FOURTH EDITION

Counseling for Multiculturalism and Social Justice

Integration, Theory, and Application

Manivong J. Ratts
Paul B. Pedersen

American Counseling Association

WILEY

FOURTH EDITION

Counseling for Multiculturalism and Social Justice

Integration, Theory, and Application

Manivong J. Ratts
Paul B. Pedersen

AMERICAN COUNSELING ASSOCIATION
5999 Stevenson Avenue • Alexandria, VA 22304
www.counseling.org

FOURTH EDITION

Counseling for Multiculturalism and Social Justice

10 9 8 7 6 5 4 3 2 1

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304

Associate Publisher • Carolyn C. Baker

Production Manager • Bonny E. Gaston

Copy Editor • Ida Audeh

Editorial Assistant • Catherine A. Brumley

Cover and text design by Bonny E. Gaston.

Library of Congress Cataloging-in-Publication Data

Ratts, Manivong J.
Counseling for multiculturalism and social justice : integration, theory, and application / Manivong J. Ratts and Paul B. Pedersen.—Fourth edition.
pages cm
Revised edition of Paul Pederson's A Handbook for developing multicultural awareness, 3rd ed., published in 2000.
Includes bibliographical references and index.
ISBN 978-1-55620-248-3 (alk. paper)
1. Cross-cultural counseling. 2. Minorities—Counseling of. 3. Ethnopsychology. 4. Counseling psychology—Moral and ethical aspects. 5. Social advocacy. 6. Social justice. I. Pedersen, Paul, 1936- II. Title.
BF636.7.C76R38 2014
158.3—dc23 2013047397

I dedicate this book to Nga Thi Truong and Kieu An Ratts. Working on this book has been challenging because it has meant time away from the both of you. Thank you for all of your love and support.

—Manivong J. Ratts

• • •

I would like to dedicate this book to students who aspire to become multicultural and social justice change agents.

—Paul B. Pedersen

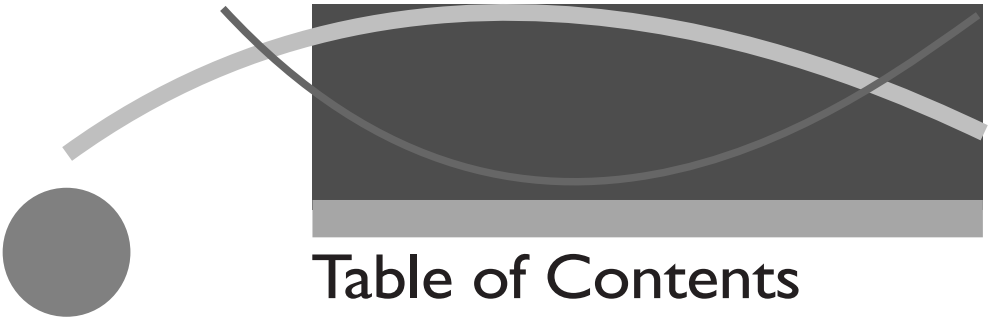
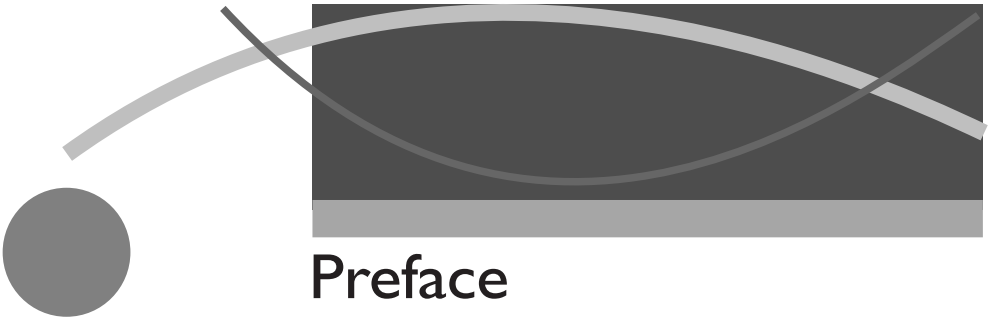


Table of Contents



Preface

"Skate to where the puck is going to be, not to where it has been."

—R. MacGregor, "Fortune Smiled Upon Us"

• • •

Retired hockey great Wayne Gretzky is known to live by this maxim, which his father shared with him. Gretzky's ability to foresee where the puck was going allowed him to stay ahead of the game and excel in the sport of hockey. This perspective can also be applied to the field of counseling and psychology. The future of counseling and psychology rests on our ability to continue to refine the multicultural and social justice counseling perspectives. We need to have the foresight to know where both perspectives are heading if counseling and psychology are to be sustainable resources. We must use research to improve our understanding of multiculturalism and social justice. Research, when done appropriately, can provide the vision to sustain the multicultural and social justice counseling forces. Just as important is the need for clinical practice to be informed by clients who seek psychological and community-based services. Clients bring with them a wealth of experiences and knowledge that should not be ignored.

As we look to the future of the counseling profession, we believe the next iteration is to bridge the multicultural and social justice perspectives. By bridging these two complementary forces, we expand the boundaries of imagination and practice on the ways in which counseling can be used to positively impact individuals and communities. Moreover, we address the challenge of living in a multicultural and socially just world in which people are able to live full and self-fulfilling lives.

The need to acknowledge and combine multiculturalism with social justice cannot be overstated. If counselors lack multicultural competence, they will be ineffective social change agents. No matter how well-intentioned, highly skilled, well trained, or intelligent they are, they can do harm if they make wrong or culturally inappropriate assumptions; they can inadvertently promote social change strategies that are not in clients' best

interests. Counselors may ignore the relevance of culture and disregard the influence of the sociopolitical milieu, or they may inappropriately use individual therapy to address systemic issues without getting at the source of the problem. The inaccuracy or misattribution resulting from wrong assumptions or from disregarding the influence of contextual factors on individuals translates into defensive disengagement by both providers and consumers of counseling, each trying to protect the truth as they perceive it.

The current trend toward increased multicultural counseling among counselors is critical and has been argued to be a *fourth force* in the helping professions with as profound an impact on counseling as the third force of humanism had on the prevailing psychodynamic (first force) and behavioral systems (second force) of that time (Pedersen, 1991). Each force reflects a new movement in counseling and psychology. The multicultural dimension is not competing with other counseling theories. By making culture central to humanism, psychodynamism, and behavioral psychology, those perspectives are strengthened, not weakened.

Similar arguments have also been made to consider social justice as a *fifth force* in counseling (Ratts, 2009; Ratts, D'Andrea, & Arredondo, 2004). Social justice is a paradigm unto itself distinct from all other helping models. Social justice counseling acknowledges that human development issues need to be understood within the context of living in an oppressive environment. Counseling is not office bound. The debilitating impact of oppression warrants the need for advocacy and activism in communities. Social justice counselors understand that counseling involves both individual and systems work.

Developing into multicultural and social justice competent counselors is not an easy task. Multiculturalism and social justice are too often classified as secondary or tertiary prevention approaches. It is something that counselors do if they have time for it, or it is something that is superficially added to an already established theory or practice. This attitude and antiquated way of thinking does nothing but hinder the profession and our clients. Some counselors will become so frustrated by their inability to connect with individuals from oppressed groups that they will blame their lack of multicultural and social justice competence on the clients themselves.

Counselors can choose either to ignore the influence of culture and oppression or to address it head on. In this book we discuss the increasing need to merge the multicultural and social justice forces into all facets of the helping field. We make several assumptions in writing this book, some of which are more controversial than others. Let us state these assumptions directly and explicitly.

- There is complexity in the multiple aspects of human identity.
- Multiculturalism is broadly defined and includes all the unique dimensions that shape human identity.
- All counseling takes place in a multicultural and sociopolitical context.
- The most important elements of multicultural and social justice competence can be learned but cannot be taught. Good teaching can, however, create the favorable conditions for multicultural and social justice competence to occur.
- Multiculturalism and social justice go hand in hand. Both are necessary conditions in any psychotherapeutic interaction.
- People experience both oppression and privilege. We are members of dominant (oppressor) and target (oppressed) groups.
- The interlocking system of power, privilege, and oppression exists on many levels and hinders human growth and development.
- Counseling that is informed by intrapsychic approaches cannot sufficiently resolve systemic based issues.

- Counseling includes both individual therapy and systems advocacy.
- Counseling can serve as a vehicle to oppress or liberate clients.

The 4th edition of this book is significantly different from previous editions. Earlier editions of this book were titled *A Handbook for Developing Multicultural Awareness*. The book was a resource guide on developing multicultural awareness, knowledge, and skill. To make this book relevant to the times, the following substantive and formative changes were made.

- We adopted a broader and more inclusive definition of multiculturalism. We focus on race, ethnicity, gender, sexual orientation, age, disability status, and religion/spirituality as it relates to counseling. We bridge the very best from the multicultural force with the strengths of the social justice force to create a new paradigm.
- We introduce two self-assessment instruments that help measure counselors' awareness of their level of multicultural and advocacy competence.
- We offer a framework that merges the multicultural and social justice forces and helps counselors to determine whether individual counseling (office-based interventions), advocacy counseling (community-based work), or both are needed when working with clients. We added an application section written by experts in the field that operationalizes multiculturalism and social justice with various client populations.

As a result of these changes we have retitled the book *Counseling for Multiculturalism and Social Justice: Integration, Theory, and Application*. We believe this title better reflects the intent of the book. We integrated both the multicultural and social justice perspectives into one unifying force. Past theories are highlighted along with their connection to current and emerging multicultural and social justice concepts. We also focused on applying multiculturalism and social justice in clinical settings. The book has three parts, each of which is described in the following sections.

Section I: An Overview of Multicultural and Social Justice Counseling

Section I encompasses Chapters 1–5, which provide foundational theories, concepts, and the context needed to understand the role of multiculturalism and social justice in counseling.

Chapter 1 provides an overview of both the multicultural counseling and social justice counseling movements and their connection. This chapter helps readers gain a historical perspective of the roots of multiculturalism and social justice in counseling. Chapter 2 highlights the five counseling forces in counseling and psychology. This chapter begins with an overview of the major tenets of the psychoanalytic, cognitive-behavioral, existential-humanistic, multicultural, and social justice counseling forces and a critique of each. Chapter 3 describes the complexities of identity as well as the influence of oppression on identity. Privilege, border, and oppressed groups are identified and discussed. This chapter highlights the need to understand identity within the context of living in an oppressive society and the influence of power and privilege. Chapter 4 bridges the multicultural and social justice counseling forces into one unified approach. We introduce readers to the counselor–advocate–scholar model, which provides a framework that counselors can use to determine whether individual therapy

or systems-level work is needed and integrates scholarship. Chapter 5 explores the concept of worldview and provides a comprehensive summary of predominant identity development models in the literature related to race, gender, and sexual orientation. Identity development models are important to understanding how oppression impacts racial, gender, and sexual identity development.

Section II. Developing Multicultural and Social Justice Competence

The chapters in this section focus on practical strategies that can help one develop into a multicultural and advocacy competent helping professional. Chapter 6 discusses the importance of terminology and its dynamic nature. We offer suggestions on how to refer to individuals based on their group membership. Using appropriate terminology is important to creating an affirming clinical environment. Chapter 7 explains the importance of developing multicultural competence. The Multicultural Competencies Self-Assessment Survey is provided as a tool to gauge the counselor's level of multicultural awareness, knowledge, and skills. Chapter 8 discusses the importance of developing advocacy competence. The Advocacy Competencies Self-Assessment Survey is introduced to help counselors develop into advocacy competent change agents. Chapter 9 explains why gaining buy-in and addressing resistance toward multiculturalism and social justice are important. We introduce E. M. Rogers's (2003) diffusion of innovation theory as a basis for how to infuse multiculturalism and social justice into counseling theories, research, and practices.

Section III. Addressing Individual and Systemic Oppression

In Section III we operationalize multiculturalism and social justice when working with oppressed client populations. This section is perhaps the most significant addition to the book. We invited scholars who are recognized experts in their respective areas to write application chapters focused on counseling from a multicultural and social justice framework. Each of the application chapters provides a historical overview of an oppressed group, identifies key multicultural concepts and systemic barriers, and offers a case study to help readers operationalize multicultural and social justice counseling tenets. Client confidentiality was maintained in all case material so that the client and third parties (e.g., family members) are not identifiable. (Some examples are actually composites of many individuals known to the authors.)

Examples of individual counseling and advocacy counseling are offered for each client group discussed. We note that practical considerations regarding book length prevented us from including chapters on all oppressed client groups. Issues relevant to the following client populations are included: Asian and Pacific Islanders (Chapter 10); African Americans (Chapter 11); Native Americans (Chapter 12); Latin@s (Chapter 13); multiracial individuals and families (Chapter 14); lesbian, gay, bisexual, and queer individuals (Chapter 15); transgender individuals (Chapter 16); women (Chapter 17); and the poor (Chapter 18). Chapter 19 takes up religious and spiritual issues in counseling.

Multiculturalism and social justice are too complex a topic for any one book to cover completely; we have barely scratched the surface here. This book is intended to guide the reader toward a deeper understanding of the connection and practical applications when multiculturalism and social justice are integrated into the field. The reader is encouraged to seek further training and professional development to gain a deeper understanding of concepts discussed in this book.

References

MacGregor, R. (1999). Fortune smiled upon us. In S. Dryden (Ed.), *Total Gretzky: The magic, the legend, the numbers* (p. 19). Toronto, Ontario, Canada: McClelland & Stewart.

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development, 70*, 6–12.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a "fifth force" among counseling paradigms. *Journal of Humanistic Counseling, Education and Development, 48*, 160–172.

Ratts, M. J., D'Andrea, M., & Arredondo, P. (2004). Social justice counseling: "Fifth force" in field. *Counseling Today, 47*, 28–30.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York, NY: Free Press.

