

4

DIVERSITY AND CULTURAL ISSUES IN CLINICAL PSYCHOLOGY

The Rise of Multiculturalism in Clinical Psychology	1	<i>Etic Versus Emic Perspective</i>	18
<i>The Diversification of the U.S. Population</i>	1	<i>Tripartite Model of Personal Identity</i>	19
<i>Multiculturalism as the “Fourth Force”</i>	2	What Constitutes a Culture?	19
<i>Recent Professional Efforts to Emphasize Issues of Diversity and Culture</i>	2	<i>Narrow Versus Broad Definitions</i>	20
Cultural Competence	7	<i>Interacting Cultural Variables</i>	21
<i>What Is Cultural Competence?</i>	7	Training Psychologists in Issues of Diversity and Culture	22
<i>Cultural Self-Awareness</i>	8	<i>Educational Alternatives</i>	22
<i>Knowledge of Diverse Cultures</i>	9	<i>Measuring the Outcome of Culture-Based Training Efforts</i>	23
<i>Culturally Appropriate Clinical Skills</i>	16	An Example of Culture Influencing the Clinical Context: The Parent–Child Relationship	24
<i>Are We All Alike? Or All Different?</i>	18		

THE RISE OF MULTICULTURALISM IN CLINICAL PSYCHOLOGY

The Diversification of the U.S. Population

Cultural diversity has historically been a hallmark of the U.S. population, but in recent years, the country has become *much* more diverse. The number of people of minority ethnicities, as well as the proportion of the U.S. population they represent, has increased dramatically. For example, in a single decade (1990–2000), the Asian American/Pacific Islander population and the Latino/Latina/Hispanic population each grew by about 50% (U.S. Census Bureau, 2001). As of 2016, there were over 43 million immigrants in the United States, representing over 13% of the population (U.S. Census Bureau, 2017).

Learning Objectives

- 4.1 Explain what it means to describe multiculturalism as the “fourth force” in clinical psychology.
- 4.2 List professional efforts in clinical psychology that demonstrate the field’s current focus on multiculturalism.
- 4.3 Speculate how cultural competence could be demonstrated with psychotherapy clients of various backgrounds.
- 4.4 Compare major perspectives on the similarities and differences among people.
- 4.5 Define “culture” in the context of clinical psychology.
- 4.6 Describe methods for training clinical psychologists in cultural issues.



Web Link 4.1

Cultural diversity in the United States

One in five U.S. schoolchildren speaks a language other than English at home (Roberts, 2004). And by 2050, about half the country’s population will identify at least partially as African American, American Indian, Asian American, or Latino/Latina (U.S. Census Bureau, 2008).

In certain parts of the United States, the increasing diversity is especially pronounced. In Miami, for example, over two thirds of the population is Latino/Latina/Hispanic (U.S. Census Bureau, 2018b). In San Francisco, individuals of Asian descent represent about one third of the population (U.S. Census Bureau, 2018c). And about three quarters of the population of Detroit and half the population of Washington, D.C., are African American (U.S. Census Bureau, 2018a, 2018d).

Clinical psychologists have recognized that the people who might seek their professional services represent a growing variety of cultural backgrounds. As individuals and as a profession, clinical psychologists are making efforts to address issues of culture sensitively and competently (Comas-Díaz, 2011a, 2011b, 2012; M. L. Melton, 2018; Suzuki & Wilton, 2016). As stated by McGoldrick, Giordano, and Garcia-Preto (2005b), “We must incorporate cultural acknowledgment into our theories and into our therapies, so that clients not of the dominant culture will not have to feel lost, displaced, or mystified” (p. 4).

Multiculturalism as the “Fourth Force”

The impact of issues of culture and diversity on mental health professionals in recent years has been so extensive that some authors have identified **multiculturalism** as a defining issue of the current era of psychology. For example, Pedersen (1990, 1999, 2008) has put forth the argument that in the evolution of the clinical/counseling field, multiculturalism represents the “fourth force.” With this label, multiculturalism takes its place

with the three previous movements that have been broadly recognized as dominant paradigms in their respective eras: psychoanalysis as the first force, behaviorism as the second force, and humanism/person-centered psychology as the third force (Bugental, 1964). Multiculturalism, then, stands as a major pervasive influence on the work of contemporary clinical psychologists (Comas-Díaz & Brown, 2016; Gelso, 2011). It represents a fundamental change of emphasis but one unlike the previous three in terms of its method of impact. Whereas behaviorism and humanism emerged as challenges to the incumbent first force of psychoanalysis, multiculturalism does not necessarily aim to dethrone any of the first three forces. Instead, it enhances and strengthens existing models by infusing them with sensitivity and awareness of how they can be best applied to individuals of various cultural backgrounds (Mio, Barker-Hackett, & Tumambing, 2006).

One reason cultural diversity is such a powerful force in the clinical and counseling fields is that it shapes the way the client understands the very problem for which he or she is seeking help. This understanding—this worldview, applied to psychological problems—is what the therapist should appreciate as he or she devises an approach to helping the client. Comas-Díaz (2011a) encourages therapists to directly assess clients' understanding of their own psychological problem by asking them these questions:



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- What do you call your problem (or illness or distress)?
- What do you think your problem does to you?
- What do you think the natural cause of your problem is?
- Why do you think this problem has occurred?
- How do you think this problem should be treated?
- How do you want me to help you?
- Who else (e.g., family, friends, religious leader) do you turn to for help?
- Who (e.g., family, friends, religious leader) should be involved in decision making about this problem? (Adapted from p. 875)

► **Photo 4.1**

Cultural diversity is a hallmark of the U.S. population, especially in certain geographical areas. How has the profession of clinical psychology emphasized the importance of cultural diversity in recent years?

Recent Professional Efforts to Emphasize Issues of Diversity and Culture

Clinical psychology and related professions have addressed the issue of cultural diversity in many tangible ways. In the 1970s, efforts toward educating therapists and therapists-in-training on the importance of race and ethnicity were in their early stages. These efforts expanded through the 1980s and by the 1990s were much more widespread and comprehensive in terms of the variables, beyond ethnicity and race, around which culture might be defined (J. E. Harris, 2012). In recent years, a plethora of efforts reflects the increasing importance of culture within clinical psychology.

Journals and Books

Numerous publications on diversity and cultural issues in mental health have appeared in recent years. Scholarly journals in clinical psychology have increasingly included articles on cultural and diversity topics, and some psychology journals are devoted entirely to such issues (Koydemir & Essau, 2015). (See Table 4.1 for examples.) In addition, a wide variety of books now offer education and guidance to psychologists working

Table 4.1 Scholarly Journals Relevant to Diversity and Multicultural Issues in Clinical Psychology

Among others, these journals focus on issues of culture and commonly include articles of clinical relevance:

<i>Asian American Journal of Psychology</i>	<i>Journal of Latinx Psychology</i>
<i>Cultural Diversity and Ethnic Minority Psychology</i>	<i>Journal of Multicultural Counseling and Development</i>
<i>Hispanic Journal of Behavioral Sciences</i>	<i>Journal of Rural Mental Health</i>
<i>Journal of Black Psychology</i>	<i>Psychoanalysis, Culture, and Society</i>
<i>Journal of Cross-Cultural Psychology</i>	<i>Psychology of Men and Masculinity</i>
<i>Journal of Cultural Diversity</i>	<i>Psychology of Sexual Orientation and Gender Diversity</i>
<i>Journal of Gender, Culture, and Health</i>	

Among others, these journals focus on clinically relevant issues and commonly feature articles emphasizing culture or diversity:

<i>Clinical Psychology: Science and Practice</i>	<i>Journal of Counseling Psychology</i>
<i>Counseling Psychologist</i>	<i>Journal of Marital and Family Therapy</i>
<i>Journal of Abnormal Psychology</i>	<i>Journal of Mental Health Counseling</i>
<i>Journal of Clinical Psychology</i>	<i>Professional Psychology: Research and Practice</i>
<i>Journal of Consulting and Clinical Psychology</i>	<i>Psychotherapy: Theory, Research, Practice, Training</i>

with diverse populations. Some of these books focus on a single population, such as *Working With Asian Americans* (E. Lee, 1997), *Psychotherapy With Women* (Mirkin, Suyemoto, & Okun, 2005), or *Counseling Muslims* (Ahmed & Amer, 2012), whereas others compile chapters on many different populations, such as *Ethnicity and Family Therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005a) or *Counseling Diverse Populations* (Atkinson & Hackett, 2003). Collectively, these publications represent a wealth of cultural knowledge for contemporary clinical psychologists, and their increasing presence acknowledges the importance of the topic.

