of consultant, adviser, and cultural facilitator combines traditional counseling and psychotherapy strategies with person-centered approaches to client advocacy. Role blending can assist counselors to ameliorate the consequences of acting purely in the role of client advocate. Many professional counselors recognize the ethical complexity of these issues and understand the potential benefits in cultivating culturally centered therapeutic relationships for people with disabilities.

MATCHING CLIENT AND COUNSELOR

LO7 Diversity includes factors such as culture, religion, race, ability, age, gender, sexual orientation, education, and socioeconomic level. Is matching client and counselor on these various aspects of diversity desirable or possible? Does the clinician have to share the experiential world of the client to be effective? It is

impossible to match client and therapist in all areas of potential diversity, which means that all encounters with clients are diverse, at least to some degree. Some argue that successful multicultural counseling is highly improbable due to the barriers between groups. Others argue that well-trained practitioners, even though they differ from their clients, are capable of providing effective counseling. A study by Owen, Leach, Wampold, and Rodolfa (2011), which included 143 clients and 31 therapists, found that neither the clients' and therapists' ethnicity nor the interactions between the two were significantly associated with the clients' perceptions of their therapists' level of multicultural competency.

Lee and Park (2013) observe that one pitfall associated with multiculturalism is that some helping professionals may give up in exasperation, asking: "How can I really be effective with a client whose cultural background is different from mine?" 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. 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 who are uncomfortable working out these differences may end up failing.

Shared Life Experiences With Your Clients

Must you have similar life experiences to work effectively with clients? Counselors do not necessarily need to have experienced each of the struggles of their clients to be effective in working with them. When the counselor and the client connect at a certain level, cultural and age differences can be transcended. Consider for a moment the degree that you can communicate effectively with the following clients:

- A person significantly older or younger than you
- A person of a different racial, ethnic, or cultural group
- A person with a disability
- A person with a criminal record
- A person who is abusing alcohol or drugs
- A person who is in recovery from an addiction

It is possible for a relatively young clinician to work effectively with an elderly client. For example, the client may be experiencing feelings of loss, guilt, sadness, and hopelessness. The young counselor can empathize with these feelings even though they come from a different source. However, it is essential that counselors develop sensitivity to the differences in their backgrounds and experiences from their clients.

To facilitate your reflection on whether you need to have life experiences similar to those of your client, assess the degree to which you think you could establish a good working relationship with Sylvia.

The case of Sylvia

At a community clinic, Sylvia, who is 38, tells you that she is an alcoholic. During the intake interview she says, "I feel bad because I've tried to stop my drinking and haven't succeeded. I am fine for a while, and then I begin to think that I could do a lot better. I see all the ways in which I do not measure up—how I let my kids down, the many mistakes I've made with them, the embarrassment I've caused my husband—and then I get so down I start drinking again. I know that what I am doing is self-destructive, but I'm not able to stop. I very much want your advice on what I should do."

- What experiences have you had with alcoholism or its treatment, and how important is that?
- If you do not have competence in dealing with substance abuse, how could you acquire the knowledge and skills to effectively work in this area?
- In what ways does Syliva's gender affect your view of her problem?
- Would you refer Sylvia to a substance abuse treatment program, either inpatient or outpatient? Explain.
- Is it ethical to treat Sylvia's psychological problems without first attending to her addiction problem? Explain.
- Sylvia wants your advice. What advice might you offer? What danger, if any, do you see in offering advice in this kind of situation?

Commentary. We support the thinking that the addiction must be treated before attempting to deal with Sylvia's other psychological difficulties, which brings up the issue of advice giving. When is it appropriate for the therapist to provide advice to a client? There are at least two kinds of advice. One form of advice could be a part of the treatment recommendations. For example, the therapist might suggest that Sylvia consult a physician or attend AA meetings. This form of advice is common and can provide necessary adjuncts to therapy. Furthermore, some racial/cultural minorities often seek solid "advice" from therapists and find the lack of concrete suggestions to be disconcerting (Sue & Sue, 2013).