Acknowledgments

We would like to acknowledge both Alexa Wayman and Jennifer Truong, recent graduate counseling students at Seattle University, for their research assistance with the book. Their commitment to multiculturalism and social justice has been important in helping to put this book together.

• • •

In memory of Dr. Judy Lewis, cofounder of Counselors for Social Justice and past president of the American Counseling Association. Dr. Lewis embodies the very best of humanity. Though she will be missed, her presence in the field will always be felt.

About the Authors

Manivong J. Ratts, PhD, NCC, is associate professor in the Department of Counseling and School Psychology at Seattle University, a program accredited by the Council for Accreditation of Counseling and Related Educational Programs. He is past-president of Counselors for Social Justice, a division of the American Counseling Association (ACA), and founder of Seattle University Counselors for Social Justice, an advocacy organization that addresses issues of equity impacting individuals and communities. Dr. Ratts received his PhD in Counseling from Oregon State University (OSU). He also holds a bachelor's degree in psychology from Western Washington University and a master's degree in counseling from OSU. Dr. Ratts's scholarship promotes social justice counseling as an emerging paradigm and addresses the need for mental health professionals to act as agents for social and political change. He has published in such peer-reviewed journals as the *Journal of Multicultural Counseling and Development*, *Journal of Counseling & Development*, and *Counselor Education and Supervision*. Dr. Ratts is the lead co-editor of the book *ACA Advocacy Competencies: A Social Justice Framework for Counselors* (2010, with Rebecca L. Toporek and Judith A. Lewis) and has produced two videos through Alexander Street Press—*Four Approaches to Counseling One Client: Medical, Intrapsychic, Multicultural, and Social Justice Counseling Paradigms* (2011) and a five-part DVD series titled *Five Forces of Counseling and Psychotherapy: Psychoanalytic, Cognitive-Behavioral, Existential-Humanistic, Multicultural, and Social Justice* (2013). Dr. Ratts has served on the editorial boards of *Journal of Counseling and Development* and the *Journal for Social Action in Counseling and Psychology*.

Paul B. Pedersen, PhD, is professor emeritus in the Department of Counseling and Human Services in the School of Education at Syracuse University. He previously held academic positions at the University of Alabama at Birmingham, Syracuse University, the East-West Center, and the University of Minnesota, and he served as faculty or visiting fellow at Harvard University, University of Hawaii, and the University of Pittsburgh—Semester at Sea. Dr. Pedersen is a fellow in Divisions 9 (Society for the Psychological Study of Social Issues), 17 (Society of Counseling Psychology), 45 (Society for the Psychological Study of Ethnic Minority Issues), and 52 (International Psychology) of the American Psychological Association. Dr. Pedersen has authored or edited 45 books, 100 articles, 82

chapters, and 22 monographs on aspects of multicultural/cross-cultural counseling and international communication. His body of work includes such classic books as *Counseling Across Cultures* (a textbook in its 6th edition, with Walter J. Lonner, Juris G. Draguns, and Joseph E. Trimble), *Case Incidents in Counseling for International Transitions* (with Nancy Arthur), *Handbook for Developing Multicultural Awareness* (3d edition), *Preventing Prejudice* (with Joseph G. Ponterotto and Shawn O. Utsey, 2d edition), *Progress in Asian Social Psychology: Conceptual and Empirical Contributions* (with Kuo-Shu Yang, Kwang-Kuo Hwang, and Ikuo Daibo), *Counseling Refugees: A Psychosocial Approach to Innovative Multicultural Interventions* (with Fred Bemak and Rita Chi-Ying Chung), *Hidden Messages in Culture-Centered Counseling: A Triad Training Model*, *Constructive Conflict Management: Asian and Pacific Cases* (with Fred E. Jandt), *Five Stages of Culture Shock: Critical Incidents Around the World*, *Culture-Centered Counseling and Interviewing Skills* (with Allen Ivey), *Mental Health Services: The Cross-Cultural Context* (with N. Sartorius and Anthony J. Marsella), and many others.

About the Contributors

Jodi L. Bartley is a doctoral candidate in the Counseling and Counselor Education program at the University of North Carolina at Greensboro. She is also a national certified counselor and a licensed professional counselor associate in North Carolina. She has a BA in education, an MA in educational psychology, and an MEd in mental health counseling. Her research interests include relational depth and spirituality.

S. Kent Butler, PhD, is associate professor of counseling at the University of Central Florida. He holds a PhD in educational psychology, with a concentration in counseling psychology, from the University of Connecticut. Dr. Butler is a licensed professional counselor, national certified counselor, and nationally certified school counselor. He joined the faculty at the University of Central Florida as an associate professor in 2007. Previously he was on faculty at the University of Missouri—St. Louis, where he served the Division of Counseling and Family Therapy as the coordinator of the School Counseling Program, coordinator of the Counseling Clinic, and faculty advisor to Chi Sigma Iota. He also served as the principal investigator on a Substance Abuse and Mental Health Services Administration Earmark Grant: University of Missouri, Division of Counseling and Family Therapy-Drug Free Family Initiative. Dr. Butler is past-president of the Association for Multicultural Counseling and Development.

Craig S. Cashwell, PhD, LPC, NCC, ACS, CSAT, is a professor in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro (UNCG) and owner of Cashwell Counseling and Consulting, PLLC. Dr. Cashwell has received numerous awards, including outstanding mentor awards from the UNCG and the Conference of Southern Graduate Schools, the Chi Sigma Iota International Thomas J. Sweeney Professional Leadership Award, and the Association for Spiritual, Ethical, and Religious Values in Counseling Lifetime Service Award. In 2011, he received designation as an American Counseling Association (ACA) Fellow.

Catherine Y. Chang, PhD, LPC, NCC, is a professor at Georgia State University and program coordinator for the counselor education and practice doctoral program. She also serves as the director for international programs for the Georgia State University College of Education. She has published and presented in the areas of social justice and advocacy, multicultural counseling competence, privilege and oppression, and supervision. Additionally, she was the lead editor for the book *Professional Counseling*

Excellence Through Leadership and Advocacy and the lead editor for the special issue on Social Justice for the *Counselor Education and Supervision* journal. She has served as president of Chi Sigma Iota (2009–2010) and vice president of the Asian and Pacific Islander American concerns of the Association for Multicultural Counseling and Development (2010–2013). She is the recipient of the ACA Research Award, the ACA Counselor Educator Advocacy Award, the Association for Assessment in Counseling and Education Measurement and Evaluation in Counseling and Development Research Award, the Pre-tenured and Tenured Counselor Educator Award from the Southern Association for Counselor Education and Supervision, and the Alumni Excellence Award from the Department of Counseling and Educational Development at University of North Carolina at Greensboro. She serves on the editorial boards for the *Measurement and Evaluation in Counseling and Development* and *Counseling Outcome Research and Evaluation* journals.

Kelley R. Kenney, EdD, is a licensed professional counselor and a full professor in the Department of Counseling and Student Affairs at Kutztown University, Kutztown, PA, where she coordinates the student affairs administration and college counseling graduate programs. Dr. Kenney is a coauthor of *Counseling Multiracial Families*, published by Sage Publications; coauthor and codirector (with Mark Kenney) **of** the training video *Counseling the Multiracial Population: Couples, Individuals, and Families*, distributed by Insight Media and Microtraining Associates; and an author and coauthor of numerous articles, monographs, and book chapters on the multiracial population. She is a cochair of the ACA's Multiracial/Multiethnic Counseling Concerns Interest Network, an advisory board member of Loving Day, and the immediate past-Governing Council representative for the ACA's North Atlantic Region.

Mark E. Kenney, MEd, is a licensed professional counselor and the coordinator of the masters program in psychology at Chestnut Hill College/DeSales University campus in Center Valley, PA. He is also a coauthor of *Counseling Multiracial Families*, published by Sage Publications; coauthor and codirector (with Kelley Kenney) of the training video *Counseling the Multiracial Population: Couples, Individuals, and Families*, distributed by Insight Media and Microtraining Associates; as well as a coauthor of several book chapters addressing the multiracial population. He is cochair of the ACA's Multiracial/Multiethnic Counseling Concerns Interest Network and an advisory board member of Loving Day.

Jennifer Londgren, MS, LAMFT, NCC, is a second-year doctoral student in the counselor education and supervision program at Minnesota State University, Mankato. She is a therapist working at an inpatient treatment center for women and their children; in her clinical work, she focuses on issues of addiction, poverty, and trauma. She is also a qualitative researcher and an adjunct faculty member at Minnesota State University, Mankato.

Laura A. Maki has a master's degree in communication studies from the University of Minnesota and is currently completing a doctoral degree in counselor education and supervision with an emphasis in college student affairs at Minnesota State University, Mankato. Her research interests include women's mentoring experiences and women's experiences in leadership in higher education.

Julian Rafferty McCullough, MAEd, is currently a doctoral student in the counselor education and supervision program at Georgia State University, a program accredited by the Counsel for Accreditation of Counseling and Related Educational Programs. He holds a BA in philosophy from Minnesota State University, Mankato, and a master's in education in school counseling from Seattle University. He is a former adjunct professor in the Department of Counseling and School Psychology at Seattle University and is one of the founding members for Seattle University Coun-

selors for Social Justice. His background as an advocate for lesbian, gay, bisexual, queer, and especially transgender youth and adults and as a middle school counselor in impoverished, urban communities has further strengthened his commitment to multicultural and social justice concerns in the field of counseling.

C. Peeper McDonald is a doctoral student in the counselor education and practice PhD program at Georgia State University. She holds master's and specialist in education degrees in professional counseling. Her professional and research interests include counselor identity development and advocacy, social justice, and diversity issues within counseling and supervision. She values servant leadership and as a result has served in her local Chi Epsilon chapter of Chi Sigma Iota between 2010 and 2013, served as a National 2013–2014 CSI Leadership Fellow, and has served in her community for several years as a youth group leader for high school girls.

Caroline O'Hara, EdS, LPC, NCC, is a doctoral student in the counselor education and practice program at Georgia State University. An active scholar and researcher, Ms. O'Hara has published and presented at the national level in the areas of identity development, social justice counseling, sexual and gender diversity, multicultural competence, counseling supervision, and advocacy (both client and professional). She has also held multiple leadership positions. Locally, she has served as president of the Chi Epsilon Chapter of Chi Sigma Iota (CSI). Nationally, she serves as chair of the Association for Assessment and Research in Counseling (AARC) Diversity Committee, Student perspectives editor for AARC's *NewsNotes*, associate student editor of the CSI *Exemplar*, and member of the CSI Professional Advocacy Committee. She has been recognized with the CSI International Leadership Fellow and Intern Award, the Southern Association for Counselor Education and Supervision Emerging Leader Fellow Award, and the American Counseling Association Courtland C. Lee Multicultural Excellence Scholarship Award.

Jennifer L. Pepperell, PhD, NCC, LPC, is an associate professor at Minnesota State University, Mankato. Prior to her faculty position, her primary clinical focus had been with children and adolescents, in both shelter and school settings. She completed her doctoral degree at Oregon State University in counselor education and supervision. She is a qualitative researcher with a research focus on the identity formation of girls and women and on youth and college students in the lesbian, gay, bisexual, and transgender community. Her research is predominantly conducted through a feminist and social justice lens.

Rebecca Reed, EdM, is a PhD candidate in the counseling psychology program at Teachers College, Columbia University. She received her EdM in psychological counseling from Teachers College. Previously, she worked in a charter school in Harlem, New York, as a guidance counselor and admissions coordinator, where she provided academic and personal counseling services for children and parents. Her research interests include participatory action research training, poverty, and the influence of social class on education.

Varunee Faii Sangganjanavanich, PhD, is an assistant professor of counseling at the University of Akron in Akron, Ohio. She is a national certified counselor and a licensed professional clinical counselor with supervisor endorsement in the state of Ohio. She received her doctoral degree in counselor education and supervision from the University of Northern Colorado. Her clinical work focuses on gender identity and transition counseling. In addition, she has authored and coauthored numerous publications and presentations in the field of counseling and counselor education, particularly in the area of gender transition counseling and career development of transgender individuals.

M. Ann Shillingford-Butler, PhD, is an assistant professor of counselor education at the College of William & Mary in Williamsburg, VA. She worked for several years as a professional school counselor prior to completing her doctorate at the University of Central Florida. Dr. Shillingford-Butler has written several articles and book chapters on multicultural issues, particularly those that affect children and those who serve them.

Laura Smith, PhD, is an associate professor in the Department of Counseling and Clinical Psychology at Teachers College, Columbia University. She earned her doctoral degree in counseling psychology from Virginia Commonwealth University and has worked in a variety of applied settings in New York City. She was formerly the founding director of the Rosemary Furman Counseling Center at Barnard College and the director of psychological services at the West Farms Center, where she provided services, training, and programming within a multifaceted community-based organization in the Bronx. Dr. Smith's research interests include social class and poverty, the influence of classism on psychological theory and practice, the development of socially just practice models for psychologists at the community level, and participatory action research in schools and communities.

Timothy C. Thomason, EdD, is a professor in the Educational Psychology Department at Northern Arizona University in Flagstaff. He is a licensed psychologist and a national certified counselor. He has conducted research on counseling Native Americans and has published many articles and book chapters, many of which are available at the website http://works.bepress.com/timothy_thomason/.

Edil Torres-Rivera, PhD, is a professor of counseling in the School of Human Development and Organizational Studies in Education at the University of Florida. He holds a PhD in counseling psychology from the University of Connecticut. His research agenda is about multicultural counseling, group work, chaos theory, liberation psychology, technology, supervision, multicultural counseling, prisons, Puerto Rican studies, identity development, and gang-related behavior. Dr. Torrres-Rivera's primary research focuses on the role of indigenous healing techniques when working with ethnic minority populations in the United States and the implications of social injustice and oppression in counseling and psychotherapy with ethnic minorities, in particular, with school-age Latinos/Latinas in the United States.