Emergence of American Psychological Association Divisions

Within the American Psychological Association, new divisions arise when a subset of members recognizes a need to study or examine a specific topic in depth. Among the divisions created most recently, many focus on diversity or cultural issues, including the following:

- Division 35—Society for the Psychology of Women
- Division 36—Psychology of Religion
- Division 44—Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
- Division 45—Society for the Study of Ethnic Minority Issues
- Division 51—Society for the Psychological Study of Men and Masculinity

American Psychological Association Ethical Code

Numerous specific standards and principles in the most recent edition of the American Psychological Association (2002) ethical code compel psychologists to work with cultural sensitivity and competence. Their inclusion as standards makes it clear that awareness of diversity issues is a requirement rather than merely an aspiration for ethical psychologists. See Table 4.2 for a list of specific ethical standards and principles that relate to multiculturalism.

 **Web Link 4.2**
*Cultural Diversity &
 Ethnic Minority
 Psychology*

Table 4.2 Selected Excerpts From the American Psychological Association’s (2002) “Ethical Principles of Psychologists and Code of Conduct” Relating to Multiculturalism or Diversity

- Principle E: Respect for People’s Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based on such prejudices.

- Standard 2.01 Boundaries of Competence

(b) 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.

- Standard 3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

(Continued)

Table 4.2 (Continued)

- Standard 9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

Source: American Psychological Association (2002), pp. 1060–1073.

American Psychological Association Accreditation Standards

When the American Psychological Association decides whether to give its “seal of approval”—in other words, accreditation—to a graduate program in psychology, cultural diversity is a primary focus. In the American Psychological Association (2005) standards of accreditation, “Cultural and Individual Differences and Diversity” is one of the eight domains that an educational program must address adequately to be accredited. This requirement applies to doctoral programs, predoctoral internships, and postdoctoral internships seeking accreditation. Specifically, the accreditation standards for doctoral programs list criteria such as (1) including people of diverse backgrounds among students and faculty and (2) educating students about the role of culture in the science and practice of professional psychology.

DSM Efforts Toward Multiculturalism

The authors of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* state in the Introduction that “key aspects of culture relevant to diagnostic classification and assessment have been considered in the development of *DSM-5*” (American Psychiatric Association, 2013, p. 14). In addition to information on cultural variation embedded in the descriptions of specific disorders, it provides more general guidance for clinicians to help with overall cultural competence. For example, it offers an “Outline for Cultural Formulation,” which instructs clinicians in various aspects of culture to assess in clients, such as cultural identity, cultural conceptualization of distress, and cultural features of the relationship with the mental health professional. It also offers a “Cultural Formulation Interview,” a series of 16 specific questions that can guide a clinician toward a culturally informed interview. All of these efforts support the growing body of research suggesting that culture influences the experience or expression of a variety of psychological problems, including anxiety disorders, eating disorders, substance use, and many others (e.g., Chentsova-Dutton & Tsai, 2007).

Another effort toward cultural awareness incorporated into *DSM-5* is a glossary listing **cultural concepts of distress** (many of which were called “culture-bound

syndromes” in previous *DSM* editions; Alarcón, 2015). The glossary of cultural concepts of distress includes nine terms that represent psychological problems observed in groups from various parts of the world. Some are described as similar to a *DSM-5* disorder, but others bear little resemblance. Examples include *taijin kyofusho*, in which a person anxiously avoids interpersonal situations because they believe that their appearance, actions, or odor will offend other people (found in Japanese and some other cultures); *susto*, in which a frightening event is thought to cause the soul to leave the body, resulting in depressive symptoms (found in some Latino/Latina/Hispanic cultures); and *maladi moun*, in which one person can “send” psychological problems like depression and psychosis to another, usually as a result of envy or hatred toward the other person’s success (found in some Haitian communities; similar experiences called the “evil eye” are more common in other parts of the world). Although some authors (McGoldrick et al., 2005b) have pointed out that a few of the official disorders included in *DSM* might in fact be better described as culturally bound to U.S. or North American cultures (e.g., eating disorders, as discussed in Chapter 7), the list of culture-bound syndromes in the *DSM* nonetheless signifies an increase in the profession’s recognition of multicultural issues.

Revisions of Prominent Assessment Methods

Several prominent assessment tools used by clinical psychologists have been revised in recent years with the specific intent of making them more appropriate and serviceable to diverse clients (Braje & Hall, 2015). The Minnesota Multiphasic Personality Inventory (MMPI), an especially popular and well-respected personality test, underwent a major overhaul in the 1980s, resulting in the publication of the MMPI-2 in 1989. Compared with the original MMPI, the normative scores for the MMPI-2 were based on population samples much more representative of the cultural diversity of the U.S. population (D. S. Nichols, 2001). (Chapter 10 includes much more information on the MMPI and MMPI-2.) Other examples include the adult and child versions of the Wechsler tests of intelligence (e.g., Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children), which are among the most widely used and highly esteemed in their respective categories. As these tests have been revised in recent years, their authors have made efforts to create instruments that minimize cultural bias and maximize cultural inclusion (D. P. Flanagan & Kaufman, 2009). (Chapter 9 includes much more information on the Wechsler tests.)

 **Web Link 4.3**
National Center
for Cultural
Competence

CULTURAL COMPETENCE

What Is Cultural Competence?

Clinical psychologists should strive for **cultural competence** (Comas-Díaz & Brown, 2016; J. R. Graham & Roemer, 2015; Vasquez, 2010). Indeed, when clients perceive their therapists as culturally competent, they are more likely to form strong working relationships with them, which leads to fewer therapy drop-outs and better therapy outcomes (Owen, Tao, Leach, & Rodolfa, 2011; Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018).



► **Photo 4.2**

Cultural self-awareness, or an appreciation of the clinical psychologist's own unique cultural viewpoint, is a key element of cultural competence.



Web Link 4.4

Cultural competence & cultural self-awareness

But what exactly does cultural competence involve? According to D. W. Sue and Sue (2008),

Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society . . . and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p. 46)

A key phrase in D. W. Sue and Sue's (2008) definition of cultural competence is "awareness, knowledge, and skills"; these are the three primary components to multicultural competence as applied to clinical/counseling work. Let's examine each one in detail.

Cultural Self-Awareness

Cultural competence begins with learning about one's own culture—not only basic facts such as where one's parents or ancestors came from but also the values, assumptions, and biases that one has developed as a result of all cultural influences (J. E. Harris, 2012). When a clinical psychologist attains **cultural self-awareness**—that is, comes to understand that their viewpoint is (like everyone's) unique and idiosyncratic—several conclusions are within reach (Fouad & Arredondo, 2007). For example, the psychologist may adopt a viewpoint toward clients that is less egocentric, more humble, and more appreciative of the varying experiences of life (Mosher et al., 2017). Also, the psychologist may come to recognize that differences between people are not necessarily deficiencies, especially if the difference demonstrated by the client is common or valued in the client's own cultural group. Rather than glossing over differences between themselves and their clients, psychologists should explore their own personal reactions to these differences and address any discomfort they may initially feel about them (B. Greene, 2007).

Of course, the process of cultural self-awareness can be difficult or unpleasant for psychologists, because it may require admitting and coming to terms with some undesirable "isms"—racism, sexism, heterosexism, classism, ethnocentrism, or similar prejudicial or discriminatory belief systems that we'd rather pretend we don't have. But by examining them and exposing them to ourselves, we can take steps toward minimizing them and the negative impact they might have on our clients (Vasquez, 2010).

Cultural self-awareness is important regardless of the psychologist's own cultural background. Whether a member of a majority or minority, the psychologist will inevitably encounter clients whose cultural backgrounds differ—sometimes slightly, sometimes considerably—from their own. Thankfully, scholars in our field are paying increasing attention to the cultural status of the therapist (e.g., Gelso, 2010; Mirsalimi, 2010; Nezu, 2010).