Another form of advice would be to tell a client like Sylvia specific things she should do, such as turn to religion, start an exercise program, or move to a new area. Telling a client specific actions to take in the face of major life events tends to be counterproductive and should generally be avoided. This kind of advice often backfires. If Sylvia does agree with the advice given, or if she has not followed the advice, she may not return for further therapy sessions. Counselors can assist their clients by brainstorming with them about possibilities leading to solutions for their problems, but they should resist the temptation to provide specific actions in the form of giving advice.

How to Address Differences in Therapeutic Relationships

Some therapists wonder whether differences should be addressed, and if they are, should the clinician or the client initiate this? La Roche and Maxie (2003) observe that not all differences between client and therapist have the same impact on the therapeutic relationship. A dissimilarity in race may not hold the same weight as differences in religious beliefs, for example. What is crucial is the client's perception of difference in the therapeutic process. Some writers maintain that most clients will not initiate discussions of cultural differences due to the power differential that exists, which suggests that the therapist can directly take responsibility to address these differences. Other writers take the position that it is more appropriate to wait for the client to bring up cultural differences. Lee (2013a) observes that "what is clearly

evident in cross-cultural encounters is that the cultural differences between counselor and client, when not fully appreciated or understood, can be a significant impediment to the counseling process" (p. 14). Lee recommends that the counselor "acknowledge the wall and decrease the cultural distance between the counselor and client" (p. 14).

LaRoche and Maxie (2003) make a point that cultural differences are subjective, complex, and dynamic. Clinicians can make a mistake by assuming there is a standard way to work with clients of a certain cultural background. Instead, practitioners need to explore the meanings that clients ascribe to these cultural differences. LaRoche and Maxie describe working with a third-generation Korean American gay client. Do you work with the client's sexual orientation itself or how his extended family deals with his being gay? We agree that the process is dynamic and that clinicians must stay with the client and be led by the client into the areas that are most important to him or her.

Becoming a multiculturally competent counselor entails more than a shift in thinking; it demands a shift in attitude. In the context of discussing gender-role attitudes, Chao (2012) notes that "to intellectually recognize gender-role attitudes is one thing; to be deeply aware of it and embody it in one's living praxis is quite another" (p. 41). The most important aspects of culture-centered counseling can be learned, but not necessarily taught.

It is our position that clinicians can learn to work with clients who differ from them in gender, race, culture, religion, socioeconomic background, physical ability, age, or sexual orientation. But our stance is tempered by certain reservations and conditions. First, clinicians need to have training in multicultural and social justice perspectives, both academic and experiential. Second, as in any other counseling situation, it is important that the client and the practitioner agree to develop a working therapeutic relationship. Third, helpers are advised to be flexible in applying theories and techniques to specific situations. The counselor who has an open stance has a greater likelihood of success than someone who rigidly adheres to a single theoretical system. Fourth, the mental health professional should be open to being challenged and tested. In multicultural counseling, many clients are more likely to exhibit caution. They may use many defenses as survival strategies to protect their true feelings. A counselor may be perceived to be a symbol of the establishment. If helpers act defensively, clients may feel that the clinician's values or solutions are being imposed on them and harm may come to these clients. Some clients believe that a professional who is not part of the solution to their problem is really part of the problem.

Addressing Unintentional Racism and Microaggressions

LO8 It is especially important in multicultural counseling situations for counselors to be aware of their own value systems, of potential stereotyping, any traces of prejudice, and of their cultural countertransference. Earlier we described those culture-bound counselors who are unintentionally racist. In some ways, such counselors can be more dangerous than those who are more open with their prejudices. The concepts of unintentional racism and microaggressions are related and usually involve demeaning implications perpetrated against clients on the basis of their race, gender, sexual orientation, or ability status. Sue and colleagues (2007) describe *racial microaggressions* as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of other races" (p. 271). Perpetrators of these offenses are frequently unaware of what they are communicating. Sue and colleagues describe three forms of this insidious type of oppression: microassault, microinsult, and microinvalidation. A *microassault* is an explicit derogation characterized by either a verbal or nonverbal attack that is designed to hurt the victim through name-calling, avoidance, or intentional discriminatory acts. *Microinsults* are rude and insensitive comments that demean a person's heritage and identity. *Microinvalidations* are characterized by communications that negate, exclude, or nullify the thoughts, feelings, or realities of a person (Sue et al., 2007).