Alexa Wayman holds an MAEd in counseling from Seattle University, wherein she completed a year-long internship at an alternative education K-8 school in Seattle. Her current work involves engaging with children and families in a low-income neighborhood through the Seattle University Center for Service and Community Engagement. Working with the Seattle University Youth Initiative, she strives to foster family resilience and advocates for early learning and closing the achievement gap with immigrant families. She is actively pursuing ways to engage in research and practice to respond to the needs of marginalized communities; she is currently involved in a qualitative study investigating causal factors for English language learners student dropout and retention rates.

Alexander C. Winninghoff is an educator and writer. She completed a BA in social justice at Antioch University and a master's in teaching from Seattle University. She has served in the greater Seattle area as a diversity trainer and policy consultant for lesbian, gay, bisexual, transgender, and queer issues in a school district and as a youth advocate with the Gay, Lesbian & Straight Education Network. She currently teaches at an inner-city high school in Atlanta.

Section I.

An Overview of Multicultural and Social Justice Counseling

Chapter 1

Multiculturalism and Social Justice: A Revolutionary Force in Counseling and Psychology

There is a growing sentiment in the counseling profession that hegemonic counseling theories do not adequately address the needs of historically marginalized populations. Predominant theories in counseling do not take into account the unique needs of people of color; women; lesbian, gay, bisexual, and transgender individuals; socioeconomically disadvantaged clients; religious minorities; and other oppressed client populations. Predominant counseling theories, which we illustrate in detail in Chapter 2, tend to discount the importance of cultural factors, place excessive weight on individual change, blame historically marginalized clients for their predicament, and ignore the relevance of external factors to clients' health and well-being. Despite the growing body of literature (Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue & Sue, 2013) indicating the importance of cultural factors in counseling and the need to contextualize client problems and interventions (Ratts, Toporek, & Lewis, 2010), counselors continue to use archaic counseling practices that are remedial at best.

Consider the following examples:

- After seeing several counselors in his community, Victor, a 36-year-old African American gay male client, decided to travel more than 100 miles each way once a week to see a counselor who specialized in gay and lesbian issues. The counselors in his rural community were not able to address the struggles he was experiencing with family and work regarding his sexual identity. Victor was shunned by his family after telling them he was gay. They had cut off all communication with him. He did not "come out" to his colleagues at work for fear of losing his job. His colleagues often made anti-gay jokes, which made him feel uncomfortable. He could not speak out mainly because he did not want them to know that he was gay and because his work's anti-discrimination policy did not include sexual orientation.
- At one campus, most students of color preferred to see the staff at the Multicultural Affairs center on campus instead of the counseling staff at the university counseling center. Although the Multicultural Affairs staff were not trained counselors or psychologists, they often talked with students of color about such issues as racial identity, relationships, college transition, and other personal or social concerns. The

counseling center staff did not approve; they believed that students of color should be referred to them because they were trained to provide clinical services. The Multicultural Affairs staff reported that students of color regarded the counseling staff as insensitive to their cultural concerns. For example, many students of color reported that counselors seemed "distant" in sessions and appeared hesitant to share about their background. Many students of color, who are collectivistic in orientation, also reported that counselors lacked an understanding of how family played a role in their career choices. Students of color also reported that counseling staff, unlike Multicultural Affairs staff, were rarely present at student functions, which made them seem distant.

- Steven, a 19-year-old transgender male client, was recently diagnosed with depression. His family had become distant from him ever since he told them he was intending to transition from female to male. He spent a majority of his time home alone and reported not having any friends. Steven did not agree with the diagnosis of depression; he believed that his struggles were due to his family's inability to accept his gender identity. After 2 months, Steven realized that the majority of time in therapy was spent educating his therapist on the issues experienced by transgender people; for example, his therapist did not know what needed to be included in a letter he was going to write to Steven's physician so that he could receive hormone medication. Steven decided to terminate therapy; he wanted a counselor who could address his concerns and not someone who he paid to educate.
- Yen, a 35-year-old Vietnamese female client living in poverty in a major urban city, received a letter in the mail from her therapist who decided to terminate their relationship because she was late for therapy a third time without calling 24 hours in advance. Because she relied on public transportation to get to her counseling sessions, it often took about an hour to get from home to her counselor's office. The therapist had a 15-minute no-excuse late policy. Yen was unable to afford a cell phone (or a car, for that matter), so she was unable to call her therapist to inform her that she was running late on the three occasions that she was delayed by heavy traffic.

In each of these examples, the counselor failed the client. Equally unfortunate about each of these situations is that the failure often goes unnoticed. The counselors in the rural community will continue practicing without realizing that they cannot provide adequate clinical services to gay clients. The counselors in the university counseling center are likely to remain entrenched in what they have been trained to do, which is to require students of color to adapt to their own theoretical orientation. The therapist working with the transgender client likely feels that she is providing the client an affirming clinical environment. Yen's therapist may never realize that requiring her client to come to her office without being flexible regarding appointment times is an added structural barrier to accessing therapy.

These examples illustrate real-life multicultural interactions that occur every day between clients and counselors. These situations highlight how inequitable social structures contribute to client problems. Each example demonstrates how race, ethnicity, gender, and social class influence the therapeutic relationship, and each example reflects the harm that well-intentioned but ill-equipped counselors have on clients when they are unable to address multicultural issues and systemic barriers.

We hope this book helps to clarify, explain, and expand on the importance of multiculturalism and social justice in counseling. Multicultural and social justice counseling have transcended the field of counseling and psychology in ways its founders could not have

imagined. These changes highlight the need for all counselors to possess multicultural and social justice competence. The issues that clients bring to therapy cannot be understood simply by exploring client cognition, affect, and behavior. Understanding people's lived experiences is not possible without a grasp of the larger cultural and social context.

The purpose of this book is to help counselors develop both multicultural and social justice competence and to understand its application with clients and communities. Both multicultural and social justice perspectives are crucial to effective and ethical practice. For this reason, we attempt to bridge these two complementary perspectives by shedding light on the distinctions, and the symbiotic relationship, between the two. We begin this chapter by providing an overview of the flaws in psychology and its impact on counseling. An overview and history of the multicultural and social justice counseling perspectives is offered along with important events that shaped both perspectives.

Promotion of the Status Quo

The failure of the counseling profession and (more broadly) psychology to respond to the needs of historically marginalized client populations has received considerable attention. This failure can be attributed to a variety of factors. One, counseling continues to use theories that minimize clients' cultural background and that discount the influence of contextual factors on human development. The lack of attention to cultural factors and the larger sociopolitical context has to do in part because psychology, and by extension counseling, is in direct competition with the natural sciences. Both the natural sciences and the social sciences are in direct competition to be at the top of the "food chain" in the helping professions. It is this competition that leads to counseling theories and practices that lack an adequate epistemology (Martin-Baró, 1996). Two, the prevailing belief that counseling is an office-bound profession is also a constraint that limits what counselors can do. By virtue of the very system they have helped to construct, such as managed care, counselors have limited their own ability to address oppressive systemic barriers impacting clients. Three, another factor contributing to the failure of counseling in this respect is the flawed practice of having counselors align with a theoretical counseling orientation prior to working with clients. For example, graduate counseling students are often taught that they need to affiliate themselves with a particular counseling theory before they are to work with clients. This approach to counselor training leads to a counselor-driven model of helping that does not sufficiently meet the needs of oppressed client groups. We discuss each of these factors below.

Psychology's Inferiority Complex

The need for the social sciences to be on par with the natural sciences contributes to the inability of psychology to address the needs of oppressed groups. In order to be viewed as equals to scientists, psychologists adopted concepts and methods from the natural sciences. For example, an important aspect of psychotherapy stresses the need for counselors to be objective and value neutral. Like scientists in a lab, counselors are trained to maintain professional distance from clients so that the therapeutic process can unfold without counselor bias. We believe that objectivity and value neutrality in counseling are impossible and that they mystify the counseling process. Counseling is a value-laden experience to which clients and counselors bring their own biases, values, and experiences.

The need of social scientists to be viewed as equals to natural scientists is also seen in counseling and psychology's acceptance of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The *DSM* is largely created by psychiatrists to promote the practice of psychiatry. Counseling and psychol-

ogy have little to no say in the development of the *DSM*. When helping professionals uncritically accept the *DSM-5* as dogma or rely solely on it without considering cultural or systemic factors, they are essentially relying on psychiatry to define what is normal and abnormal. This practice is both dangerous and careless. It places the profession in a predicament where psychiatry dictates psychological practice and determines the value and worth of psychological practice in ways that serve its own interests.

There is an inherent flaw in applying methods and concepts from the natural sciences in the social sciences. Both are completely different disciplines with unique rules, variables, and nuances. Concepts and methods established in one discipline do not necessarily apply to another. By uncritically incorporating methodologies and concepts from the natural sciences, counseling and psychology assume lesser significance as disciplines.

Lack of an Adequate Epistemology

Martin-Baró (1996) discussed five assumptions inherent in psychology that limit its ability to address the needs of marginalized client populations:

- *Positivism*, the belief that knowledge should be based on logic, facts, events, and empirical research. The assumption is that society, much like science, operates according to general laws. These general laws are often based on dominant value systems and tend to place value of quantitative research over qualitative research. That which cannot be measured quantitatively (e.g., client and community voices) is rejected.
- *Individualism*, the belief that human behavior can be understood separate from the social context. Values such as independence, self-reliance, and autonomy are promoted over those of the group. Structural problems are perceived as being rooted in individual problems. Not all cultures value individualism. For instance, many Asian cultures place high value on collectivism and making decisions that promote the larger group (e.g., family). Psychology's promotion of individualism creates a hierarchy whereby collectivism is devalued.
- *Hedonism*, the belief that all human behavior is a never-ending quest for pleasure. Human beings seek happiness over pain. All theories are imbedded in hedonism in that they strive to help people achieve full pleasure. This perspective ignores alternative perspectives. For instance, within the Buddhist perspective suffering is considered a natural and healthy aspect of human development.
- The *homeostatic vision*, whereby human beings endeavor to have balance in life. Disequilibrium, change, crisis, or anything that ruptures this ideal balance is viewed negatively. This explains why social change is difficult for many in society to accept—it often leads to disequilibrium in the sense that it changes the status quo.
- *Ahistoricism*, a core tenet of science that all humans are the same regardless of race, gender, sexual orientation, social class, disability status, and religion. The assumption that predominant theories and concepts can be modified to make them applicable to all groups is an example in psychology. This belief often leads to the application of dominant cultural theories and concepts on cultures and groups that hold differing worldviews and perspectives, which in turn can lead to labeling marginalized communities as abnormal.

For psychology, and thereby counseling, to truly be appropriate to historically oppressed groups, such issues need to be addressed. To ignore these issues would mean running the risk of doing harm to clients from oppressed groups and communities.

Office-Bound Profession

Students often enter graduate counseling programs with a predetermined idea of what counseling entails. Many begin their training with the idea that counseling is a one-on-one process that takes place in an office setting. Their notion of counseling, formed well before they take their first class, is based on personal experience as clients or is formed through popular culture. They hold the belief that clients come to counseling seeking insight, guidance, and direction. Clients enter therapy hoping that counselors can help them feel better by resolving their problems.

The belief that counseling is an office-bound profession is further reinforced in counselor training programs. Students are told throughout their training that they need to maintain "professional boundaries" and preserve their "professional identity." These are code words for "Don't leave your offices." "Don't question the status quo." "Systems work is social work." This message is both subtle and direct. Students who question the social order of things are threatened with failing grades or placed on remedial plans. Because students do not have power, most choose to say nothing. Some decide to leave their programs because they are frustrated by the lack of support. Some graduate, enter the field, and eventually leave, unable to loosen the shackles of their training.

Counselor-Driven Approach

Determining the origin of client problems should begin with the client (Lewis et al., 2011). Unfortunately, prevailing practice has it that counselors enter the counseling relationship with a predetermined theoretical orientation and idea of how they intend to work with clients (see Figure 1.1). When this occurs, counselors risk doing things that are not consistent with the client's cultural background. This approach may also disregard important social factors that contribute to client problems. Such counselors risk missing the mark because they come with a preconceived notion of client needs before they even establish a working relationship with the client.

In the multicultural and social justice approaches to counseling, counselors enter the counseling relationship without a predetermined theory or expectation of how to work with clients (see Figure 1.1). When counselors enter the therapeutic relationship without preconceived notions of what theory or approach to use, they are better able to see clients for who they are. This tactic can lead to counseling strategies that are more consistent with the client's cultural background, worldview, and lived experiences. We believe that the client's presenting problems should determine the theories and approaches counselors take in counseling. This is a perspective shared by Martin-Baró (1996):

> What is needed is a revision, from the bottom up, of our most basic assumptions in psychological thought. But this revision cannot be made from our offices; it has to come from a praxis that is committed to the people. (p. 23)

Unless fundamental change occurs in how to use psychology to help others in a different way, the status quo of how counseling is practiced will remain the same. Culturally

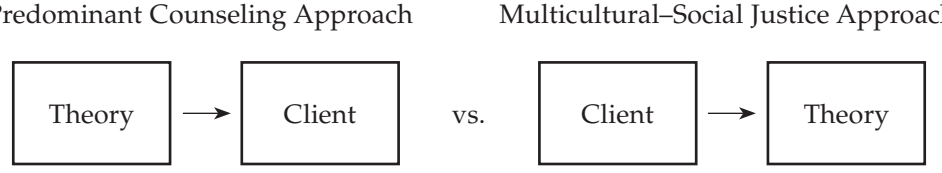


Figure 1.1 • **Approaches to Counseling**

diverse clients will continue to receive services that do not adequately attend to their needs because it overlooks cultural variables. Counselors will remain ill-equipped in their ability to address systemic issues experienced by clients.