In My Practice . . .

In my practice, self-awareness of my own cultural background has always been important. It consistently reminds me that my way is just one way of understanding the world and helps me appreciate the validity of the perspectives that diverse clients hold.

With regard to my own cultural background, one particular challenge involves disclosing it to clients. The questions that I consider are the same that most other clinical psychologists (and other mental health professionals) consider: How much of my cultural background should my clients know? Are there certain characteristics about myself that I should voluntarily share with every client? Are there certain characteristics about myself that I should willingly share if the client requests it? Are there certain characteristics about myself that no client ever needs to know?

Clients may come to certain conclusions about me (whether right or wrong) based on what they see when they sit in my office: my race/ethnicity, my approximate age, my gender. But other variables may be tougher for them to guess: my religion, my ethnicity, my sexual orientation, my socioeconomic status, where I was raised, and more. Usually, when clients ask me to fill in those blanks, their underlying concern is whether I have the experience necessary to

fully understand or empathize with them—in other words, whether I’ll “get” them. A teen client who eventually came out asked me directly in an early session about my sexual orientation, later explaining that he thought a gay therapist would better recognize the issues he had around telling his family about his sexual orientation. When an 80-year-old client called me to inquire about my services, her first question was how old I was, because she was concerned that a young therapist couldn’t grasp how it felt to experience the illnesses, cognitive declines, and deaths of friends that she had endured in recent years. A 21-year-old woman who was considering an abortion asked me about my religion, hoping that if mine matched hers I would have a more immediate appreciation of the issues with which she wrestled.

Over the course of my career, I have leaned toward keeping my own cultural background private, but in selected situations (including some of the above), when I thought it would benefit the client, I selectively disclosed.

In your opinion, should therapists disclose this kind of information about themselves? Why or why not? Does a shared cultural background in fact make a therapist better able to “get” a client, and does that lead to better assessment or treatment?

To see this box come to life as a whiteboard video, please visit edge.sagepub.com/pomerantz5e.

Knowledge of Diverse Cultures

To know one’s own culture is a good first step for the psychologist, but it won’t amount to much unless the psychologist also possesses information about the client’s cultural groups. Simply put, the psychologist should know as much as possible about the client’s culture. Efforts in this direction should be continual—learning through reading, direct experiences, relationships with people in various cultures, and other means. Of course, therapists can’t know everything about every culture that might be represented by a client in a country as diverse as the United States. In fact, acknowledging cultural

Considering Culture

Interviews With Multicultural Experts: Cultural Competence With Clients From Specific Cultures

Knowledge of diverse cultures is one of the core elements of cultural competence. Here, we ask nine highly respected experts in multicultural mental health to provide their thoughts about what clinical psychologists should know about particular cultural groups. The cultural groups they discuss span ethnicity, gender, religion, and sexual orientation.

This box is just a start! It contains brief excerpts of the experts' responses, but this textbook's companion website ([edge.sagepub/pomerantz5e](http://edge.sagepub.com/pomerantz5e)) contains the experts' full biographies as well as their full-length responses to these five questions about clinical work with their cultural groups:

1. In general, why is it important for clinical psychologists to be culturally competent when working with members of this culture?
2. What can clinical psychologists (or students in training) do to enhance their cultural competence with members of this culture?
3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, intelligence testing, personality testing, etc.) and diagnosis with members of this culture?
4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with members of this culture?

5. Any other thoughts about culturally competent practice with members of this culture?

Latino/Latina Clients

Dr. Melba Vasquez is the cofounder of the Society for the Psychological Study of Ethnic Minority Issues (American Psychological Association Division 45), the first Latina member-at-large on the board of directors of the American Psychological Association, and 2011 president of the American Psychological Association. She sees clients in private practice in Texas.

- “Latino/a cultural factors for assessment may include relevant generational history (e.g., number of generations in the country, manner of coming to the country); citizenship or residency status (e.g., number of years in the country, parental history of migration, refugee flight, or immigration); fluency in ‘standard’ English or other language; extent of family support or disintegration of family; availability of community resources; level of education; change in social status as a result of coming to this country (for immigrant or refugee); work history; and level of stress related to acculturation and/or oppression.”
- “The demographic changes in the world and in this country have significant implications for counseling and clinical psychologists. Although Latinos/Latinas typically present with similar problems, relative to other clients, variations in conceptualizations and interventions may be important in providing effective services.”

Asian and Asian American Clients

Dr. Frederick Leong is a professor of psychology at Michigan State University, director of the Consortium for Multicultural Psychology Research, and founding editor of the *Asian American Journal of Psychology*.

1. “Intra-group heterogeneity is particularly important to recognize when it comes to a group such as Asian Americans given that this population comprises approximately 43 different ethnic groups with over 100 languages and dialects represented.”
2. “For many Asian Americans, constancy and equilibrium, duty, obligation and appearance of harmonious relations are important in their family relations. In addition, Asian families tend to emphasize connectedness of the family, while European Americans tend to prioritize separateness and clear boundaries in relationships due to the two groups’ value differences. It has become well known that Asian Americans tend to be more collectivistic in cultural orientation while European Americans tend to be individualistic.”

American Indian/Alaska Native Clients

Dr. Joseph E. Trimble is a Distinguished University Professor and member of the Department of Psychology and a research associate in the Center for Cross-Cultural Research at Western Washington University. In 1994, he received a Lifetime Distinguished Career Award from American Psychological Association Division 45 for his research and dedication to cross-cultural and ethnic psychology. He also won

the American Psychological Foundation’s 2017 Gold Medal Award for Life Achievement in Psychology in the Public Interest.

- “Providers of traditional helping services in Indian communities most likely exemplify empathy, genuineness, availability, respect, warmth, congruence, and concreteness, characteristics that are likely to be effective in any therapeutic treatment setting, regardless of the provider’s theoretical orientation or counseling style. Effective counseling with Indians begins when a counselor carefully internalizes and uses these basic characteristics in counseling settings.”
- “A constant theme occurs repeatedly in the Indian and Native counseling literature—counselors of Indian and Native clients must be adaptive and flexible in their personal orientations and in their use of conventional counseling techniques.”

African American Clients

Dr. Robert L. Williams was a founding member of the National Association of Black Psychologists in 1968. From 1970 to 1992, he served as professor of psychology and African and African-American studies at Washington University in St. Louis. He is currently professor emeritus of the departments of Psychological & Brain Sciences and African and Afro-American Studies at Washington University in St. Louis.

- “The first step in gaining cultural competence is self-knowledge. Psychologists need to become aware of their own racial scripts and beliefs, and how these might

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affect the way they conduct therapy. Racial scripts are programmed messages from parents to children about African Americans of which the children, even when they have become adults, are not fully aware. They can have a powerful influence, so it's important for psychologists to recognize their own racial scripts and alter them to meet the reality of the African American community.”

- “Perhaps most importantly, psychologists working with clients of diverse backgrounds, including African American clients, need to know and accept that a *cultural difference is not a deficiency*. In other words, differences between the cultures exist, but they need not suggest that one is better or worse than the other.”

Irish American Clients

Dr. Monica McGoldrick is the director of the Multicultural Family Institute of New Jersey and an adjunct associate professor of clinical psychiatry at UMDNJ–Robert Wood Johnson Medical School. Her many books include *Ethnicity and Family Therapy* (McGoldrick et al., 2005a) and *The Expanding Family Life Cycle* (McGoldrick, Carter, & Garcia-Preto, 2016).

- “Traditionally (and I’m overgeneralizing a bit to make the point) the Irish, although they were big talkers, were not big talkers about emotional issues. In fact, they seemed afraid of emotional issues. So, if you asked them the kinds of questions that would, say, come from a Freudian perspective

(which is still very strong in psychology), they would probably look much more pathological than they really are, because they would be extremely uncomfortable with questions about their inner feelings, especially negative feelings or sexual feelings.”

- “The Irish have a long history in which they learned how to keep their emotional process under wraps, and often the church encouraged certain attitudes which led them to feel guilty about some feelings that wouldn’t even be an issue in other cultural groups.”