Microaggressions in the counseling relationship can be subtle; here are a few examples:

- A couples counselor refers to the female client in a heterosexual couple as a wife, rather than using the woman's name.
- A male therapist asks his female client who is a mother of three children if she has a job.
- A school counselor discourages her students of color from taking college preparatory courses or tells them they should apply for jobs that are more "realistic" for someone from their background.
- During an intake session a counselor comments to her African American male client that he "speaks so eloquently."
- During an intake a counselor says to his plus-sized client, "Obviously your weight is a problem as well."
- A counselor asks his new client if he has a girlfriend or a wife, without knowing the client's sexual orientation.

According to Pedersen (2000), unintentional racists must be challenged either to become intentional racists or to modify their racist attitudes and behaviors. The key to changing unintentional racism lies in examining our basic assumptions. Two forms of covert racism that Ridley (2005) identifies are color blindness and color consciousness. The counselor who says, "When I look at you, I see a person, not a Black person" may encounter mistrust from clients who have difficulty believing that. Likewise, a therapist is not likely to earn credibility by saying, "If you were not Black, you wouldn't have the problem you're facing." These examples of color blindness and color consciousness are rather extreme, but there are many more subtle variations on these themes.

Increasing Your Sensitivity to Cultural Diversity

Try to identify your own assumptions as you think about these questions:

- Does a counselor need to share the cultural background of the client to be effective?
- If you were to encounter considerable "testing" from a client who is culturally different from you, how would you react? What are some ways in which you could work with such a client?
- How might your own experiences with discrimination help or hinder you in working with clients who have been discriminated against?
- What stereotypes are you aware of having?

When counselors identify "unusual behavior" in a client, it is important to determine whether such behavior is unusual within the client's cultural context. Clients may become suspicious if they sense the therapist has already come to a conclusion. Rather than suffering from clinical paranoia, these clients may be reacting to the realities of an environment in which they have suffered oppression and prejudice. In such cases, clients' responses may make complete sense. Practitioners who appreciate the context of such perceptions are less likely to pathologize clients and are able to begin working with clients from their experiential framework.

MULTICULTURAL TRAINING FOR MENTAL HEALTH WORKERS

LO9 Although referral is sometimes an appropriate course of action, it should not be viewed as a solution to the problem of inadequately trained helpers. Many agencies have practitioners whose cultural backgrounds are less diverse than the populations they serve. With the increasing number of culturally diverse clients seeking counseling, we recommend that all counseling students, regardless of their racial or ethnic background, receive training in multicultural counseling and therapy (MCT).

The standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) require that programs provide curricular and experiential offerings in multicultural and pluralistic trends, including characteristics within and among diverse groups nationally and internationally. CACREP standards call for supervised practicum experiences that include people from the environments in which the trainee is preparing to work. It is expected that trainees will study about ethnic groups, subcultures, the changing roles of women, sexism, urban and rural societies, cultural mores, spiritual issues, and differing life patterns. The Council on Rehabilitation Education (CORE, 2009) also has accreditation standards that address these issues. It is not realistic to develop expertise with every culture or subculture. However, trainees should take active steps to increase their competence with those groups they plan to serve (Barnett & Johnson, 2010).