Multicultural and Social Justice Counseling

The inherent flaws in counseling and psychology spawned the development of the multicultural and social justice perspectives in the field. The multicultural and social justice counseling perspectives are separate but equally important forces that have revolutionized the field of counseling and psychology. Both perspectives draw on the need to consider the relevance of cultural and sociopolitical contexts in counseling. Together, the multicultural and social justice perspectives help counselors develop into competent, ethical, and socially responsible helping professionals. Both approaches are described in this section.

Multicultural Counseling Perspective

Historical Overview

The multicultural perspective evolved in the 1950s during the civil rights era (Jackson, 1995). The 1950s was a time when overt racial segregation and systematic racial inequities were the norm in U.S. society. Professional counseling organizations were not immune from such racial biases in society. For example, the American Personnel and Guidance Association (later renamed the American Association for Counseling and Development in 1983 and the American Counseling Association [ACA] in 1992; Sheeley, 2002) has a history of racism. Racial and ethnic minorities, namely African Americans, were barred from leadership positions within the American Personnel and Guidance Association, the parent organization for those in the counseling profession (Jackson, 1995). Racial discrimination and exclusionary practices made it difficult for racial and ethnic minority counseling scholars and professionals to contribute to multiculturally oriented counseling research. The lack of multiculturally oriented research led to insensitive clinical practices that proved ineffective when counseling culturally diverse client populations. Instead, clinical practices focused on assimilating culturally diverse clients into White culture.

The prevailing belief at the time was that racial and ethnic minorities should adapt to White culture to survive in U.S. society. This belief was rooted in the "melting pot" metaphor, the notion that people from different cultures could co-exist by identifying and building on dominant similarities across racial groups. Unfortunately, this practice often came at the expense of minority individuals, who were expected to sacrifice their cultural identity.

In the counseling profession, the melting pot metaphor manifested itself in the belief that one theory or approach could apply to any client. As long as a theory was academically "sound" and supported by "research," it would be appropriate for use with any client regardless of that client's cultural background. Patterson (1996) argued against tailoring counseling approaches to specific client populations and promoted a universal approach to counseling that was applicable to all cultures.

The melting pot metaphor has never been an accurate descriptor of reality in the United States. Even when faced with pressure to assimilate, many immigrants and refugees maintain their cultural heritage and language. Many live in a bicultural world where they successfully operate in mainstream society at work and are able to maintain their cultural heritage by living in ethnic enclaves. Ethnic districts such as Chinatowns, Little Saigons, Jewish neighborhoods, Latino neighborhoods, and Black communities provide historically oppressed racial and ethnic groups a safe haven from the inherent racial and religious discrimination rampant in society.

In the United States, the 1960s were characterized by social unrest, political upheaval, and overt racial tension. Black and White Americans openly questioned the White establishment. Racist political beliefs, institutions, and policies were openly challenged and discussed. The social and political unrest in America served as an impetus for the emergence of the multicultural counseling perspective (Arciniega & Newlon, 2003; Jackson, 1995; Robinson & Morris, 2000).

Counseling professionals began to question White racist policies and practices (Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue & Sue, 1977). For example, many African American counseling professionals called for the eradication of racist counseling theories and practices that dehumanized racial and ethnic minority clients (Robinson & Morris, 2000). As an example, many African Americans were viewed as "sick," "ill," and "abnormal" because theories that were based on White-dominant perspectives were being utilized to determine healthy development. In addition, African American psychologists were often excluded from positions of leadership, which made it difficult to integrate psychological theories and concepts that better reflected African American peoples in psychology. Multicultural counseling research also began to materialize in the counseling literature during this period (Jackson, 1995).

The multicultural counseling perspective led to the formation of the Association of Non-White Concerns in Personnel and Guidance in 1969. The creation of the association was spearheaded by William Banks, a professor at the University of California, Berkley (Jackson, 1995). The association began as a non-White caucus established by the American Personnel and Guidance Association, the organization now known as the ACA (McFadden & Lipscomb, 1985). The primary purpose of the Association of Non-White Concerns in Personnel and Guidance was to ensure that minority issues were being addressed in the counseling profession; in 1972 it launched a journal, *Journal of Non-White Concerns* (McFadden & Lipscomb, 1985), which has been influential in publishing scholarly work in areas relating to race and ethnicity. The first editor of the journal was Gloria Smith.

In 1985, the association was renamed the Association for Multicultural Counseling and Development and the *Journal of Non-White Concerns* was renamed the *Journal of Multicultural Counseling and Development* (Parker, 1991). The change in name reflected the growing need for multicultural counseling to be more inclusive of other underrepresented racial and ethnic groups such as Asians, Latino/as, and Native Americans (W. M. Lee, Blando, Mizelle, & Orozco, 2007).

Multicultural Counseling Defined

What exactly is multicultural counseling? Early definitions of the term were based on racial or ethnic identity:

> [It is] any counseling relationship in which two or more of the participants are culturally different. This definition of cross-cultural counseling includes situations in which both the counselor and client(s) are minority individuals but represent different racial/ethnic groups (African American counselor–Latino client; Asian American counselor–American Indian client, and so forth). It also includes the situation in which the counselor is a racial/ethnic minority person and the client is European American (African American counselor–European American client, Latino counselor–European American client, and so on). (Atkinson, Morten, & Sue, 1993, p. 15)

Jackson's (1995) definition of *multicultural counseling* is broad: "counseling that takes place between or among individuals from different cultural backgrounds" (p. 3). D'Andrea and Daniels's (1995) definition of *multicultural counseling* is more specific: it is "a process in which a trained professional from one culture/ethnic/racial background interacts with a

client of a different cultural/ethnic/racial background for the purpose of promoting the client's cognitive, emotional, psychological, and/or spiritual development" (p. 18).

Sue and Sue (2013) offered a more current definition of *multicultural counseling* that speaks to it as both a role and a process:

> . . . both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients; recognizes client identities to include individual, group and universal dimensions; advocates the use of universal and cultural-specific strategies and roles in the healing process; and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems. (p. 46)

In essence, multicultural counseling is based on the assumption that no two people are alike. We are all cultural beings who are exposed to a complex web of cultural influences that shape our worldview, behaviors, and lived experiences. How we see and experience the world is a result of cultural conditioning that begins at birth and continues throughout the life span. For this very reason helping professionals need to be committed to understanding the relevance of culture throughout the therapeutic process.

Seeing clients through a cultural lens has become increasingly important because of the diversity of the United States population. The need to frame counseling around a client's cultural background has led to a call to integrate multiculturalism into all aspects of counseling. The push for a more multicultural centered practice has increased the necessity for counselors to develop multicultural competence. The belief was that counselors lacked the requisite knowledge and skills to effectively work with culturally diverse clients. This belief led to the development of the multicultural counseling competencies developed by Sue, Arredondo, and McDavis (1992), which we highlight in subsequent chapters of this book; the competencies provide a framework that helping professionals can use to develop the awareness, knowledge, and skills needed to work with culturally diverse clients.

Social Justice Counseling Perspective

Historical Overview

When counselors develop multicultural competence, inevitably they begin to acquire an increased sense of social responsibility. As multiculturally competent counselors begin to see client problems more contextually, they gain insight into how oppression affects people's lives and the ways in which systemic inequities lead to internalized oppression (J. Lewis & Arnold, 1998). This awareness leads counselors to want to do something more because they see the struggles clients face and realize the limitations of traditional ways of helping. Dworkin and Dworkin (1971) observed that "counselors can sit on the sidelines and hope that everything turns out all right, or they can become actively involved and try to have an impact on the direction of the change process" (p. 749). Implicit in this statement is that counselors need to be more creative and proactive if they are to address the root of client problems. Specifically, counselors need to consider integrating social advocacy in addition to individual counseling in their practice.

The roots of social justice in counseling date to the inception of the counseling profession (Kiselica & Robinson, 2001). Although Frank Parson was not a counselor per se, his work in career development in the early 1900s has been credited with helping counselors today see the relevance in addressing the social and political barriers that hinder client development. Early evidence of social justice as a paradigm unto itself is reflected in the 1971 special issue of the *Personnel and Guidance Journal* (the predecessor to the *Journal of Counseling & Development*). The special issue, titled "Counseling and the Social Revolu-

tion" (M. D. Lewis, Lewis, & Dworkin, 1971), addressed the harsh realities of the world faced by historically marginalized client populations and the critical need for counselors to expand their role to include social advocacy. Counselor preparation programs were also challenged to consider how they prepare emerging counselors to be agents for social and political justice (M. Lewis & Lewis, 1971). Hutchinson and Stadler's (1975) book, *Social Change Counseling: A Radical Approach,* discussed using counseling and psychology as a vehicle to promote social change.

C. C. Lee and Walz's (1998) edited book *Social Action: A Mandate for Counselors* made a case for viewing social justice and advocacy as ethical issues in counseling. This book addressed why counselors who see an injustice and choose to do nothing may not be well-suited for the profession. The editors challenged counselors to build on the work of multicultural counselors by using advocacy to address systemic forms of oppression hindering client well-being and growth.

The social justice perspective is presented clearly in J. Lewis and Bradley's (2000) edited book *Advocacy in Counseling: Counselors, Clients, and Community*. This book frames what advocacy entails and how it aligns with the counseling profession. The contributors to this book discuss counselors as change agents in addition to their well-understood role as counselors. In 2000, Jane Goodman, then president of the ACA, commissioned a task force to develop a conceptual framework to help counselors implement advocacy strategies with clients. The task force created the Advocacy Competencies, which the ACA Governing Council formally adopted in 2003. Formal adoption of the Advocacy Competencies by the ACA's Governing Council helped add legitimacy to the social justice perspective. Toporek, Gerstein, Fouad, Roysircar, and Israel's (2006) edited book *Handbook for Social Justice in Counseling and Psychology: Leadership, Vision, and Action* provided a "road map" of sorts to understanding the relevance of social justice in counseling and psychology. In Summer 2009, the *Journal of Counseling & Development* published a special issue on the Advocacy Competencies, which further framed the relevance of the Advocacy Competencies in counseling. Ratts et al.'s (2010) edited book *ACA Advocacy Competencies: A Social Justice Framework for Counselors* offered practical ways to use the Advocacy Competencies across various counseling settings, client populations, and specialty areas.

Social Justice Defined

Many definitions of *social justice* exist in the counseling literature. C. C. Lee and Hipolito-Delgado's (2007) definition of *social justice counseling* promotes access and equity

> to ensure full participation of all people in the life of a society, particularly for those who have been systematically excluded on the basis of race or ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership. (xiv)

Fouad, Gerstein, and Toporek's (2006) definition of *social justice* within counseling emphasizes the redistribution of resources by altering social structures:

> [Social justice] focuses on helping to ensure that opportunities and resources are distributed fairly and helping to ensure equity when resources are distributed unfairly or unequally. This includes actively working to change social institutions, political and economic systems, and governmental structures that perpetuate unfair practices, structures, and policies in terms of accessibility, resource distribution, and human rights. (p. 1)

Counselors for Social Justice, a division of ACA, defined *social justice counseling* as follows:

> [It is a] multifaceted approach to counseling in which practitioners strive to simultaneously promote human development and the common good through addressing challenges related to both individual and distributive justice. Social justice counseling includes empowerment of the individual as well as active confrontation of injustice and inequality in society as they impact clientele as well as those in their systemic contexts. In doing so, social justice counselors direct attention to the promotion of four critical principles that guide their work: equity, access, participation, and harmony. This work is done with a focus on the cultural, contextual, and individual needs of those served. (http:// counselorsforsocialjustice.net)

Ratts (2009) contended that social justice "is related to a growing need to connect human development issues with toxic environmental conditions" (p. 163) and added:

> Environmental factors, such as racism, sexism, heterosexism, and classism, can delay people's growth and development and hinder people's ability to reach their potential. This is especially true for clients who have been historically marginalized in society such as people of color, those in poverty, and individuals who are lesbian/gay/bisexual/transgender (LGBT). Helping clients recognize the presence of oppressive factors is important because it prevents them from blaming themselves for their plight. (pp. 163–164)

We add our definition to this list; we define *social justice counseling* as a role, a mutually collaborative process, and an ideal that counselors strive to achieve. Counselors can play a role in either maintaining or dismantling oppression. Those who seek a more just world actively work to ensure that high-quality resources such as education, health care, and employment are equitable and accessible to everyone. Such counselors strive to ensure that all people are able to live with dignity and respect so they may become participatory members of society. Social justice counseling necessitates that counselors embrace a certain role. Moyer, McAllister, Finley, and Soifer (2001) identified four different roles social activists play: (a) citizen (social activists must be perceived by others as responsible members of society who seek the common good), (b) rebel (social activists know when to speak up when injustices violate core societal values), (c) change agent (social activists actively collaborate with others to educate and change institutional barriers), and (d) reformer (social activists work to get multicultural and social justice ideas and concepts institutionalized into policy and laws). Each of these roles is equally important at varying points of social change.

The process of achieving social justice is a mutually collaborative one that involves counselors, clients, and community. Counseling is not a process where counselors act as experts imparting knowledge to passive and unaware clients. This perspective is similar to Freire's (1993) critique of the "banking education" model where students are sponges who uncritically soak up knowledge imparted on them from teachers. For clients to find therapy to be meaningful, they need to be active participants. Being active participants in therapy allows them to take responsibility and ownership of the counseling process. When they sense that counselors trust in their knowledge of the world, they begin to feel empowered. Accordingly, both counselors and clients are actively engaged in the process of exploring and gaining knowledge of how social structures influence client development.

As an ideal, the goal of social justice is to empower all individuals, regardless of background, so they may develop the knowledge and skills to achieve their full potential. Social justice counselors recognize that client problems can be attributed to oppressive structural factors. Accordingly, both counselors and clients are actively engaged in the process of exploring and gaining knowledge of how social structures influence client development. This process leads counselors and clients to consider whether interventions should focus on individual change or systems-level changes.