Female Clients

Dr. Nadya A. Fouad is Mary and Ted Kellner Endowed Chair of Educational Psychology and Distinguished Professor of Counseling Psychology, School & Clinical Mental Health Counseling in the Department of Educational Psychology at the University of Wisconsin–Milwaukee. She served as cochair of the writing team for the American Psychological Association’s *Multicultural Guidelines on Education, Training, Research, Practice, and Organizational Change*. She is also the recipient of the Leona Tyler Award for Lifetime Achievement in Counseling Psychology from APA Division 17.

- “It’s important to understand how a client’s gender is interwoven in his or her culture or ethnicity. For example, a traditional Hispanic woman facing a decision like moving across the country to go to college and moving away from her family might experience that decision in a unique way, and

differently from a man in the same situation. If a client senses that the psychologist isn't taking these kinds of issues into account, the client might not return at all."

- "Be aware of your own biases with regard to gender. For example, do you have a bias toward women being in a particular role, either traditional or nontraditional? Do you have a bias toward one type of relationship in which women should be?"

Middle Eastern Clients

Dr. Karen Haboush (1961–2016) was a clinical associate professor in the Department of Applied Psychology at Rutgers University and maintained a private practice as well. She published articles and chapters on culturally competent practice with children and families of Middle Eastern descent.

- "Because the popular media often presents predominantly negative images of Middle Easterners (i.e., terrorists, religious extremists), psychologists may unwittingly internalize these images, which subsequently influences their clinical work. As with all ethnic groups, the first step in developing cultural competence is for psychologists to examine their own attitudes and knowledge."
- "In Middle Eastern culture, the welfare of the family has much greater significance than individual autonomy and independence. . . . This makes Middle Eastern culture quite different from the prevailing emphasis on individual

achievement, which is more characteristic of North American and European countries. Of course, great variability exists across cultures and countries, but generally speaking, a collectivist emphasis on the well-being of the family tends to characterize the Middle East."

Lesbian/Gay/Bisexual/ Transgender (LGBT) Clients

Dr. Kathleen J. Bieschke is a professor of counseling psychology at Pennsylvania State University. Dr. Bieschke has written extensively about the delivery of affirmative counseling and psychotherapy to LGBT clients. Dr. Bieschke is a coeditor of the *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients* (Bieschke, Perez, & DeBord, 2007) and the *Handbook of Sexual Orientation and Gender Diversity in Counseling and Psychotherapy* (DeBord, Fischer, Bieschke, & Perez, 2017).

- "Attention must be paid to the development of a productive therapeutic relationship. This is particularly true when working with sexual minority clients, as LGBT individuals have learned to carefully assess the extent to which therapists are affirmative. There are myriad ways in which therapists can convey affirmation to clients. For example, having a symbol in one's office indicating knowledge of the LGBT community (e.g., a small pink triangle) or using language that is inclusive (e.g., not using gender-specific pronouns when referring to sexual partners) can provide LGBT clients with concrete evidence of

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- a therapist's openness to sexual minorities.”
- “A particularly fruitful strategy is getting to know someone who identifies as a sexual minority or as a strong ally; relationships such as these can shatter stereotypes and assumptions.”

Jewish American Clients

Dr. Lewis Z. Schlosser has worked as associate professor of counseling psychology at Seton Hall University and has practiced in counseling and forensic settings. He has published articles and book chapters on multicultural counseling and development, specifically the intersection of race, religion, and ethnicity; anti-Semitism; and psychotherapy for American Jews (e.g., Schlosser, 2006; Schlosser, Ali, Ackerman, & Dewey, 2009; Schlosser, Safran, Suson, Dettle, & Dewey, 2013).

- “Being Jewish is largely an invisible minority status. Psychologists might never know that they have a Jewish client in front of them unless the client discloses her or his identity. Because Jews have endured a long history of oppression, many American Jews will assess the safety of the current environment prior to disclosing their identity. A culturally competent psychologist will strive to foster an environment of safety so that the American Jewish client would feel comfortable disclosing her or his Jewish identity.”
- “It is important to note that cultural competence is not assured simply by being Jewish. That is, we can't assume that Jews are going to be culturally competent with Jewish clients, as internalized anti-Semitism or other factors might be operating.”

differences with clients can be a good idea, and asking a client to explain the meaning or importance of a particular experience from their point of view can ensure a more culturally sensitive understanding. But clients shouldn't bear too much of the burden of educating the psychologist; instead, the psychologist should aim to enter each session with sufficient knowledge of the client's cultural background.

Cultural knowledge should include not only the current lifestyle of the members of the cultural group but also the group's history, especially regarding major social and political issues. For example, the history of African Americans—including slavery, cruelty, exploitation, and overt and covert racism—can understandably affect the formation of a trusting relationship with a psychologist or with the mental health system more generally (Constantine, Redington, & Graham, 2009; Terrell, Taylor, Menzise, & Baret, 2009). A clinical psychologist who fails to recognize these historical realities and their potential impact on clients may form expectations or make interpretations that are culturally insensitive and jeopardize the therapeutic relationship (Shorter-Gooden, 2009).

Of course, the psychologist should not assume that every individual is typical of their cultural group. In other words, although a cultural group may have a collective tendency, an individual member of that group may vary greatly from that tendency. To assume that a member of a cultural group will exhibit all the characteristics common to that group is to prejudge. The individual would be better served by a psychologist who

appreciates the cultural group norms but also appreciates the **heterogeneity** inherent in every culture. See Box 4.3 for further discussion of heterogeneity within a culture.

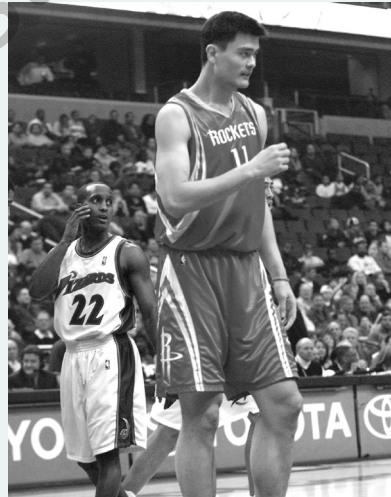
Some of the heterogeneity within a culture stems from differences in **acculturation** (J. Chu, Leino, Pflum, & Sue, 2017; Organista, Marin, & Chun, 2010; Rivera, 2010). That is, when people find themselves in a new cultural environment, they may respond in a variety of ways, especially with regard to adopting elements of the new culture or retaining elements of their original culture. Four separate acculturation strategies have been identified (Berry, 2003; Rivera, 2008): *assimilation*, in which the individual adopts much of the new culture and abandons much of the original; *separation*, in which the individual rejects much of the new culture and retains much of the original; *marginalization*, in which the individual rejects both the new and the original culture; and *integration*, in which the individual adopts much of the new culture and retains much of the original. As these four strategies illustrate, individuals can combine an appreciation of their new and original cultures in many ways, resulting in remarkable diversity within any cultural group. So simply knowing that Hajra immigrated to the United States from Bosnia 15 years ago leaves much unknown about her cultural identity. To what extent has she embraced mainstream U.S. culture? To what extent has she carried on her Bosnian cultural beliefs and traditions? Culturally competent clinical psychologists strive to learn their clients' acculturation strategies in an effort to understand more completely their unique ways of life (Shin & Muñoz, 2009).

Metaphorically Speaking

If You've Seen Yao Ming, You Understand Heterogeneity Within a Culture

The average height of a Chinese man is about 5 ft. 7 in.—about 2 to 3 in. shorter than the average height of men from the United States. So if you are a clinical psychologist and you know that the new client in your waiting room is a Chinese man, you might expect to see someone around 5 ft. 7 in. tall. But when you open the waiting room door and Yao Ming stands up—all 7 ft. 6 in. of him—you understand right away that your client is a huge exception to the rule.

Yao Ming is a Chinese man and was a star basketball player who entered the NBA Hall of Fame in 2016. His height illustrates a powerful lesson about cultural competence: Although members of a culture as a group may tend



► Photo 4.3

Yao Ming's extraordinary height illustrates that the characteristics of an individual do not necessarily follow cultural trends. Regarding their clients' psychological characteristics, culturally competent clinical psychologists appreciate the exceptions as well as the rules.