Characteristics of the Culturally Skilled Counselor

Part of multicultural competence entails recognizing our limitations and is manifested in our willingness to (a) seek consultation, (b) participate in continuing education, and (c) when appropriate, make referrals to a professional who is competent to work with a particular client population. Acquiring cultural competence is an active and lifelong learning process rather than a fixed state that is arrived at. This process may include formal training, critical self-evaluation, and questioning of what is occurring in cross-cultural therapeutic partnerships. Lum (2011) contends that "cultural proficiency involves becoming adept, skilled and to a certain degree competent in a helping relationship where cultural and ethnic diverse issues are involved" (p. 19). He adds that too much emphasis is given to building the cultural competence of the counselor. Instead, he emphasizes that the counselor and the client together need to learn to be competent in cultural ways in coping with the problems of living. Lum is calling for a paradigm shift from an exclusive focus on the counselor's competence to an inclusive relationship between helper and client as they both strive toward cultural proficiency in the helping process. Lee and Park (2013) make the point that multicultural competency must be acquired and maintained by all counselors. Cultural competency involves more than self-awareness and knowledge; it entails acquiring skills for effective multicultural intervention. Ivey, Ivey, and Zalaquett (2014) emphasize that awareness, knowledge, and skills are meaningless unless we take action. Counselors who are committed to taking action are willing to work and practice at reducing the gap between knowledge and doing.

A major contribution to the counseling profession has been the development of **multicultural competencies**, a set of knowledge and skills that are essential to the culturally skilled practitioner. Clinicians do not have to master all of these competencies before they begin to see clients, but gaining proficiency should be an ongoing process. Initially formulated by Sue and colleagues (1982), these competencies were later revised and expanded by Sue, Arredondo, and McDavis (1992). Arredondo and her colleagues (1996) updated and operationalized these competencies, and Sue and his colleagues (1998) extended multicultural counseling competencies to individual and organizational development. The multicultural competencies have been endorsed by the Association for Multicultural Counseling and Development (AMCD), by the Association for Counselor Education and Supervision (ACES), and recently by the American Psychological Association (APA, 2003a). For an updated and expanded version of these competencies, see Multicultural Counseling Competencies 2003: *Association for Multicultural Counseling and Development* (Roysircar et al., 2003). Refer also to the APA's (2003a) "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists." For those interested in diversity in group work, refer to the Association for Specialists in Group Work (2012), *Multicultural and Social Justice Competence Principles for Group Workers.* The essential attributes of culturally competent counselors, compiled from the sources just cited, are listed in the box titled "Multicultural Counseling Competencies."

MULTICULTURAL COUNSELING COMPETENCIES

I. Counselor Awareness of Own Cultural Values and Biases

A. With respect to *attitudes and beliefs*, culturally competent counselors:

- are sensitive to cultural group differences because they possess self-awareness of their own cultural heritage and identity.
- are aware of how their personal attitudes and beliefs about people from different cultural groups may facilitate or hamper effective counseling.
- are aware of their own racist, sexist, heterosexist, or other detrimental attitudes and beliefs.
- are able to recognize the limits of their multicultural competencies and expertise.
- recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity, culture, gender, sexual orientation, and other sociodemographic variables.

continued on next page

B. With respect to *knowledge*, culturally competent counselors:
- have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions of and biases about normality/abnormality and the process of counseling.
- possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work.
- possess knowledge about their social impact on others. They are knowledgeable about communication style differences, how their style may clash or foster the counseling process with persons of color or others different from themselves, and how to anticipate the impact it may have on others.
- consider clients as individuals within a cultural context.

C. With respect to *skills*, culturally competent counselors:
- seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations.
- are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

II. Understanding the Client's Worldview

A. With respect to *attitudes and beliefs*, culturally competent counselors:
- are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.
- are aware of stereotypes and a monolithic perspective they may hold toward other racial and ethnic minority groups.

B. With respect to *knowledge*, culturally competent counselors:
- possess specific knowledge and information about the particular client group with whom they are working.
- understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help-seeking behavior, and the appropriateness or inappropriateness of counseling approaches.
- understand and have knowledge about sociopolitical influences that impinge on the lives of racial and ethnic minorities.

C. With respect to *skills*, culturally competent counselors:
- familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.
- become actively involved with minority individuals outside the counseling setting so that their perspective of minorities is more than an academic or helping exercise.