Social justice counseling recognizes the limitations of conventional counseling methods that place excessive weight on intrapsychic techniques to resolve problems that are systemically based. Using individual counseling to resolve systemically based problems is akin to a physician using a functional magnetic resonance imaging scan to treat a common cold. The physician who does so completely misses the mark! In counseling, too, some approaches completely miss the mark; this point is illustrated in the chapters that follow.

Distinctions Between Multiculturalism and Social Justice

There are fundamental philosophical and practical distinctions between the multicultural and social justice counseling perspectives. Multicultural counseling brought attention to the importance of cultural factors and the need to attend to cultural differences in counseling. Emphasis is placed on using culturally appropriate counseling strategies that align with clients' cultural background. Since its inception multicultural counseling has become more inclusive. Yet, its scope of practice continues to be too population specific as it tends to address racial and ethnic concerns over other dimensions of identity such as sexual orientation, gender, social class, religion, and disability (Pope-Davis, Ligiero, Liang, & Codrington, 2001). The practice of multicultural counseling tends to focus on individuals and interpersonal dynamics within the comforts of the office setting. Very little attention is given to working in communities to change oppressive structures that affect clients.

Social justice counseling addresses power dynamics, issues of equity, and oppression in all of its forms. Counselors operating from a social justice perspective realize that some situations require change at the individual level and other situations call for systemic-level changes. Such counselors seek to create a just world where resources such as education, health care, and employment are equitable and available to everyone. Social justice counseling also places equal weight on addressing the needs of all oppressed groups. All forms of oppression are harmful. Concentrating on one form of oppression while being neutral to other oppressive systems is harmful and creates a hierarchy of oppressions.

Multiculturalism and Social Justice: A Seamless Connection

Multiculturalism and social justice are seamlessly connected, in part because what counselors do in the traditional office setting can inform the advocacy work they do in the community (J. Lewis & Arnold, 1998). Through direct counseling intervention, counselors are able to recognize the relevance of cultural factors, and they can see firsthand the impact that oppression has on historically marginalized client populations. When counselors recognize this impact, they are faced with a decision to consider whether clients are best served through direct intervention or through advocacy on their behalf.

Both multiculturalism and social justice counseling highlight inherent flaws in psychotherapeutic approaches that discount the relevance of cultural and social factors. This realization led to important insights about counseling and psychotherapy:

- Not all counseling is good counseling.
- A "one size fits all" approach is harmful to culturally diverse clients.
- We are all cultural beings.
- Clients come to counseling with complex cultural backgrounds that require attention.
- Oppression is real and has devastating consequences if left ignored.
- Both individual counseling and advocacy counseling are essential ingredients to change.

To ignore the relevance of culture and sociopolitical factors would be a grave mistake. There are limits to what counselors are able to accomplish when they do not recognize the importance of cultural and sociological variables in counseling. These limitations, if not addressed, can have drastic effects on clients. Clients may leave counseling feeling that they are the cause of the problem. Counselors may mistakenly perceive cultural issues or responses to oppression as abnormal behavior. The lack of cultural empathy by counselors has been cited as a cause for the disproportionate number of clients of color who terminate therapy after the first session (Sue & Sue, 2013).

Conclusion

It goes without saying that multiculturalism and social justice have been instrumental in bringing counseling and psychology into the 21st century. Both perspectives have transformed the field in significant ways. Multicultural counseling sheds light into the dire consequences that occur when cultural factors are not considered in the helping process. Social justice brings attention to how oppression influences psychological health and the need for counselors to be social change agents. Both perspectives grew in response to the changing demographics of the U.S. population, the globalization of the economy, the harmful effects of oppression, and the increasing realization that predominant theories in counseling and psychology do not adequately prepare helping professionals to address these concerns.

The future of counseling and psychology rests on our ability to continue to change with the times. This means continuing to refine the multicultural and social justice counseling perspectives. We need to have the foresight to know where both perspectives are heading if counseling and psychology are to be sustainable resources. We must use research to improve our understanding of multiculturalism and social justice in counseling. Research provides the vision to sustain the multicultural and social justice perspectives. Clinical practices must also be informed by clients who seek psychological services. Clients bring with them a wealth of experiences and knowledge that should not be ignored.

As multiculturalism and social justice approaches in counseling continue to mature, there is danger in allowing complacency to set in. Stagnation and complacency can hinder innovation in counseling. When a profession becomes complacent, it runs the risk of becoming obsolete and irrelevant. We see this in the technology field, where companies fade into the background or become irrelevant because they are unable to change with the times or take risks to remain sustainable. Similarly, counseling must be dynamic and respond to the changing needs of society if it is to remain relevant.

References

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

Arciniega, G. M., & Newlon, B. J. (2003). Counseling and psychotherapy: Multicultural considerations. In D. Capuzzi & D. R. Gross (Eds.), *Counseling and psychotherapy: Theories and interventions* (2nd ed., pp. 435–458). Upper Saddle River, NJ: Merrill Prentice Hall.

Atkinson, D. R., Morten, G., & Sue, D. W. (1993). *Counseling American minorities: A cross-cultural perspective* (4th ed.). Dubuque, IA: Brown and Benchmark.

D'Andrea, M., & Daniels, J. (1995). Promoting multiculturalism and organizational change in the counseling profession. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 17–33). Thousand Oaks, CA: Sage Publications.

Dworkin, E. P., & Dworkin, A. L. (1971). The activist counselor. *Personnel and Guidance Journal, 49*, 748–754.

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

Freire, P. (1993). *Pedagogy of the oppressed* (Rev. ed., M. B. Ramos, Trans.). New York, NY: Continuum.

Hutchinson, M. A., & Stadler, H. A. (1975). *Social change counseling: A radical approach*. Boston, MA: Houghton Mifflin.

Jackson, M. L. (1995). Multicultural counseling: Historical perspectives. In J. G. Ponterotto, J. M. Casas, L. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 3–16). Thousand Oaks, CA: Sage Publications.

Kiselica, M. S., & Robinson, M. (2001). Bringing advocacy counseling to life: The history, issues, and human dramas of social justice work in counseling. *Journal of Counseling & Development, 79*, 387–398.

Lee, C. C., & Hipolito-Delgado, C. P. (2007). Introduction: Counselors as agents of social justice. In C. C. Lee (Ed.), *Counseling for social justice* (2nd ed., pp. xiii–xxviii). Alexandria, VA: American Counseling Association.

Lee, C. C., & Walz, G. R. (Eds.). (1998). *Social action: A mandate for counselors*. Alexandria, VA: American Counseling Association.

Lee, W. M. L., Blando, J. A., Mizelle, N. D., & Orozco, G. L. (2007). *Introduction to multicultural counseling for helping professionals.* New York, NY: Routledge.

Lewis, J., & Arnold, M. S. (1998). From multiculturalism to social action. In C. C. Lee, & G. R.Walz (Eds.), *Social action: A mandate for counselors* (pp. 51–65). Alexandria, VA: American Counseling Association.

Lewis, J., & Bradley, L. (Eds.). (2000). *Advocacy in counseling: Counselors, clients, and community*. Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services.

Lewis, J. A., Ratts, M. J., Paladino, D. A., & Toporek, R. L. (2011). Social justice counseling and advocacy: Developing new leadership roles and competencies. *Journal for Social Action in Counseling and Psychology, 3*, 5–16.

Lewis, M., & Lewis, J. (1971). Counselor education: Training for a new alternative. *Personnel and Guidance Journal, 49*, 754–758.

Lewis, M. D., Lewis, J. A., & Dworkin, E. P. (1971). Counseling and the social revolution [Special issue]. *Personnel and Guidance Journal, 49*.

Martin-Baró, I. (1996). *Writings for a liberation psychology*. Cambridge, MA: Harvard University Press.

McFadden, J., & Lipscomb, W. D. (1985). History of the association for non-White concerns in personnel and guidance. *Journal of Counseling & Development, 63*, 444–447.

Moyer, B., McAllister, J., Finley, M. L., & Soifer, S. (2001). *Doing democracy: The MAP model for organizing social movements*. Gabriola Island, BC, Canada: New Society.

Parker, W. M. (1991). From ANWC to AMCD. *Journal of Multicultural Counseling and Development, 19*, 52–65.

Patterson, C. H. (1996). Multicultural counseling: From diversity to universality. *Journal of Counseling & Development, 74*, 227–231.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling* (3rd ed.). London, UK: Sage Publications.

Pope-Davis, D. B., Coleman, H. L. K., Liu, W. M., & Toporek, R. L. (Eds.). (2003). *Handbook of multicultural competencies in counseling and psychology*. Thousand Oaks, CA: Sage Publications.

Pope-Davis, D. B., Ligiero, D. P., Liang, C., & Codrington, J. (2001). Fifteen years of the *Journal of Multicultural Counseling and Development. Journal of Multicultural Counseling and Development, 29*, 226–238.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a "fifth force" among counseling paradigms. *Journal of Humanistic Counseling, Education and Development, 48*, 160–172.

Ratts, M. J., Toporek, R. L., & Lewis, J. A. (Eds.). (2010). *ACA advocacy competencies: A social justice framework for counselors*. Alexandria, VA: American Counseling Association.

Robinson, D. T., & Morris, J. R. (2000). Multicultural counseling: Historical context and current training considerations. *The Western Journal of Black Studies, 24*, 239–253.

Sheeley, V. L. (2002). American Counseling Association: The 50th year celebration of excellence. *Journal of Counseling & Development, 80*, 387–393.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64–89.

Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*, 420–429.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley and Sons.

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

Chapter 2

Five Forces in Counseling and Psychology

As multiculturalism and social justice approaches in counseling gain ground, it is useful to clarify their complementary nature and relevance in the counseling profession. For readers to fully appreciate the significance of the multicultural and social justice counseling perspectives, we begin this chapter by providing an overview of the major paradigms or forces in counseling from its infancy. Understanding the profession's roots gives context for the evolution of multicultural and social justice counseling. Moreover, it provides insight into the limitations of previous theories, and it sheds light on the dire consequences when multiculturalism and social justice are not considered.

The counseling profession's continued evolution is reflected in the five counseling paradigms, which are also referred to as *forces*: (1) psychoanalytic, (2) cognitive–behavioral, (3) existential–humanistic, (4) multicultural, and (5) social justice (Ratts, 2009; see Figure 2.1). Each paradigm was developed to address perceived limitations in existing understandings, and each transcended explanations of human development and changed the rules of how psychology is approached. With each change, controversy and confusion brew because the new paradigm shifts prevailing beliefs and practices.

Each change in the field has brought new understanding of human development issues (see Table 2.1). For example, the psychoanalytic force provided a framework for exploring how the past shapes the present. The cognitive–behavioral approach brought attention to the importance of evidence-based practices. The existential–humanistic perspective led counselors to consider the importance of the therapeutic relationship. Multicultural counseling helped bring attention to the importance of culture in the therapeutic relationship. Social justice counseling addresses issues of injustice and calls on helping professionals to consider balancing individual counseling with systems work.

Each counseling force is considered a paradigm unto itself. A *paradigm* is an agreed upon set of practices and understandings that defines a scientific discipline and determines the scope of practice (Kuhn, 1970). For instance, in the medical profession a set of practices and norms shapes Western medicine and makes it fundamentally distinct from Eastern medicine. Paradigms are also culturally based because they evolve out of the social, political, and economic thinking of the times. The changes in the counseling profession are often a microcosm of social changes. For instance, multicultural counseling evolved in the 1960s because of the

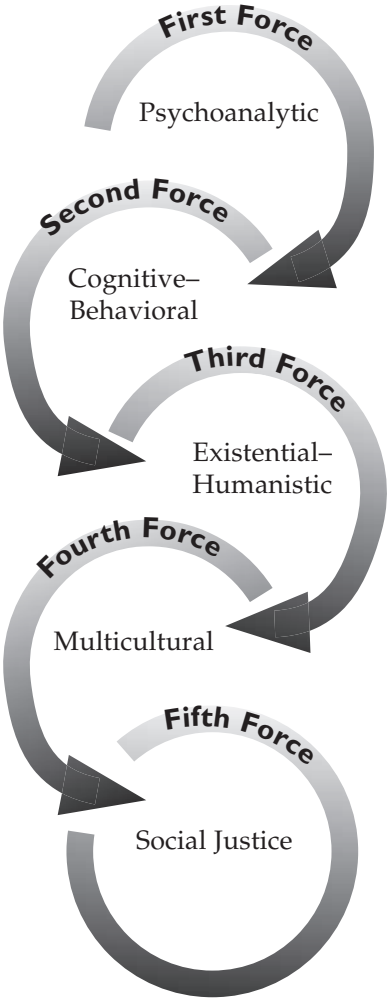


Figure 2.1 • **Five Forces in Counseling**

Source. Manivong J. Ratts © 2014. Reprinted with permission. For permission to use for research or publication purposes, contact Manivong J. Ratts: vong@seattleu.edu.

racial oppression of African Americans in the United States (Jackson, 1995). Kuhn (1970) expressed the belief that a major paradigm shift occurs when scientific theories cannot adequately account for ideas, concepts, or data and when some new competing perspective better accommodates these data. In other words, paradigms are fluid and dynamic. They are constantly evolving as a result of new and emerging research, which often shifts the social order of things in a discipline. Often, resistance surfaces when changes occur in a paradigm. E. M. Rogers (2003) contended that new innovations, even when they have benefits, are difficult to adopt because they often require change in the structure of things.