(Continued)

BOX 4.3

(Continued)

toward certain norms, any *individual* within that group may fall far from that norm. Clinical psychologists should aspire to understand the norms of the cultures with which they work, but if they rigidly assume that every person in that culture fits those norms, they are guilty of unfair and often inaccurate prejudice. To some extent, generalizing is inevitable when discussing cultural groups (McGoldrick et al., 2005a), but our generalizations should be “guidelines for our behaviors, to be tentatively applied in new situations, and they should be open to change and challenge. It is exactly at this stage that generalizations remain generalizations or become stereotypes” (D. W. Sue & Sue, 2008, p. 154).

Actually, your statistics course probably included some basic concepts that can help illustrate this point: measures of central tendency, such as the mean, and measures of variability, such as range or standard deviation. Any group of numbers will yield a mean, but a quick glance at the scatterplot shows that there is some variation around that mean, and in some cases the outliers are quite extreme. The client in the psychologist’s office represents one of those points on the scatterplot, and although it is important to appreciate the central tendencies of that group, it is equally important to recall that the client might be an outlier.

Consider another central tendency of Chinese and many other Asian cultures—the emphasis on collectivism over individualism. In contrast to the tendencies in European American cultures, members of Asian cultures tend to value the welfare of the family or group over their own welfare as individuals. Numerous authors on the subject have indicated that members of Asian cultures assign great significance to harmony, interdependence, respect, and loyalty in close relationships, and they will often forgo individual self-directed accomplishments as a result (e.g., Dana, 1993; E. Lee & Mock, 2005; Shibusawa, 2005). It is important for clinical psychologists to be aware of this tendency toward collectivism among this group but simultaneously be aware that any particular client may be an exception to the rule. Just as Yao Ming stands almost 2 ft. higher than the average Chinese man, the Chinese client in the waiting room may hold very individualistic—rather than collectivistic—values. Although this client’s status as a cultural outlier is less obviously visible than Yao Ming’s height, it is nonetheless the responsibility of clinical psychologists to be perceptive and responsive to the existence of such atypical cultural members.

Culturally Appropriate Clinical Skills

Once the psychologist has attained cultural knowledge of self and clients, the next step is to develop suitable strategies for assessment and treatment. In other words, the approaches and techniques that a psychologist uses to improve a client’s life should be consistent with the values and life experience of that client (Hall, Hong, Zane, & Meyer, 2011; Hwang, 2011; Toporek, 2012). “Talk therapy” may work well for many, but for members of some cultural groups, it may be a bad fit. Similarly, clients from some cultures may place great value on “insight” into their psychological problems obtained over many months, but clients from other cultures may respond much more positively to action-oriented therapies with a short-term focus. Other common features of traditional psychotherapy, including verbal self-disclosure of personal problems and 50-minute

sessions in an office building, may not be entirely compatible with clients from certain cultural backgrounds (Comas-Díaz, 2012).

One essential culturally appropriate clinical skill that is receiving more attention in recent years involves microaggressions. **Microaggressions** are comments or actions made in a cross-cultural context that convey prejudicial, negative, or stereotypical beliefs and may suggest dominance or superiority of one group over another (Fouad & Arredondo, 2007; D. W. Sue, 2010; D. W. Sue et al., 2007). Often, they are “little things” that one person may say to another without any intention of hostility or any awareness that the comments might be invalidating or insulting—but, in fact, they are. Microaggressions often center on ethnicity or race (e.g., A. J. Franklin, 2007; D. W. Sue, Capodilupo, & Holder, 2008) but can involve any number of differences between people, such as age, gender, socioeconomic status, religion/spirituality, or sexual orientation. A review of research on the effects of microaggressions finds that they cause distress and can contribute to serious psychological problems (P. P. Lui & Quezada, 2019). Unfortunately, clinical psychologists (and other mental health professionals) are not immune from committing microaggressions against their clients, and those microaggressions can cause damage to the progress a client might otherwise make (Owen et al., 2018; Spengler, Miller, & Spengler, 2016). As an example, consider a psychologist who, during an initial interview with a 19-year-old male college student, asks, “Do you have a girlfriend?” The “girlfriend” question might communicate an assumption on the psychologist’s part that being straight is the norm or what is expected or “right.” Especially if the client is gay or bisexual, such a question might have negative consequences in terms of forming a therapeutic relationship in which the client feels valued and accepted. Or if a psychologist meets with a 7-year-old therapy client on December 27 and asks, “So what did Santa bring you?” the child may feel devalued if he or she is Muslim, Jewish, or Buddhist, or doesn’t celebrate Christmas for any other reason. The best way for psychologists to avoid microaggressions is to examine the thoughts and beliefs that underlie them, which can result in greater humility and self-awareness for the psychologist (Vasquez, 2010).

Recent efforts toward the attainment of culturally appropriate clinical skills have emphasized the notion of *cultural adaptation* of treatments with empirical evidence to support them (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Smith, Domenech Rodríguez, & Bernal, 2011). In other words, now that clinical psychology has generated lists of treatments that work, an important subsequent step is to determine how those treatments might need to be adapted for members of diverse cultures (Castro, Barrera, & Steiker, 2010; J. R. Graham & Roemer, 2015; Mulvaney-Day, Earl, Diaz-Linhardt, & Alegría, 2011). (After all, many of the studies that generated the empirical support for evidence-based treatments were conducted on clients whose collective cultural range was very narrow.) For example, La Roche, Batista, and D’Angelo (2011) examined a large number of guided imagery scripts—the instructions that psychologists read or record for their clients when they are trying to induce relaxation. Often, these scripts include statements such as “Imagine yourself alone on a calm beach” or “Picture yourself in a beautiful meadow.” Such situations are remarkably “solo”—in other words, the idyllic setting involves the client alone. In many ethnicities, scenes that invoke feelings of togetherness or connectedness with other people might better capture relaxation or happiness—something along the lines of “Imagine yourself among people who are positive and make you feel good about yourself.” La Roche et al. found that guided imagery scripts emphasize a “solo” (or idiocentric) orientation rather than a “together”

 **Web Link 4.5**
Microaggressions

(or allocentric) orientation, which could prove inconsistent with the cultural values of many clients. They recommend that clinicians who use such techniques develop a variety of guided imagery scripts, including some that are allocentric, rather than imposing idiocentric scripts on all clients. This kind of adaptation—in which clinicians consider how diverse clients might respond differently to the standard (often evidence-based) treatment, versus one that has been customized for them—is on the rise (Gelso, 2011; G. C. N. Hall & Ibaraki, 2016; Hwang, 2011). Another study shows the importance of cultural adaptation of therapies by showing what can happen when such adaptation does not happen: Expressive writing, a technique that has produced positive therapy outcomes for many clients struggling with posttraumatic symptoms (in studies that featured mostly White clients) unexpectedly worsened symptoms of a group of about 100 Chinese American women (Gallagher, Long, Tsai, Stanton, & Lu, 2018). Meta-analyses suggest that overall, cultural adaptations to evidence-based therapies produce positive therapy outcomes (Soto et al., 2018).

Another clinically appropriate skill to consider, as basic as it may sound, is simply the language in which the therapist talks with the client. For clients who speak more than one language, this choice can have important consequences. One study focused on the assessment of bilingual individuals with symptoms of schizophrenia and schizoaffective disorder. Those who were interviewed in their first language (their “mother tongue”) generally reported a higher number and severity of symptoms than those who were interviewed in their second (“acquired”) language (C. A. Brown & Weisman de Mamani, 2017). Of course, no therapist is required to speak every language, but a skillful therapist might either keep such language effects in mind during their interactions with a client, or be aware of other available mental health resources (including therapists who speak other languages) and be capable of referring clients when appropriate.

ARE WE ALL ALIKE? OR ALL DIFFERENT?

The discussion of cultural issues brings up some important, fundamental questions about human beings that are applicable to psychologists and the clients they see. To what extent are all people—and the experiences and problems they bring to therapy—similar? And to what extent might they differ from one another?