III. Developing Culturally Appropriate Intervention Strategies and Techniques

A. With respect to *attitudes and beliefs*, culturally competent counselors:
- respect clients' religious and spiritual beliefs and values, including attributions and taboos, because these affect worldview, psychosocial functioning, and expressions of distress.
- respect indigenous helping practices and respect help-giving networks among communities of color.
- value bilingualism and do not view another language as an impediment to counseling.

B. With respect to *knowledge*, culturally competent counselors:
- have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy and how they may clash with the cultural values of various cultural groups.
- are aware of institutional barriers that prevent minorities from using mental health services.
- have knowledge of the potential bias in assessment instruments and use procedures and interpret findings in a way that recognizes the cultural and linguistic characteristics of clients.
- have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.
- are aware of relevant discriminatory practices at the social and the community level that may affect the psychological welfare of the population being served.

C. With respect to *skills*, culturally competent counselors:
- are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied to only one method or approach to helping but recognize that helping styles and approaches may be culture bound.
- acquire skills that are consistent with the life experiences and cultural values of their clients.
- are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a problem stems from racism or bias in others so that clients do not inappropriately personalize problems.
- are not adverse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
- take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals.
- have training and expertise in the use of traditional assessment and testing instruments.
- attend to and work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions and develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.
- take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.

For the complete description of these competencies, along with explanatory statements, refer to "Operationalization of the Multicultural Counseling Competencies" (Arredondo et al., 1996). Also see Sue and colleagues (1998, chap. 4) and Sue and Sue (2013, chap. 2) for detailed listings of multicultural counseling competencies.

The case of Talib

Talib, an immigrant from the Middle East, is a graduate student in a counseling program. During many class discussions, his views on gender roles become clear, yet he expresses his beliefs in a respectful and nondogmatic fashion. Talib's attitudes and beliefs about gender roles are that the man should be the provider and head of the home and that the woman is in charge of nurturance, which is a full-time job. Although not directly critical of his female classmates, Talib voices a concern that these students may be neglecting their family obligations by pursuing a graduate education. Talib bases his views not only on his cultural background but also by citing experts in this country who support his position that the absence of women in the home has been a major contributor to the breakdown of the family. There are many lively discussions between Talib and his classmates, many of whom hold very different attitudes regarding gender roles.

Halfway through the semester, his instructor, Dr. Berny, asks Talib to come to her office after class. Dr. Berny tells Talib that she has grave concerns about him pursuing a career in counseling in this country with his present beliefs. She encourages him to consider another career if he is unable to change his "biased convictions" about the role of women. She tells him that unless he can open his thinking to more contemporary viewpoints he will surely encounter serious problems with clients and fellow professionals.

- If you were one of Talib's classmates, what would you want to say to him?
- What assumptions underlie Dr. Berny's advice to Talib?
- If you were a faculty member, what criteria would you use to determine that students are not suited for a program because of their values?
- How would you approach a person whose views seem very different from your own? How would you respond to Talib?

Commentary. Dr. Berny seemed to assume that because Talib expressed strong convictions he was rigid and would impose his values on his clients. She did not communicate a respect for his value system along with her concern that Talib might impose his values on clients. She did not use this situation as a teaching opportunity in the classroom to explore the issue of value imposition.

As a faculty member, Dr. Berny is charged with helping to evaluate whether Talib possess the competence and character to become a mental health professional. Although her concern about his attitudes may be warranted, her supervisory intervention appears to be based on assumptions about how Talib manages his own attitudes when working with clients. Ironically, Dr. Berny conveys the very disrespect for cultural differences that she accuses Talib of demonstrating. We cannot assume that Talib will necessarily impose his value system on his clients.