Paradigms are useful in counseling because they provide a framework for working with clients (Barclay, 1983) and they help to connect theory with practice. For example, each counseling force is unique in its view of human nature, conceptualization of client problems, understanding of the role of the professional counselor and psychologist, goals of therapy, and types of therapeutic techniques used. In this chapter we discuss the five counseling forces in the profession. We illustrate the predominant thinking within each force, examine how each force has transformed current approaches to helping, and discuss

Table 2.1 • **Counseling Forces**

Variable	First Force	Second Force	Third Force	Fourth Force	Fifth Force
Paradigm	Psychoanalytic	Cognitive–behavioral	Existential–humanistic	Multicultural	Social justice
Key figures	Alfred Adler Erik Erikson Sigmund Freud Carl Jung Margaret Mahler	Albert Bandura Aaron T. Beck Albert Ellis Arnold Lazarus Donald Meichenbaum B. F. Skinner Joseph Wolpe	Victor Frankl Rollo May Carl Rogers Irvin Yalom	Patricia Arredondo Courtland Lee Cirecie West-Olatunji Paul Pedersen Joseph G. Ponterotto David Sue Derald W. Sue	Stuart Chen-Hayes Hugh Crethar Michael Hutchinson Judith A. Lewis Manivong J. Ratts Rebecca Toporek
Primary assumptions	Psychosexual and psychosocial development, biological and instinctual drives, and unconscious forces shape human behavior.	Cognitive processes and behavior influence the human experience.	Humans have the inner capacity to grow and the freedom to choose, and they possess personal responsibility over their own lives.	People are cultural beings who are influenced by larger social, political, and cultural context.	Client problems are connected to larger sociopolitical contexts. Problems are coping strategies to oppression rather than pathology.
Key concepts	Psychosexual development Psychosocial development Transference Unconscious drives Past oriented	Empirically based interventions Conditioning Present oriented	Genuineness Empathy Unconditional positive regard Present oriented	Universal and culture-specific strategies Individual, group, and universal dimensions of existence Identity development Multicultural competence Past and present oriented	Personal is political Critical consciousness Advocacy competence Past and present oriented
Therapeutic goals	Help clients gain insight Make the unconscious conscious	Change cognitive processes Measure outcomes	Help clients recognize factors blocking growth, become self-aware, and reach their potential through the counseling relationship	View clients in context Egalitarian relationship	Externalize oppression Connect client problems with systemic barriers
Techniques	Analysis of resistance Free association Interpretation Dream analysis Analysis of transference	Dispute irrational beliefs Change language Cognitive role play Desensitization Meditation Behavioral modification Education	Techniques are secondary to understanding and experiencing the therapeutic relationship	Education Culturally appropriate skills	Individual counseling and systems change
Critique	Medical model Culturally encapsulated Ignores sociopolitical context Diagnoses clients	Culturally encapsulated Ignores sociopolitical context	Culturally encapsulated Ignores sociopolitical context Lacks true techniques	Additive approach Ignores systems advocacy Exclusive definition of multiculturalism	Liberal bias Too political Doing social work Promotes notion of White guilt

the need for helping professionals to consider multicultural and social justice counseling as a generic helping modality. Considering the multicultural and social justice counseling paradigms as generic approaches in counseling is critical if counselors and psychologists are serious about working with culturally diverse clients.

First Force: The Psychoanalytic Tradition

One cannot discuss the impact of psychoanalytic theory without focusing on Freud, its founder. Although much of Freud's thinking on psychoanalysis is outdated, he remains an important figure. Freud's (1949) thinking about the human psyche was significant because he brought attention to the ways in which unconscious and instinctual sexual drives shape human behavior and lead to human psychosis. These topics were considered taboo at the time, yet Freud formulated a theory of psychoanalysis as a platform to discuss them, which made them socially acceptable. Freud's methods of treating the mentally ill were based on the use of interpretation, introspection, and clinical observations.

Freud's approach to the treatment of neurosis was progressive at the time. He believed that medical professionals, and psychiatrists in particular, relied too heavily on their eyes and their senses to explain physical symptoms in their patients. Freud (1920/2011) believed that psychoanalysis would be different and argued that it "must divorce itself from every anatomical, chemical, or physiological supposition which is alien to it. It must work throughout with purely psychological concepts" (pp. 9–10). A deeper understanding was needed to explain abnormal behaviors displayed by patients. According to Jones (1961), Freud reflected "a crusade of revolution against the accepted conventions of medicine," which at the time viewed "neuroses as mere abnormalities, as diseases that are deviations from the normal" (p. 163).

Freud's view on human psychosis and the way to treat it paved the way for the development of psychoanalysis as a paradigm. Freud's interest in clinical psychopathology led him to develop a comprehensive theory, which posited that psychosexual development, biological instinctual drives, and unconscious forces shape human behavior. Freud believed that the purpose of psychoanalysis was to bring the unconscious to the conscious mind and that this was best accomplished by having clients talk about their problems with a trained expert. Psychoanalysis was an emerging process involving "the interchange of words between the patient and the physician. The patient talks, tells of his past experiences, and present impressions, complains, confesses his wishes and emotions. The physician listens, tries to direct the thought processes of the patient" (Freud, 1920/2011, p. 8). Psychoanalysts were experts and authority figures who served as the guiding voice for patients. Freud's impact is evident through the many iterations of the psychoanalytic paradigm. Contemporary psychoanalysis includes ego psychology, object-relations approaches, self-psychology, and relational approaches. These approaches focus on development of the ego and differentiation of the self, whereas Freudian psychology focused on the id.

The psychoanalytic force is sometimes criticized for placing excessive weight on individual factors, pathologizing clients, and using androcentric concepts to explain female psychology. (*Androcentrism* is the use of male-oriented concepts to determine female development; Worell & Remer, 2003.) For example, psychoanalysis uncritically frames social issues from an intrapsychic lens. Rather than understand "the psychic processes and needs of man as a product of a social and historical development, psychoanalysis derives from instinct inherent in the organism, thereby, giving a narrowly biological interpretation to all of a man's psychic activity" (Cohen, 1986, p. 6). The decontextualization of human development frames social situations as being a direct result of internally driven unconscious drives and sexual libido.

The exclusion of social factors can be attributed to the reliance on the medical model. For example, in the late nineteenth century people thought that criminal behavior and neurosis were due to genetics. Socially unacceptable behavior such as prostitution or

abnormal behavior such as hysteria were often attributed to one's heredity (Brunner, 2001). Lombroso (2006), an Italian criminologist, posited that criminals could be identified by physical defects that were similar to those found in early humans and apes. In other words, biological factors were often used to explain abnormal and deviant behavior.

In the medical model perspective, clients are viewed as ill and needing to be fixed. Relying solely on the medical model approach gives an incomplete picture of the human organism. When only biological and individual factors are entertained, counselors risk using approaches that blame clients for their predicament. Often this approach leads counselors to consider solutions that focus only on change within the individual. The implicit message is that clients, and not their environment, must change.

Feminists have argued that psychoanalytic constructions of women's psychology are degrading because of their androcentric nature. Horney (1973) challenged androcentric concepts such as penis envy, a Freudian concept, because of the denigrating view of women implicit in their theoretical grounding and application. Horney argued that females did not desire to possess male genitals; rather, they envied the exclusiveness of male power and privilege (which inherently presented restrictions for women). Freud's (1930) perspective on gender was informed by the social and political climate of the times; he promoted traditional gender roles and viewed women as inferior and submissive to men.

> Women stand for the interests of the family and sexual life, whereas the work of civilization has become more and more the business of menfolk, setting them increasingly difficult tasks and obliging them to sublimate their drives—a task for which women have little aptitude. (p. 35)

Lerman (1986) called for a complete abandonment of the psychoanalytic paradigm because "assumptions about the inherent inferiority of women are embedded in the very core of psychoanalytic theory" (p. 6). Prilleltensky (1994) argued that using a helping model that denigrates women and ignores social context further promotes a status quo that benefits those in power. Similarly, Ratts (2011) contended that the psychoanalytic theory does not adequately equip counselors with the tools to address sociocultural factors.

Second Force: The Cognitive–Behavioral Tradition

Cognitive–behaviorism grew in popularity because of its applicability across settings. The widespread acceptance of the cognitive–behavioral force is evident in its use in schools, hospitals, college counseling centers, and agency settings. Cognitive–behaviorists believe that human behavior can be measured and that psychology can be fully explained by the use of experiments and the scientific method. The focus on using the scientific method was in part a response to the call to be on par with the medical profession.

The cognitive–behavioral movement evolved in reaction to the psychoanalytic emphasis on exploring the unconscious and instinctual drives. Cognitive–behaviorism, which combines cognitivism and behaviorism, questioned the underpinnings of psychoanalysis. Rather than view abnormal behavior as a result of natural causes or unconscious drives, cognitive–behaviorists share the following elements: (a) a focus on cognitive processes to address mental health and well-being, (b) empirically based interventions that focus on measurable and concrete behavioral and cognitive change, (c) time-limited counseling sessions, (d) the use of education to help clients, and (e) a focus on the present.

Cognitive–behaviorism draws from the behavioral and cognitive schools of thought. Behaviorism, which became the dominant school of thought in the 1950s in part because of

the work of John B. Watson, evolved with the work of Edward Thorndike, Clark L. Hull, and B. F. Skinner. Watson, known as the founder of behaviorism, rejected the psychoanalytic perspective of studying the conscious mind and questioned the use of introspection in counseling and psychology. Watson's (1913) view of psychology is perhaps best articulated in what is known as *The Behaviorist Manifesto*:

> . . . a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behavior. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness. The behaviorist, in his efforts to get a unitary scheme of animal response, recognizes no dividing line between man and brute. The behavior of man, with all of its refinement and complexity, forms only a part of the behaviorist's total scheme of investigation. (p. 248)

Behaviorists such as Edward Thorndike and Ivan Pavlov further popularized behaviorism with their study of animals, which they used to explain human behavior. Their research helped lay the foundation for educational psychology and classical conditioning. Similarly, Skinner brought attention to the importance of studying observable behavior through his research. Skinner questioned psychotherapeutic approaches that use introspection and case history to explain human development because they lacked scientific rigor.

Cognitive theory is a branch of psychology that focuses on cognitive processes, learning, and how people recollect memories. According to Beck (1976):

> This new approach to emotional disorders changes man's perspective on himself and his problems. Rather than viewing himself as the helpless creature of his own biochemical reactions, or of blind impulses, or of automatic reflexes, he can regard himself as prone to learning erroneous, self-defeating notions and capable of *unlearning* or correcting them as well. By pinpointing the fallacies in his thinking and correcting them, he can create a more self-fulfilling life for himself. (p. 4)

Beck (1976) believed that psychotherapy should be focused on distorted thinking and on helping clients learn alternative ways to conceptualize their experiences. Implicit in this approach is that counselors help clients adapt to their environment rather than work to alter the environment to adapt to the client.

Aaron T. Beck, Albert Ellis, and Arnold Lazarus helped bring cognitive theory into the mainstream of psychology. Beck developed cognitive techniques through his work with clients with depression. Ellis founded rational emotive behavior therapy (REBT) in reaction to the psychoanalytic paradigm in the 1950s. He argued against psychoanalytic explanations of abnormality and posited that "at the heart of neurotic disturbance lies the tendency of humans to make devout, absolutistic evaluations of the perceived events in their lives" (Ellis & Dryden, 1997, p. 14). Ellis and Dryden (1997) further defined the focus of therapy in REBT:

> Unlike most other theories of therapy, which stress the impact of significant life events on the development of psychological disturbance, REBT theory hypothesizes that the biological tendency of humans to think irrationally and dysfunctionally has a notable impact on such disturbance. (p. 6)

The assumption in REBT is that much of human behavior and emotion could be managed if people could skillfully control their thoughts.

One critique of the cognitive–behavioral approach is that it places considerable weight on individual and internal factors while ignoring the sociocultural context. Little to no

attention is given to how cognitive processes may be influenced by such social ills as racism, poverty, and homophobia. Ellis and Harper (1997) contended that "When people and events are the way you would like them not to be, there is actually relatively little pernicious effect they can have on you unless you *think* they can" (p. 163). The underlying message is that if clients can change their thinking about events in their lives, they will feel better about their situation. In other words, it is not the event (e.g., oppression) that causes a client's problems but rather the client's perception of that event. This perspective tends to blame clients for their predicament.

Because it ignores cultural factors, decontextualization of client problems leads to limitations in a counselor's capacity to fully address a client's presenting issue and optimize client growth. Rather than examine how sociopolitical factors affect cognitive and behavioral processes, psychology is used to rid clients of "irrational" thoughts and behaviors. Human cognition and behavior are separated from contextual factors despite considerable research suggesting that oppression plays a significant role in human development. Cognitive–behaviorists view human beings as affectless organisms that control the experience of their own environments. When environmental variables are separated from cognitive–behavioral processes, counselors are forced to search for internal explanations to client problems. The belief that human behavior and cognition are internally driven and separate from the social context is grounded in the Protestant work ethic of individualism. In a classic analysis of individualism, Sampson (1977) noted:

> Our contemporary views of mental health emphasize a self-contained, individualistic ideal: The person who possesses all the qualities from whatever listing of positive traits we choose, for example, self-actualization, autonomy, or mastery. We have difficulty in thinking of these traits as functions that can be located within an interdependent collectivity rather than within the single individual. Thus, the burden for good health is the individual's; he or she must come to possess all that is good and desirable. (p. 775)

In other words, individuals and their environments are mutually exclusive. Positive mental health and success come through hard work and determination regardless of societal obstacles.

The lack of attention to cultural factors is an issue in cognitive–behavioral therapy. The promotion of European American values systems is seen in Western psychology's support of helping clients develop an internal locus of control. The concept of *locus of control*, developed by Rotter (1966), refers to whether people believe their fate is internally driven or a result of external factors. For instance, a client with high internal locus of control might attribute the lack of a promotion at work with needing to work harder as an individual employee. A client with a high external locus of control might believe that not getting a promotion is due to external factors such as racism, sexism, or heterosexism. Counseling and psychology tend to place value on developing one's internal locus of control.