Etic Versus Emic Perspective

Dana (1993) describes two distinct perspectives that psychologists have used during the history of the profession. The first, known as the **etic** perspective, emphasizes the similarities between all people. It assumes universality among all people and generally does not attach importance to differences among cultural groups. This perspective was more dominant in the early days of psychology, when most of the people teaching and practicing psychology were male, of European descent, and of middle-class or higher socioeconomic standing. Generally, their viewpoint was put forth as the normative viewpoint on issues such as defining psychological health, identifying and labeling psychological disorders, and developing therapy approaches.

The **emic** perspective differs from the etic perspective in that it recognizes and emphasizes culture-specific norms. A psychologist employing the emic perspective—which has grown in prominence along with the rise in multiculturalism—considers a client’s behaviors, thoughts, and feelings within the context of the client’s own culture rather than imposing norms of another culture on the client (Koydemir & Essau, 2015). Compared with the etic perspective, the emic perspective allows psychologists more opportunity to appreciate and understand how the client might be viewed by members of their own cultural group. In short, the emic approach stresses that individuals from various cultural groups “must be understood on their own terms” (Dana, 1993, p. 21).

As a side note, Dana (1993) mentions that the terms *etic* and *emic* were derived from the field of linguistics and, specifically, from the terms *phonetic* and *phonemic*. Historically, linguists have used the term *phonetics* for sounds that are common to all languages and the term *phonemics* for sounds that are specific to a particular language (Dana, 1993; Pike, 1967). The distinction between the way the two terms were used in linguistics—essentially, emphasizing *universality* versus *culture specificity*—remains in the way the terms *etic* and *emic* are currently used in psychology.

Tripartite Model of Personal Identity

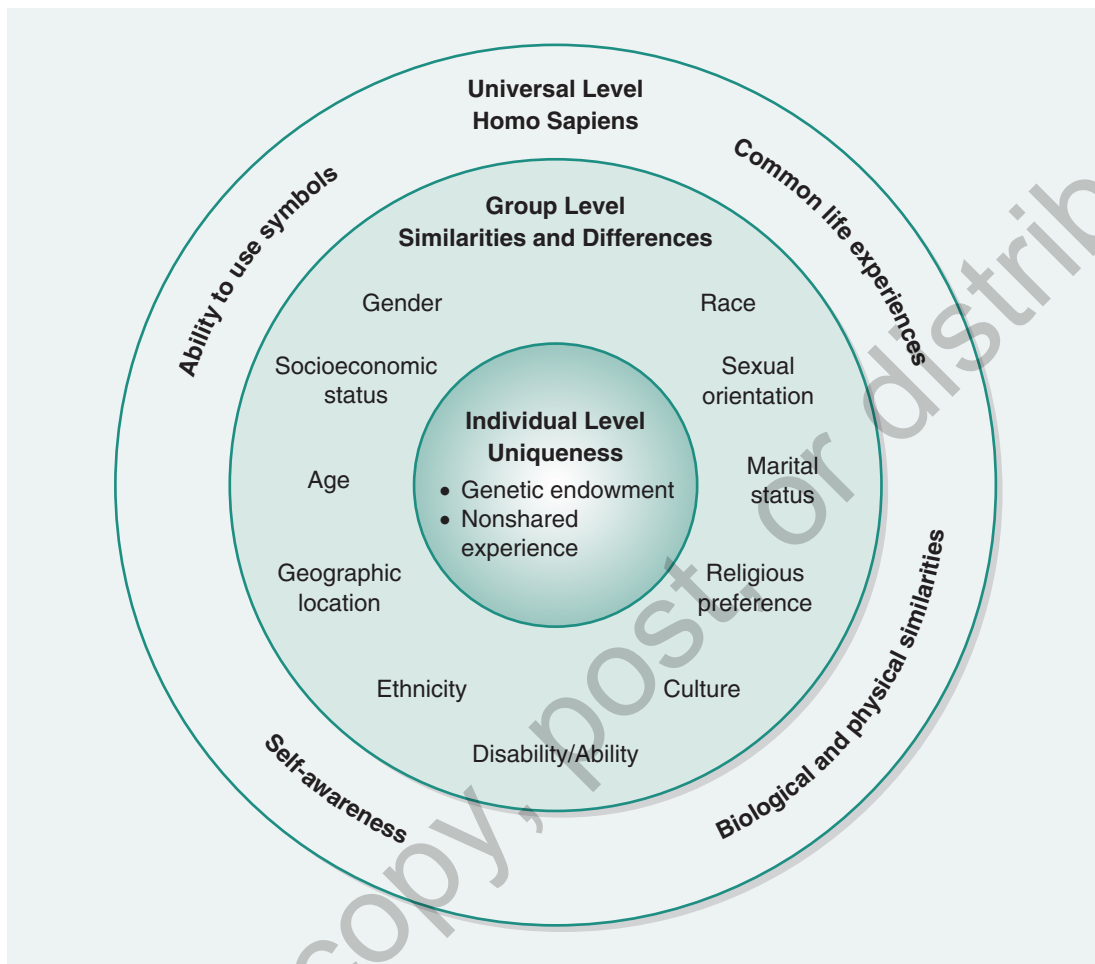
If the etic and emic perspectives represent two opposite viewpoints, perhaps it would be beneficial to consider a continuum that includes not only these two extremes but also some middle ground. D. W. Sue and Sue (2008) offer a three-level model called the **tripartite model of personal identity** in which all levels hold some degree of importance.

One level in this model is the **individual level**. Here, the premise is that “all individuals are, in some respects, like no other individuals.” A second level is the **group level**, where the premise is that “all individuals are, in some respects, like some other individuals.” The final level is the **universal level**, based on the premise that “all individuals are, in some respects, like all other individuals” (D. W. Sue & Sue, 2008, pp. 38–39). A psychologist who can appreciate a client on all three levels will be able to recognize characteristics that are entirely unique to the client, others that are common within the client’s cultural group, and still others that are common to everyone. D. W. Sue and Sue (2008) argue that appreciation of all three levels is indeed the goal but that the group level has been overlooked traditionally in psychology, especially when the group is a minority culture, so psychologists may need to make more deliberate efforts in that direction. See Figure 4.1 for a visual representation of the tripartite model of personal identity.

WHAT CONSTITUTES A CULTURE?

When someone inquires about your cultural background, which of your characteristics come to mind? Many would list their race and ethnicity, and others would include a multitude of additional characteristics. If clinical psychologists are to function in a culturally competent and sensitive way, it makes sense to consider what exactly we might mean when we say “culture.”

Figure 4.1 Tripartite Model of Personal Identity



Source: D. W. Sue & Sue (2008), p. 12.

Narrow Versus Broad Definitions

Those who argue for a more narrow definition of culture typically point to ethnicity and race as the defining characteristics. Indeed, many books and articles on the topic of culture focus exclusively on issues of race or ethnicity. According to some who endorse this perspective, the inclusion of other variables as “cultural” would unfairly deemphasize the socially, politically, and personally important characteristics of race and ethnicity (Mio et al., 2006).

On the other hand, some argue that culture can be defined by a much broader range of variables, including “any and all potentially salient ethnographic, demographic, status,

or affiliation identities” (Pedersen, 1999, p. 3), or that culture can be composed of “any group that shares a theme or issues(s)” (D. W. Sue, Ivey, & Pedersen, 1996, p. 16). Others have stated that ethnicity may be the primary determinant of culture but not the only one: Further factors can include socioeconomic status, gender, geography/region, age, sexual orientation, religion/spirituality, disability/ability status, immigrant/refugee status, and political affiliation, among others (Alessi, Dillon, & Kim, 2015; Artman & Daniels, 2010; Consoli, Wang, Delucio, & Yakushko, 2017; Goldblum, Pflum, Skinta, Evans, & Balsam, 2017; Hope & Chappell, 2015; Liang & Molenaar, 2017; Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010; McGoldrick et al., 2005a; McKittrick & Li, 2008; Moradi & Budge, 2018; Pepping, Lyons, & Morris, 2018; Robinson-Wood, 2009; Sewell, 2009; Shipherd, 2015; Vasquez & Vasquez, 2017).