Students such as Talib who express strong values are often told that they should not work with certain clients. As a result, these students may hesitate to expose their viewpoints if they differ from the "acceptable norm." In our view, a critical feature of multicultural counseling and therapy is the personal development of trainees, which includes helping them clarify a set of values and beliefs concerning culture that increases their chances of functioning effectively in working with culturally diverse client populations. We want to teach students that having strong convictions is not the same as imposing them on others. Students are challenged to become aware of their value systems and to be open to exploring them. However, their role is not to go into this profession to impose these values on others, nor is their role to declare their superiority about their cultural values. If trainees maintain a rigid position regarding the way people should live, regardless of their cultural background, educators must be prepared to address these issues with trainees.

Our Views on Multicultural Training

We recommend these four dimensions of training in multicultural counseling: (1) self-exploration, (2) didactic course work, (3) internship, and (4) experiential approaches. The first step in the process of acquiring multicultural counseling skills is for students to become involved in a **self-exploratory journey** to help identify any potential blind spots. Ideally, this would be required of all trainees in the mental health professions and would be supervised by someone with experience in multicultural issues.

In addition to self-exploration, students can take course work dealing exclusively with multicultural issues and diverse cultural groups. **Course work** is essential for understanding and applying cultural themes in counseling. It is our position that multicultural topics need to be integrated throughout the curriculum, and not simply limited to a single course.

Bemak, Chung, Talleyrand, Jones, and Daquin (2011) describe how the Counseling and Development Program at George Mason University was revamped to emphasize multicultural social justice work, which entailed redesigning 98% of the course curriculum: "The overhaul of the curriculum resulted in the implementation of multicultural social justice issues throughout the entire program from the beginning Foundations in Counseling class to the Practicum and Internship courses" (p. 32). To be consistent with their mission statement that adopted social justice as a core value, this program also focused on recruiting faculty of color and attracting students of color. As the authors note, the faculty are committed to supporting their students once admitted to ensure they are successful in the program; thus students are presented with information and materials with which they can identify and that are culturally relevant.

In a training program that holds diversity as a central value, supervised experiences in the field and internships are given special prominence. Trainees should participate in at least one required **internship** in which they have multicultural experiences or reframe their experiences from a multicultural viewpoint. Ideally, the agency or school supervisor will be experienced in the cultural variables of that particular setting and also be skilled in cross-cultural understanding. Students would also have access to both individual and group supervision on campus from a qualified faculty member. Trainees will be encouraged to select supervised field placements and internships that will challenge them to work on gender and cultural concerns, developmental issues, and other areas of diversity. Through well-selected internship experiences, trainees will not only expand their own consciousness but will increase their knowledge of diverse groups and will have a basis for acquiring intervention skills.

EXPERIENTIAL APPROACHES TO TRAINING. In addition to didactic approaches to acquiring knowledge and skills in multicultural competence, we strongly favor **experiential approaches** as a way to increase self-awareness and to identify and examine attitudes associated with diversity competence. Experiential approaches encourage trainees to pay attention to their thoughts, feelings, and actions in exploring their worldviews.

In conjunction with course work, experiential learning can assist students in developing self-awareness, knowledge, and the skills that are a part of becoming a culturally competent counselor. It is also essential for counselors who work extensively with a specific cultural group to immerse themselves in knowledge and approaches specific to that group through reading, cultural events, workshops, and supervised practice. Revisiting the model adopted by the faculty of George Mason University, trainees engage in community-driven social justice projects outside of the classroom that involve serving marginalized populations (Bemak et al., 2011).

In *Social Justice Counseling*, Chung and Bemak (2012) devote a chapter to the reflections of their graduate students at George Mason University who enrolled in two classes: Multicultural Counseling, and Counseling and Social Justice. The Counseling and Development Program has the core mission of training future multicultural and social justice counselors. The student reflections give examples of students' life changes, the risks they demonstrated in critically evaluating their values and life experiences, and the courage they had in speaking out and acting on social injustices. Rita Chung required that her students participate in a character portrayal, "assuming the identity" of a person of a different gender, class, sexual orientation, race, or ethnic group from their own. Each character described and advocated for a particular issue..