Third Force: The Existential–Humanistic Tradition

The existential–humanistic force rejected both psychoanalytic and cognitive–behavioral explanations of human development. Existential–humanistic theorists saw limitations in viewing fragmented parts of a client's personality and in examining only client cognitions, and they questioned the validity of using experiments conducted on animals to explain human behavior. Carl Rogers (1951), a staunch critic of the psychoanalytic and cognitive–behavioral approach, believed that the improvements clients experienced from psychoanalytic and cognitive–behavioral treatment were temporary at best. He (1961) argued that "such methods are, in my experience, futile and inconsequential. The most they can

accomplish is some temporary change, which soon disappears, leaving the individual more than ever convinced of his inadequacy" (p. 33). C. Rogers saw potential in all people and believed that therapeutic techniques were secondary to the client–counselor relationship. His critique of the psychoanalytic and cognitive–behavioral forces is also seen in his use of the term *client* rather than *patients* because "it avoids the connotation that he is sick, or the object of an experiment" (1951, p. 7). Similarly, May (1961) stated:

> Psychotherapy is not a "problem" that the patient brings in, such as impotence; or a pattern, such as a neurotic pattern or sadomasochism or a diagnostic category of sickness, such as hysteria or phobia, ad infinitum; or a drive or pattern of drives. (p. 73)

These beliefs led to the development of the existential–humanistic force in counseling and psychology.

The existential–humanistic approach draws from the existential and humanistic traditions in psychology. Common to both traditions are the emphases placed on self–awareness, a belief in the potential of every human being, personal responsibility, the innate good in people, freedom, and personal insight. Within the existential perspective, helping clients develop awareness, find meaning and purpose, and become responsible for life choices is central to therapeutic improvement. Coming to terms with the idea that we all eventually face death is also a key concept in existential psychology.

The humanistic tradition sees the good in every individual and believes that the purpose of psychotherapy is to help clients reach their potential. An egalitarian therapeutic relationship between client and counselor is central. The role of the therapist is to model genuineness and authenticity and to accurately understand the subjective world of the client. The goal of therapy is less about solving problems and more about helping clients lead self-fulfilling lives.

Existential–humanistic counselors who operate from an intrapsychic perspective make what Prilleltensky (1994) referred to as a *fundamental attribution error:* They did not consider how culture shapes client experiences. For example, existential–humanistic concepts such as personal freedom and self-awareness promote individualism and autonomy. This approach works well with clients whose cultural backgrounds recognize independence as integral to healthy development. However, promoting individualism with clients from collectivist cultures (including people of color) can be misguided, because these groups generally place higher value on relationships, harmony, and group needs than on individual needs.

Another limitation of the existential–humanistic tradition is that it does not take external factors into account. The focus of this therapeutic approach is on helping clients understand the workings of their own inner world, which leads to self-awareness, congruence, and balance—all qualities that are considered necessary for healthy development. Although insight is important, it should not be examined without also exploring how cultural and sociopolitical forces influence the cultivation of this inner world. External forces and cultural factors are fundamental in shaping the ways in which clients experience life and construct meaning.

Fourth Force: The Multicultural Tradition

Up until the 1950s, the field of counseling and psychology was a monocultural science, even though, since its origin in Central Europe, it had spread throughout much of both the Western and non-Western world. Adler and Gielen (1994) were among the first to

document the trends suggesting that this monocultural emphasis in psychology was changing:

> Following a brief review of global society, it is argued that (a) at present American psychology routinely neglects perspectives and findings developed in other countries; (b) this is true even if foreign contributions appear in English; (c) this state of affairs differs from the situation prevailing in the hard sciences; and (d) in response to the multicultural movement and global developments, mainstream psychology in the United States and elsewhere will become less ethnocentric in the near future. (p. 26)

Contemporary global changes are having an increased influence in psychology and counseling, demonstrating the positive consequences of a culture-centered perspective.

- The ratio of non-American to American psychological and counseling researchers is gradually but steadily increasing (Rosensweig, 1992), suggesting that psychology and counseling are growing faster outside than inside the United States.
- All fields are becoming more globally focused as a result of technological innovations.
- There is a multicultural movement particularly in the social sciences that has raised sensitivity to cultural variables.
- The topic of cultural and multicultural issues is now mainstream in counseling and psychology.
- There is a reexamination of cultural bias in counseling and psychology so that instead of making assumptions about a client's values and beliefs, there is greater emphasis on discovering each population's unique explanation of its behavior and meaning.

Thompson, Ellis, and Wildavsky (1990) described cultural theory as providing the basis for a new perspective, dimension, or force in psychology and counseling:

> Social science is steeped in dualism: culture and structure, change and stability, dynamics and statics, methodological individualism and collectivism, voluntarism and determinism, nature and nurture, macro and micro, materialism and idealism, facts and values, objectivity and subjectivity, rationality and irrationality, and so forth. Although sometimes useful as analytic distinctions, these dualisms often have the unfortunate result of obscuring extensive interdependencies between phenomena. Too often social scientists create needless controversies by seizing upon one side of a dualism and proclaiming it the more important. Cultural theory shows that there is no need to choose between, for instance, collectivism and individualism, values and social relations or change and stability. Indeed we argue there is a need not to. (p. 21)

Multiculturalism has been described by Pedersen (1991) as a "fourth force" or fourth dimension, but neither of these terms is completely adequate. By referring to it as a fourth force, it is implicitly framed as being in competition with humanism, behaviorism, and psychodynamism, which is not the intent. Multiculturalism is a means of coping with cultural and social diversity in society.

As mentioned in Chapter 1, the multicultural counseling force evolved during the civil rights era in the 1950s as a result of a lack of attention to cultural factors in counseling and psychology and the increasing diversity of the U.S. population (Jackson, 1995). Factors such as racial segregation, systematic discrimination, and prejudice led professionals in the field to help clients of color assimilate into the dominant White culture (Copeland, 1983).

The belief in racial integration and the denial of group differences was based on the notion that racial and ethnic minorities needed to adapt to White society in order to survive. Though professional literature at the time had begun to address these issues, predominant theories continued to view client problems through an intrapsychic lens, which often used biological and intrapsychic explanations to frame human development issues. Little to no attention was given to sociocultural factors, largely in part because people of color were underrepresented within the profession. The prevalence of racism kept many racial and ethnic minorities, namely African Americans, from being able to fully contribute to the counseling field. For example, many racial and ethnic minorities were excluded from holding leadership positions within the American Personnel and Guidance Association (now the American Counseling Association; Jackson, 1995).

Sue and Sue (2013) described the implications of rapid increases in racial and ethnic populations as the diversification of the United States or the changing complexion of society. Recent migrations are different from earlier White European migrations that were more oriented toward assimilation. According to the United States Census Bureau (2011), White Americans accounted for 72% of the population in 2010. All racial groups increased in number between 2000 and 2010, but they did so at different rates. Asian Americans experienced the fastest rate of growth because of higher rates of immigration, and White Americans grew at the slowest rate. The Asian population increased by 43.3%, Hispanic or Latino by 43%, Native Hawaiian and Other Pacific Islander by 35.4%, American Indian and Alaska Native by 18.4%, Black or African American by 12.3%, and White by 5.7%. An overwhelming majority of people (92%) reported being a member of two races, with White and Black being the largest multiple-race combination. The racial and ethnic data suggest that the United States continues to become a more racially diverse society.

Multicultural counseling stresses the sociopolitical nature of counseling and the need for predominant paradigms to view clients in context of their culture and environment (Sue & Sue, 2013). Clients and the problems they present cannot be understood in a vacuum. Social, political, and economic conditions often influence academic, career, personal, and social issues. For this reason, human development issues need to be considered from a biopsychosocial lens, which allows for a holistic understanding of client problems. The combination of sociological factors along with biological and psychological factors is considered in explaining mental health issues. In contrast, the psychoanalytic, cognitive–behavioral, and existential–humanistic forces use either biological or intrapsychic (biopsycho) explanations to frame client problems (Ratts, 2011). The popularity of the biopsychosocial perspective is reflected in its presence in such disciplines as psychiatry, counseling psychology, and social work and in the medical profession (Santrock, 2012).

Multicultural counseling brought attention to how culture shapes people's worldview, experiences, and need for culturally competent helping professionals. Culture is the "characteristic values, behaviors, products, and worldviews of a group of people with a distinct sociohistorical context" (Kehe & Smith, 2004, p. 329). Rubel and Ratts (2011) added:

> Cultural differences may be readily observable as differences in clothing, foods, customs or traditions, and languages, or as subtler but crucial differences in parenting beliefs, family structure, social hierarchy, gender role expectations, communication style, and relationship to time and space. (p. 49)

Multicultural counselors view the "one size fits all" approach, promoted by the psychoanalytic, cognitive–behavioral, and existential–humanistic forces, as ineffective because it discounts cultural variables. Both clients and counselors bring with them unique histories,

backgrounds, and cultural influences that affect the client–counselor relationship. The need to be cognizant of a client's culture and worldview led to the creation of the multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992), which provide a framework for developing cultural awareness, knowledge, and skills to effectively work with diverse clients. Counselors and therapists must be aware of their values, beliefs, biases, and worldviews as well as those of their clients; knowledgeable about their cultural background as well as that of their clients; and skilled using culture-specific counseling strategies. There are many sources of resistance to multiculturalism as a fourth force.

- Some view multiculturalism as competing with already established theories of psychological explanation in ways that threaten the professions of counseling and psychology (Weinrach & Thomas, 2004).
- The terms *multiculturalism* and *diversity* are closely associated with affirmative action, quotas, civil rights, discrimination, reverse discrimination, racism, sexism, political correctness, and other emotional terms (Goodman, 2001).
- To the extent that multiculturalism is connected with postmodernism (as in multiple perspectives and belief systems), the arguments against postmodernism as a valid theory would also apply to multiculturalism (Pedersen, 1991).
- Those favoring a universalist perspective contend that the same practice of counseling and therapy apply equally to all populations without regard to cultural differences (Weinrach & Thomas, 2004).
- There are still no accepted standards for describing multiculturalism as a theory in practice, and it is too loosely defined to be taken seriously.
- There are no measurable competencies for multicultural applications of counseling or adequate standards of practice.
- Multiculturalism is too complicated and it would be unrealistic to expect counselors to attend to such a range of factors simultaneously.
- More research is needed on multicultural competencies, standards, methods, and approaches (Ponterotto, Casas, Suzuki, & Alexander, 2010).
- Multicultural standards cannot be incorporated into the counseling profession until all groups have been included.
- Multiculturalism represents reverse racism and quotas and is anti-White.

A prominent debate within multicultural counseling concerns the scope and limitations of the movement. One criticism is that multicultural counseling overemphasizes the importance of race and ethnicity over other dimensions of identity such as gender, sexual orientation, economic class, religion, and disability status. The prominence given to racial and ethnic concerns in multicultural counseling is due to its civil rights origins. Lee (2006) made a persuasive argument against the broad definition of *multiculturalism*. Lee argued that the term *multicultural* is in imminent danger of becoming so inclusive that it renders itself to be almost meaningless. The broad definition includes all constituent groups that perceive themselves as being disenfranchised in some fashion. This has resulted in diffusing the coherent conceptual framework of multiculturalism in training, teaching, and research. According to Locke (1990, cited in Pedersen, 1997), "As the term has been increasingly stretched to include virtually any group of people who consider themselves 'different' the intent of multicultural counseling theory and practice has become unclear" (p. 7). Another critique of multicultural counseling pertains to its failure to adequately prepare counselors for the realities of social justice work. In their critique of the multicultural

counseling competencies, Vera and Speight (2003) argued that the competencies do not address issues of injustice and that a commitment to social justice requires more than individual counseling and psychotherapy. The lack of attention to community-based work stems from the belief that helping professionals should be apolitical.

Ratts, Anthony, and Santos (2010) added that counseling theories that purport to meet the needs of culturally diverse populations should be examined with a critical eye. Most counseling theories that are repackaged to meet the needs of culturally diverse clients take an "additive approach" to counseling (Ratts et al., 2010). This concept was derived from Banks's (2012) stages of multicultural education. An additive approach to counseling occurs when multicultural concepts are superficially integrated into predominant counseling theories and practices without changing the core tenets of an existing theory or practice. On the surface, it appears as if the theory or practice has evolved to align with the needs of culturally diverse clients. However, the central tenets of the theory or practice remain the same. For example, toward the latter part of his career Albert Ellis began to acknowledge the importance of cultural factors in counseling. Yet, the core tenets of rational–emotive behavior therapy did not change. This point is similar to renovating a house with a bad foundation by only painting the walls and adding new trim and then selling it without full disclosure: The structure of the house is still weak because the existing foundation has not changed. We acknowledge that it is easier to revise an existing theory than to create a new theory from the ground up. New theories take time to develop, require extensive research, and often require challenging the existing structure of practice.

Fifth Force: The Social Justice Tradition

Ratts, D'Andrea, and Arredondo (2004) classified social justice counseling as a fifth force in the profession. They argued for a more balanced perspective that includes individual counseling and systems-level advocacy. This approach is based on the belief that toxic environmental conditions influence human development issues. Ratts et al. recognized a need to change how counseling is practiced. Many counselors placed excessive weight on the need to help individuals and families gain insight or on behavioral change without regard to how oppressive social conditions influence human behavior. Thus, instead of actively seeking to change oppressive structures clients are often required to change and adapt to their oppression.

Ratts (2009) added that counselors cannot expect a different outcome if they continue to do the same things. Working harder at the same things will drive counselors to exhaustion. Instead, counselors need to build new theories and approaches to helping clients. This understanding requires a renewed commitment to the use of psychology. Ratts (2009) identified three ways in which social counseling shifted the helping paradigm in psychology: (a) the way in which client problems are conceptualized, (b) the counselor role and identity, and (c) the skills required by effective counselors. We describe each below.