Whether or not the characteristics beyond race and ethnicity are universally accepted as components of culture per se, quite a few books, chapters, and articles have been written with the intent of making psychotherapists and counselors more sensitive to these characteristics. For example, therapists can educate themselves about LGBT clients (Bieschke et al., 2007; Diamond, Butterworth, & Savin-Williams, 2011; Russell & Fish, 2016); clients with disabilities (Kosciulek, 2003); deaf clients (Leigh, 2010); elderly clients (Qualls, 2003); rural clients (Rainer, 2010; Smalley et al., 2010); low-income clients (Acosta, Yamamoto, & Evans, 1982); Appalachian clients (Harper, 1996); Orthodox Jewish clients (Mirkin & Okun, 2005); and many, many other specific groups whose defining characteristic is neither race nor ethnicity. Indeed, as time goes by, the range of variables that clinical psychologists include when they consider culture continues to broaden (L. S. Brown, 2011; Green, Callands, Radcliffe, Luebke, & Klonoff, 2009).

Additionally, some subsections of society—**subcultures**, if you will—may be especially relevant for certain clients. As an example, consider a psychologist working in a prison setting or with a former prison inmate who was recently released. If there is such a thing as “prison culture”—a shared lifestyle with its own unique norms, expectations, values, and so on—it would probably be wise for the psychologist to consider it in addition to variables such as race, ethnicity, gender, and others. Likewise, a psychologist working with military personnel should have some appreciation of how military culture differs from civilian culture (Atuel & Castro, 2018). Even adolescents have been identified as having a culture of their own, with shared values around the importance of technology, peer relationships, and independence from parents (Nelson & Nelson, 2010). Many other “subcultures” based on specific work settings, living communities, or other variables may represent enough of an influence on the life experiences of clients to justify tailoring the treatment to best fit them (Arredondo et al., 1996; Truscott, 2010).



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► Photo 4.4

In your opinion, what variables should clinical psychologists consider when they appreciate their clients' cultural backgrounds?

Interacting Cultural Variables

When we consider how many variables might contribute to culture, it's hard to avoid the conclusion that for any individual with whom a psychologist works, culture might be

multifactorial. In other words, lots of cultural variables may interact in unique ways to shape the life experience of a client. Of course, ethnicity and race may be most important for certain clients. But other variables might play significant roles as well.

Consider, for example, Esteban and Maria, two clients who share similar Latino/Latina/Hispanic ethnic backgrounds. In the spirit of cultural competence, their respective therapists should appreciate their ethnicity, but perhaps the cultural considerations should incorporate other factors as well. If Esteban is a 28-year-old gay man living an upper-middle-class life in Los Angeles, while Maria is a 66-year-old heterosexual woman living a lower-class life in a small town in rural West Virginia, the cultures of their day-to-day lives are probably quite different in spite of similar ethnic heritage. Indeed, if they visited each other's homes, they might find themselves living in very different worlds. Culturally competent therapists would certainly appreciate their ethnicity, but such therapists would also consider the way that other variables in their lives interact with their ethnicity to create a unique set of cultural circumstances (Arredondo et al., 1996; Truscott, 2010).

TRAINING PSYCHOLOGISTS IN ISSUES OF DIVERSITY AND CULTURE

With the increasing emphasis on multiculturalism in clinical psychology comes an increased responsibility to train psychologists to become culturally sensitive and competent. Graduate program directors, professors, and providers of continuing education share this challenge, along with psychologists striving to educate themselves.

Educational Alternatives

What are the best methods for training clinical psychologists in multicultural issues? Graduate programs have tried a variety of approaches (Benuto, Casas, & O'Donohue, 2018; Tormala, Patel, Soukup, & Clarke, 2018). Often, graduate programs include one or more courses specifically designed to address culture. In addition, some graduate programs may weave cultural training into all the educational experiences of the graduate student. Courses in psychotherapy, assessment, and research, as well as practicum training, can be designed to incorporate issues of culture. This way, issues of culture are not considered a specialized topic to be examined in isolation but a factor relevant to all professional activities of the clinical psychologist.

Another, less traditional approach to training in cultural issues emphasizes real-world experience with individuals of diverse cultures. Supporters of this approach contend that reading about a different culture in a book, or discussing a different culture in class, is no substitute for immersing oneself in that culture to some extent. Thus, through experiences that are professional (such as clinical work or research projects incorporating diverse clients, participants, colleagues, or supervisors) or personal in nature, some training programs promote learning about cultural groups by interacting directly with their members (Center for Multicultural Human Services, 2006; Magyar-Moe et al., 2005).

No single “best method” or consensus has emerged for training psychologists to be culturally competent. However, leaders in this field have begun to identify essential

components for graduate training programs. For example, Fouad and Arredondo (2006, as cited in Fouad, 2006) identify seven specific “critical elements of a multiculturally infused psychology curriculum” that they believe will improve the training of psychologists working as practitioners, teachers, or researchers. According to these authors, graduate training programs should

1. explicitly state a commitment to diversity;
2. actively make an effort to recruit graduate students from diverse populations;
3. actively make an effort to recruit and retain a diverse faculty;
4. make efforts to make the admissions process fair and equitable;
5. ensure that students gain awareness of their own cultural values and biases, knowledge of other groups, and skills to work with diverse populations;
6. examine all courses for an infusion of a culture-centered approach throughout the curriculum; and
7. evaluate students on their cultural competence on a regular basis. (Adapted from Fouad, 2006, pp. 7–9)

Regardless of the methods used to train clinical psychologists to be culturally competent, an essential ingredient is that the psychologist (or trainee) reaches a deeper appreciation of their own cultural identity. Hardy and Laszloffy (1992) describe numerous ways in which self-knowledge can be examined during training, such as in-class discussions, in-class presentations, self-guided assignments, and assigned discussions with one’s own family of origin. In the end, the ability to relate to clients of diverse cultures may depend not only on information obtained through courses and assignments but also on an attitude of “respect, curiosity, and especially humility” (McGoldrick et al., 2005b, p. 6). Cultural humility, in fact, has been explored by numerous researchers in recent years and linked to better outcomes for therapy clients (D. E. Davis et al., 2018; Mosher et al., 2017).

Measuring the Outcome of Culture-Based Training Efforts

Let us not forget that psychology is a science, and as such we take a keen interest in measuring the outcome of our efforts to increase cultural sensitivity and competence of psychologists. But consider some of the difficult methodological questions:

- How should we reliably and validly measure the outcome of culture-based training efforts?
- How can we reliably and validly establish a baseline for the level of cultural competence of a psychologist or trainee before the training takes place?
- When we assess the cultural competence component of psychotherapy, whose opinion should we seek? The client’s? The psychologist’s? The supervisor’s? Another interested party’s?

- How can we make a causal connection between particular culture-based training efforts and particular outcomes? How can we be sure that confounding or unexamined variables aren't responsible for the outcomes we observe?

At the moment, measuring the outcome of culture-based efforts is at a very early stage of empirical investigation, as researchers grapple with issues such as those suggested by the questions above. There is some evidence to suggest that psychologists are learning the ideals of cultural competence but are not always implementing them as often or as comprehensively as they know they should. In other words, there may be a gap between what psychologists “practice” and what they “preach” regarding multicultural competence (Hansen et al., 2006).

On a more positive note, efforts promoting multiculturalism are clearly resulting in some needed improvements related to clinical and research activities of clinical psychologists. In 2003, D. W. Sue and Sue lamented the fact that evidence-based treatments very rarely incorporate significant numbers of minority clients in their research trials, so despite the growing number of evidence-based treatments, these treatments may not be applicable to diverse populations. Only 2 years later, however, Muñoz and Mendelson (2005) provided one of the first reports of a study attempting to establish empirical evidence for a treatment with a specific minority population. This report outlined the development and empirical evaluation of prevention and treatment manuals for depression and other mental health problems designed for San Francisco's low-income ethnic minority populations at San Francisco General Hospital. The authors noted many promising evaluations of these culture-specific manuals and concluded that “certain psychological theories describe universal aspects of human behavior and can thus profitably inform core therapeutic strategies. However, the effective clinical application of such strategies requires group-specific knowledge and cultural adaptation to increase the likelihood of positive outcomes” (p. 797). Additional research (M. Barrera & Castro, 2006; Lau, 2006; Spilka & Dobson, 2015) has significantly advanced the efforts to adapt evidence-based practices for specific cultural groups. In fact, as suggested earlier in the chapter, reviews of studies that examine the outcomes of evidence-based practices that have been tailored for a particular culture generally find that they work more effectively than nontailored versions (Huey, Tilley, Jones, & Smith, 2014; Soto et al., 2018).