For many students these activities were a life-transforming event. Some students entered the program thinking there was not much more they could learn. The safety created by the professor enabled students to participate in difficult conversations and allowed for significant shifts in students' attitudes. The students were involved in a reading program and wrote about significant turning points for them and how they experienced transformation through activism and social change. One student struggled with the concept of White privilege, and found that Janet Helms's (2008) book, *A Race Is a Nice Thing to Have*, helped her move beyond her anger and continue to develop an identity as a White person. Helms wrote this book to help White people take responsibility for ending racism, understand how racism affects Whites as well as others, analyze racism, and discover positive alternatives for living in a multicultural society. Another White female student said she experienced anger, guilt, embarrassment, and shame when reading Helms's book. She became aware of what it was like for her to grow up with family members who viewed the world through a racist lens.

GET THE MOST FROM YOUR TRAINING. To get the most from your training, we suggest that you accept your limitations and be patient with yourself as you expand your vision of how your culture continues to influence the person you are today. Overwhelming yourself by all that you do not know will not help you. You will not become more effective in multicultural counseling by expecting that you must be completely knowledgeable about the cultural backgrounds of all your clients, by thinking that you should have a complete repertoire of skills, or by demanding perfection. Rather than feeling that you must understand all the subtle nuances of cultural differences when you are with a client, we suggest that you develop a sense of interest, curiosity, and respect when faced with client differences and behaviors that are new to you. Recognize and appreciate your efforts toward becoming a more effective person and counselor, and remember that becoming a multiculturally competent counselor is an ongoing process. In this process there are no small steps; every step you take is creating a new and significant direction for you in your work with diverse client populations.

CHAPTER SUMMARY

Over the past couple of decades mental health professionals have been urged to learn about their own culture and to become aware of how their experiences affect the way they work with those who are culturally different. By being ignorant of the values and attitudes of a diverse range of clients, therapists open themselves to criticism and ineffectiveness. We are all culture-bound to some extent, and it takes a concerted effort to monitor our positive and negative biases so that they do not impede the establishment of helping relationships. In our view, imposing one's own vision of the world on clients not only leads to negative therapeutic outcomes but also constitutes unethical practice.

Culture can be interpreted broadly to include racial or ethnic groups, as well as gender, age, religion, economic status, nationality, physical capacity or handicap, or sexual orientation. We are all limited by our experiences in these various groups, but we can increase our awareness by direct contact with a variety of groups, by reading, by special course work, and by in-service professional workshops. It is essential that our practices be accurate, appropriate, respectful, and meaningful for the clients with whom we work. This entails rethinking our theories and modifying our techniques to meet clients' unique needs and not rigidly applying interventions in the same manner to all clients. Ongoing examination of our assumptions, attitudes, and values is basic to understanding how these factors may influence our practice.

Suggested Activities

1. Select two or three cultures or ethnic groups different from your own. What attitudes and beliefs about these cultures did you hold while growing up? In what ways, if any, have your attitudes changed and what has contributed to the changes?
2. Which of your values do you ascribe primarily to your culture? Have any of your values changed over time, and if so, how? How might these values influence the way you work with clients who are culturally different from you?
3. Interview students or faculty members who identify themselves as ethnically or culturally different from you. What might they teach you about differences that you can apply as a counselor to more effectively work with clients?
4. Do you have a good sense of how people from other cultural groups perceive you? What perceptions do you think others have about you? How do you feel these perceptions reflect on how you see yourself? In what ways might this play out in your work with clients who differ from you culturally? Be specific.
5. To what degree have your courses and field experience contributed to your ability to work effectively with people from other cultures? What training experiences would you like to have to better prepare you for multicultural counseling?
6. How often are students in your program encouraged to engage in difficult dialogues around issues of difference? Do you think the faculty models this for students and creates an environment in which you are willing to share your views regarding differences?
7. People from various ethnic groups are often pressured to give up their beliefs and ways in favor of adopting the ideals and customs of the dominant culture. What do you think your approach would be in working with clients who feel

such pressure? How might you work with clients who see their own ethnicity or cultural heritage as a burden to be overcome?