AN EXAMPLE OF CULTURE INFLUENCING THE CLINICAL CONTEXT: THE PARENT-CHILD RELATIONSHIP

Let's consider the cultural issues related to a specific aspect of clients' lives that might be involved in the assessment or treatment of a wide variety of individuals and families: the relationship between parents and their children. Perhaps the first thing that the psychologists should recall is that their own expectations regarding parent-child relationships are probably influenced by their own culture and that those expectations don't hold true for everyone. For example, in some cultures (e.g., British), parenting that produces a child who grows up, moves out, and lives an independent life is usually considered successful. But families of other cultural backgrounds (e.g., Italian) usually prefer that their children

stay geographically and emotionally close even after they reach adulthood. Some cultures (e.g., Chinese) tend to insist that children obey parental authority without discussion or negotiation. But families of other cultural backgrounds (e.g., Jewish) tend to create a home life in which open discussion of feelings, including children disagreeing or arguing with parents, is tolerated or even encouraged (McGoldrick et al., 2005a). (Of course, there is heterogeneity within any of these groups.)

It is essential that the clinical psychologist seeing an individual or family such as those described above attain the multicultural competence to consider these varying norms and implement a form of treatment that is consistent with them. Especially in the United States, where diversity is extensive and on the rise, clinical psychologists are likely to work with clients from a wide variety of backgrounds. And, as in this example, the cultural issue may serve as a backdrop to any number of presenting problems, including mood disorders, disruptive behavior disorders, relationship problems, and many others. A culturally sensitive appreciation of the Italian family, for example, might include exploration of parents' depressive feelings about a 25-year-old daughter whose successful career has served to separate her from them. But if the family were British, an exploration of depressive feelings in the parents might strike the clients as off the mark. Similarly, if an 11-year-old boy had a heated argument with his parents because he didn't want to take the piano lessons they had arranged, a culturally sensitive response might depend on whether the family were Chinese, Jewish, or of another cultural background.



► Photo 4.5

Norms or expectations for the parent–child relationship can differ across cultures. How is this fact important to clinical psychologists who work with adults, children, or families?

CHAPTER SUMMARY

As the U.S. population has become increasingly diverse, multiculturalism has risen to prominence in clinical psychology. Evidence of its growing influence includes books and articles on diversity and multiculturalism; revisions to the *DSM*, including the inclusion of cultural concepts of distress; the creation of culturally relevant American Psychological Association divisions; and the addition of ethical standards directly related to culture. Cultural competence, for which all clinical psychologists should strive, involves cultural self-awareness, knowledge of diverse cultures, and culturally appropriate clinical skills. Knowledge of cultural norms should be accompanied by an appreciation of the heterogeneity of that culture and the likelihood

that an individual may vary from some cultural norms, especially when acculturation strategies are considered. The tripartite model of personal identity suggests that an individual can be understood as an entirely unique person, similar to members of a cultural group, or similar to all human beings. Cultures are often defined by ethnicity or race, but numerous other variables may also constitute culture, such as gender, religion/spirituality, disability status, socioeconomic status, age, and sexual orientation. Training efforts intended to increase cultural sensitivity and competence among clinical psychologists and trainees include traditional coursework as well as direct interaction with members of diverse cultures.

KEY TERMS AND NAMES

acculturation 15	etic 18	multiculturalism 2
cultural competence 7	group level 19	subcultures 21
cultural concepts of distress 6	heterogeneity 15	tripartite model of personal identity 19
cultural diversity 1	individual level 19	universal level 19
cultural self-awareness 8	microaggressions 17	
emic 19		

CRITICAL THINKING QUESTIONS

1. In your opinion, how important is the issue of cultural self-awareness to clinical psychologists? What is the best way to increase cultural self-awareness among current members of the profession?
2. In your opinion, which level of the tripartite model of personal identity (individual level, group level, or universal level) is most important in the conceptualization of clients?
3. What are the pros and cons of defining culture in a narrow versus broad way?
4. If you were a client, how important would it be to you that your clinical psychologist had received training in cultural issues? Which methods of training would you expect to contribute most to your clinical psychologist's cultural competence?
5. Considering the discussion in Box 4.3 about heterogeneity within a culture, can you think of a cultural group to which you belong but within which you represent an exception to a cultural tendency?

LOOKING TOWARD GRADUATE PROGRAMS

The following table is a list of index entries in the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Sayette & Norcross, 2018) relevant to the topics in this chapter (see page XX in Chapter 1 for more information about the *Insider's Guide*). Keep in mind a few things as you consider

these listings: They are current as of the 2018/2019 edition of the *Insider's Guide* (which typically revises every two years); they may have changed as faculty members retire, take new jobs, or develop new interests; and a graduate program's own website may have more extensive or up-to-date information.

Research Areas	Specialty Clinical and Practica Sites	Program Concentrations and Tracks
Acculturation	Aging/Gerontology	Gender Studies
African American Studies	Correctional Psychology/Prisons	Latino Psychology/Spanish Bilingual
Aging/Gerontology/Adult Development	Immigrant/Refugee Populations	Multicultural/Cross-Cultural/Diversity
Asian Studies	Lesbian/Gay/Bisexual/Transgender	

Deafness/Hard of Hearing	Men's Issues	Geropsychology/Aging
Discrimination	Military/Armed Forces	Miscellaneous/Other—Global Mental Health
Gender Roles/Sex Differences	Minority/Cross-Cultural/Multicultural	Miscellaneous/Other—LGBTQ
Hispanic Studies	Native American Health Services	Miscellaneous/Other—Rural Integrated Primary Care
Immigration	Religion/Spirituality	Miscellaneous/Other—Rural Mental Health
Indigenous/Native American	Rural Mental Health/Psychology	Miscellaneous/Other—Rural/Multicultural Psychology
Lesbian/Gay/Bisexual/Transgender	Spanish-Speaking Clients	Miscellaneous/Other—Women and Diversity Studies
Men's Issues	Underserved Populations	
Minority/Cross-Cultural/Diversity	Women's Issues	
Poverty	Miscellaneous—Deaf and Hard-of-Hearing	
Religion/Spirituality	Miscellaneous—Indian Health Services	
Rural Mental Health	Miscellaneous—Inner-City Populations	
Veteran/Military Issues	Miscellaneous—Low Income	
Women's Studies/Feminism	Miscellaneous—Socioeconomic Disadvantage	
Miscellaneous and Other—American Indian		
Miscellaneous and Other—Cultural Adaptations		
Miscellaneous and Other—Cultural Humility		
Miscellaneous and Other—Filipino American Psychology		
Miscellaneous and Other—Intersectionality; Microaggressions		
Miscellaneous and Other—Interventions With Refugees		
Miscellaneous and Other—Microaggressions		
Miscellaneous and Other—Muslim Mental Health		
Miscellaneous and Other—Stereotyping and Prejudice		

KEY JOURNALS

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Asian American Journal of Psychology

<http://www.apa.org/pubs/journals/aap/index.aspx>

Cultural Diversity & Ethnic Minority Psychology

<http://www.apa.org/pubs/journals/cdp/index.aspx>

Journal of Black Psychology

<http://jbp.sagepub.com/>

Journal of Latinx Psychology

<http://www.apa.org/pubs/journals/lat/index.aspx>

Psychological Services

<http://www.apa.org/pubs/journals/ser/index.aspx>

Psychology and Aging

<http://www.apa.org/pubs/journals/pag/index.aspx>

Psychology of Sexual Orientation and Gender Diversity

<http://www.apa.org/pubs/journals/sgd/index.aspx>

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- eFlashcards
- Culture expert interviews
- In My Practice demonstration video
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- Additional web resources
- Mock assessment data