8. What was your own "internal dialogue" as you read and reflected on this chapter? Share some of this internal dialogue in small group discussions.
9. In small groups, discuss a few of your assumptions that are likely to influence the manner in which you counsel others. From the following list, select one of the assumptions discussed in this chapter that most applies to you. Explore and share your attitudes.
   - What assumptions do you make about the value of self-disclosure on the part of clients?
   - What are your assumptions pertaining to autonomy, independence, and self-determination?
   - To what degree do you assume that it is better to be assertive than to be nonassertive?
   - How would you describe an authentic person?
   - What other assumptions can you think of that might either help or hinder you in counseling diverse client populations?
10. In small groups, explore what you consider to be the main ethical issues in counseling lesbian, gay, bisexual, and transgender clients. Review the discussion of the case of *Bruff v. North Mississippi Health Services* on pages **130–132**. What legal issues are involved in this case? What are the ethical issues in this case? To what degree do you think the counselor imposed her values on her client? Do you think counselors have a right to refuse to provide services to homosexual clients because of the counselors' personal beliefs?
11. Select any one of the many cases described in this chapter, and reflect on how you would deal with this case from an ethical perspective. After you select the case that most interests you, review the steps in the ethical decision-making process described in Chapter 1, and then go through these steps in addressing the issues involved in the case.
12. In small groups review the list of traits of the culturally encapsulated counselor who exhibits cultural tunnel vision. If you recognize any of these traits in yourself, what do you think you might do about them?
13. *The Color of Fear*, produced and directed by Lee Mun Wah, is an emotional and insightful portrayal of racism in America.* Its aim is to illustrate the type of dialogue and relationships needed if we are to have a truly multicultural society based on equality and trust. After viewing the film in class, share what it brought out in you.
14. Check out the Teaching Tolerance website at www.tolerance.org for interesting material on topics explored in this chapter. The website contains information pertaining to a range of issues that can be the topics of discussion in small groups and in class.

**The Color of Fear* is available from Stir Fry Productions in Berkeley, California. The Stir Fry Productions Company provides trained facilitators (in some areas) to assist with discussion after the film is shown.

15. Are you aware of any prejudices you have held toward others on the basis of cultural differences? Have you been the object of prejudice or discrimination? Engage in an honest, courageous, and respectful dialogue with classmates about prejudice and discrimination and ways to combat the *isms* that continue to be a destructive force in society and in the lives of many clients.
16. Replicate Dr. Rita Chung's character portrayal exercise and assume the identity of a person of a different gender, class, race, or ethnic group from your own. In a small group, discuss some of the challenges you might face as this person in society. Discuss what you imagine it is like to be this person.

Ethics in Action *Video Exercises*

17. In video role play 3, Challenging the Counselor: Culture Clash, the client (Sally) directly questions the counselor's background. She says that she didn't expect the counselor (Richard) to be so young and seemingly inexperienced. She presses him further about whether he knows much about the Chinese culture. Role play a situation in which a clash between you and a client might develop (such as difference in age, race, sexual orientation, or culture).
18. In video role play 6, Multicultural Issues: Seeking More From Life, the client (Lucia) is presenting her struggle, which can be understood only to the extent that the counselor (Janice) understands her client's cultural values. In this case, Lucia is struggling with a decision of what she wants to do with her life. Her parents would like her to stay at home and take care of her children. She asks Janice how she might be able to help her. The counselor lets Lucia know that the most important thing is that she is at peace with whatever decision she makes. This situation can be role played in class or a small group and can then be used as a springboard for discussion of what it takes for a counselor to be able to ethically and effectively counsel diverse clients.
19. Refer to the section titled "Becoming an Effective Multicultural Practitioner" in the *Ethics in Action* video. Complete the self-examination of multicultural counseling competencies. Bring your answers to class and explore in small discussion groups what you need to do to become competent as a counselor of clients whose cultural background differs from your own.