Client problems are viewed through a social justice lens where oppression is assumed to affect psychological health. There is research suggesting the negative impact of oppression on mental health. Research by Whitbeck, McMorris, Hoyt, Stubben, and Lafromboise (2002) indicated that discrimination experienced by Native Americans is associated with increased depressive symptoms. Diaz, Ayala, Bein, Henne, and Marin (2001) have discussed how the combination of poverty, homophobia, and racism leads to social alienation, low self-esteem, and increased psychological distress such as suicide among gay Latino men in the United States. Similarly, the achievement gap between rich and poor schools is

attributed to generational poverty and racial segregation (Kozol, 2005). K–12 youth who identify as (or are perceived to be) lesbian, gay, bisexual, transgender, or questioning are also more likely to experience depression, drop out of school, and have lower grade point averages than their heterosexual peers as a result of feeling unsafe because of their sexual orientation, gender identity, and gender expression (Gay, Lesbian & Straight Education Network, 2011). These examples provide important research evidence of the harmful effects of living in an oppressive society and demonstrate how easily clients can internalize things that are external to them.

The shift in how client problems are conceptualized changes the counselor role and identity (Ratts, 2009). Conventional terms used to describe helping professionals such as *counselor, therapist, school counselor, psychologist,* and *family therapist* are being modified to include *social change agent*, *activist,* and *advocate*. We add the term *counselor advocate* because we feel that it better reflects the merging of counseling and community advocacy. When helping professionals identify as counselor advocates, they are called on to do more than provide traditional therapy.

Counselor advocates realize that individual counseling is not sufficient to address systemic-based problems. There is a limit to the impact individual counseling can have with clients whose problems are external to them. As counselors begin working in communities, address unjust systemic barriers, advocate for legislative change, and collaborate with community leaders, they begin to develop new skills: organizational development, negotiation, mediation, the art of persuasion, grant writing, community engagement, policy and legislative writing, lobbying legislators, forming rallies, and participatory action research. Such skills are informed by a deep knowledge and understanding of the inner workings of social and political conditions and their impact on human development.

Critics of social justice counseling argue that it is too political, has liberal undertones, and requires counselors to perform social work-related activities (Canfield, 2008; R. Hunsaker, 2008). We note that many detractors of the social justice counseling movement tend to be White heterosexual males who argue for maintaining tradition. They believe that advocacy and social justice are outside the purview of counseling and that counseling is a process where client and counselor come together within the comfort of an office environment.

Social justice critics question the need for counselors to work outside the office setting. These critics draw a line between counseling and social work. They argue that community-based work is an area that requires the expertise of social workers. Counselors work in the office setting providing psychological services, and social workers provide case management in the community setting. Blurring the line between these two professions clouds the professional identity of counselors within the field and among human services generally.

Dissenters of social justice also argue that counseling should be a "value-neutral" endeavor where counselors help clients achieve optimal health and well-being. Counseling should not be used as a forum to promote political agendas. Political bias, especially one steeped in liberalism, taints the "science" and purity of counseling. R. C. Hunsaker (2011) argued that social justice in counseling is actually liberal propaganda supported by activists who use counseling as a platform to further a political agenda.

Toward an Interdisciplinary Approach

As mentioned, the psychoanalytic, cognitive–behavioral, and existential–humanistic counseling approaches place weight on the medical model and heavily promote intrapsychic explanations without critically exploring the significance of sociocultural factors on mental

health. Considerable weight is given to individual factors and biological determinism to explain client development. The use of the medical model and intrapsychic explanations are reflected in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the authoritative reference that describes and codifies mental disorders in the United States. Diagnostic labels were created to explain mental health problems. However, they are also used in child custody cases and to determine insurance premiums; they may also affect job prospects. However, questions abound regarding the reliability in diagnostic labels. In their critique of the Text Revision of the 4th edition of the *DSM* (*DSM–IV–TR*; American Psychiatric Association, 2000), Caplan and Cosgrove (2004) wrote:

> The terms "mental illness," "mental disorder," "abnormality," "normality," and even "insanity" are constructs, terms that do not correspond to clearly identifiable "real" objects. Constructs are defined by whoever does the defining, and the power to make a definition stick resides usually in groups that have the most social, political, and/or economic power. Beginning in the last twenty years of the twentieth century, the small number of primarily White, high status, male psychiatrists who make the ultimate decisions about what goes into the therapists' diagnostic "Bible," the [*DSM–IV–TR*], have had more power than any group to decide who is and is not psychologically normal. But the *DSM* authors are not the only creators of diagnostic categories, for drug companies and book authors with "M.D." or "Ph.D." after their names have also been granted authority. (p. xx)

The most recent iteration of the manual, the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM–5*; American Psychiatric Association, 2013), seems to indicate that things have not changed. *The Washington Post* highlighted a conflict of interest between pharmaceutical companies and creators of the *DSM–5* (Whoriskey, 2012). This article questioned the ethics of having a panel of experts who receive funding from drug companies (in the form of grants, stock options, and speaker and consultant fees) create diagnostic categories for the *DSM–5* that financially benefit pharmaceutical companies.

What is perhaps most interesting is that counselors and psychologists are one of the major consumers of the *DSM*, often relying on it for insurance reimbursement. Yet counselors and psychologists have little to no input in how diagnostic categories are developed within the *DSM*. It is dangerous to uncritically use diagnostic labels based on biological determinism and to have a small segment of the population determine what is healthy. When society gives power to a small group of professionals to determine normal and abnormal behavior without proper checks and balances, it opens itself to potential bias in diagnostic categories and raises concerns about unethical practices.

Counseling is becoming more interdisciplinary, drawing from such fields as biology, psychology, and sociology. Ratts (2011) added advocacy to the biopsychosocial helping paradigm to acknowledge that helping professionals should also integrate such disciplines as community engagement and activism. A biopsychosocial advocacy perspective is based on the belief that biological, psychological, and sociological factors all play a role in human development and that advocacy is necessary to help clients achieve optimal mental health and well-being. The biopsychosocial advocacy perspective is also reflected in such fields as engineering, medicine, social work, and family therapy.

Considerable debate remains as to whether mental illness is a result of biological, psychological, or sociological factors. The summer 2004 special issue of the *Journal of Primary Prevention* explored this debate. Agrawal and Hirsch (2004), both trained psychiatrists, argued that biological determinism is the root of mental health problems; they cited schizophrenia as a brain disease. They contended that mental illness such as schizophrenia is

a disease similar to cancer because of complex physiological abnormalities. Joffe (2004) questioned this assertion: "The claim that they are alike diminishes the likelihood of effective prevention by distracting attention from important social causes of a wide range of mental disorders" (p. 416). The belief is that clients and the problems they present must be understood within a larger context. Viewing clients solely through a biological lens limits our understanding of client problems.

Proponents of the psychosocial perspective attribute mental illness to stressful environmental conditions (Albee & Joffe, 2004) such as poverty (Silvestri & Joffe, 2004). What society may categorize as "pathological" is actually a healthy coping strategy to stressful environmental conditions. Unfortunately, counselors do not always explore whether clients have internalized their oppression for a couple of reasons: (a) The use of predominant theoretical paradigms ignores the connection between oppression and mental health problems, and (b) clients seldom indicate that they are experiencing internalized oppression. Instead, clients present with depression, substance abuse, low self-esteem, or relationship problems, to name a few of the issues that are typically expressed. These problems are often surface-level issues that can be attributed to larger systemic issues if counselors are willing to explore this possibility with clients. Exploring the connection between mental health and oppression can help rule out systemic barriers that hinder client development. A social justice oriented counseling professional will ask, "How is my client's issue influenced by oppressive sociopolitical conditions?"

We believe that taking a comprehensive approach to assessing human development issues is both ideal and ethical. Relying on biological, psychological, or sociological explanations alone is limiting. Clients come to therapy trusting that their counselors will be comprehensive in their approach. For this reason, it is critical that helping professionals consider multicultural and social justice factors in their work. When they do not do so, counselors run the risk of doing more harm than good. Clients may conclude that they are the problem and that they need to change.

Conclusion

Given the social ills in the United States, people are beginning to realize that there is a need to do things differently. The achievement gap in K–12 schools, the resegregation of America's public schools, the prevalence of racially segregated neighborhoods, the growing economic gap between social classes, the technological divide between rich and poor, anti-immigration sentiments, and homophobia across grade levels in education and in society at large all underscore the need for counselors to become involved with multicultural and social justice initiatives. Counselors can no longer ignore the cultural and societal realities placed on clients. The urgency to transform counseling practice may be considered a mandate for the field, given the harsh realities of the world in which we live. More than ever before, society needs counselors who are multiculturally competent agents of social change.

By virtue of their position in society, counselors have a personal and professional responsibility to promote a more just and humane world. Helping professionals who are unable to see the relevance of multiculturalism and social justice in counseling may need to reconsider their commitment to the profession. We know this statement may seem rather harsh. However, the stakes of maintaining the status quo in systems of oppression in counseling practice are too drastic for clients. Counselors need to develop a sense of urgency or run the risk of unethical practice.

References

Adler, L. L., & Gielen, U. P. (1994). *Cross-cultural topics in psychology*. Westport, CT: Praeger.

Agrawal, N., & Hirsch, S. R. (2004). Schizophrenia: Evidence for conceptualising it as a brain disease. *The Journal of Primary Prevention, 24*, 437–444.

Albee, G. W., & Joffe, J. M. (2004). Mental illness is NOT "an illness like any other." *The Journal of Primary Prevention, 24*, 419–436.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Banks, J. A. (2012). *Multicultural education: Issues and perspectives*. New York, NY: Wiley.

Barclay, J. R. (1983). Searching for a new paradigm in counseling. *The Personnel and Guidance Journal, 62*, 2.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders*. New York, NY: International University Press.

Brunner, J. (2001). *Freud and the politics of psychoanalysis*. New Brunswick, NJ: Transaction.

Canfield, B. S. (2008). Together, we make a difference. *Counseling Today, 50*, 5.

Caplan, P. J., & Cosgrove, L. (Eds.). (2004). *Bias in psychiatric diagnosis*. New York, NY: Jason Aronson.

Cohen, C. I. (1986). Marxism and psychotherapy. *Science and Society, 50*(1), 4–24.

Copeland, E. J. (1983). Cross-cultural counseling and psychotherapy: A historical perspective. Implications for research and training. *Journal of Counseling & Development, 62*, 10–15.

Diaz, R. M., Ayala, G., Bein, E., Henne, J., & Marin, B. V. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 U.S. cities. *American Journal of Public Health, 91*, 927–936.

Ellis, A., & Dryden, W. (1997). *The practice of rational–emotive behavior therapy*. New York, NY: Springer.

Ellis, A., & Harper, R. A. (1997). *A guide to rational living* (3rd ed.). Hollywood, CA: Wilshire.

Freud, S. (1930). *Civilization and its discontents* [iBooks version]. Retrieved from https://itunes.apple.com/us/book/civilization-its-discontents/id725567615?mt=11

Freud, S. (1949). *An outline of psychoanalysis*. New York, NY: Norton.

Freud, S. (2011). *A general introduction to psychoanalysis* [Kindle version]. (Original work published 1920). Retrieved from http://www.amazon.com/General-Introduction-Psychoanalysis-Sigmund-Freud-ebook/dp/B006IZ8VJI/ref=sr_1_1?s=books&ie=UTF8&qid=1384624093&sr=1-1&keywords=A+general+introduction+to+psychoanalysis

Gay, Lesbian & Straight Education Network. (2011). *The 2011 national school climate survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. Retrieved from http://glsen.org/sites/default/files/2011%20National%20School%20Climate%20Survey%20Full%20Report.pdf

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

Horney, K. (1973). *Feminine psychology*. New York, NY: Norton.

Hunsaker, R. (2008). Social justice: An inconvenient irony. *Counseling Today, 50*, pp. 21, 43.

Hunsaker, R. C. (2011). Counseling and social justice. *Academic Questions, 24*, 319–340.

Jackson, M. L. (1995). Multicultural counseling: Historical perspectives. In J. G. Ponterotto, J. M. Casas, L. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 3–16). Thousand Oaks, CA: Sage.

Joffe, J. M. (2004). Mental disorders: Should our emphasis be on biological or psychosocial factors? An introduction to the special issue. *The Journal of Primary Prevention, 24*, 415–418.

Jones, E. (1961). *The life and work of Sigmund Freud*. New York, NY: Basic Books.

Kehe, J. V., & Smith, T. B. (2004). Glossary. In T. B. Smith (Ed.). *Practicing multiculturalism: Affirming diversity in counseling and psychology* (pp. 325–337). Boston, MA: Allyn & Bacon.

Kozol, J. (2005). *The shame of the nation: The restoration of apartheid schooling in America*. New York, NY: Three Rivers Press.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago Press.

Lee, C. C. (Ed.). (2006). *Multicultural issues in counseling: New approaches to diversity* (3rd ed.). Alexandria, VA: American Counseling Association.

Lerman, H. (1986). From Freud to feminist personality theory: Getting here from there. *Psychology of Women Quarterly, 10*, 1–18.

Locke, D. C. (1990). A not so provincial view of multicultural counseling. *Counselor Education and Supervision, 30*, 18–25.

Lombroso, C. (2006). *Criminal man*. Durham, NC: Duke University Press.

May, R. (Ed.). (1961). *Existential psychology*. New York, NY: Random House.

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling & Development, 70*, 6–12.

Pedersen, P. B. (1997). *Culture-centered counseling interventions: Striving for accuracy*. Thousand Oaks, CA: Sage Publications.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling* (3rd ed.). London, UK: Sage.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. New York: State University of New York Press.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a "fifth force" among counseling paradigms. *Journal of Humanistic Counseling, Education and Development, 48*, 160–172.

Ratts, M. J. (Writer). (2011). *Four approaches to counseling one client: Medical, intrapsychic, multicultural, and social justice counseling models* [DVD]. United States: Microtraining, An Imprint of Alexander Press.

Ratts, M. J., Anthony, L., & Santos, K. N. T. (2010). The dimensions of social justice model: Transforming traditional group work into a socially just framework. *The Journal for Specialists in Group Work, 35*, 160–168. doi: 10.1080/01933921003705974

Ratts, M., D'Andrea, M., & Arredondo, P. (2004). Social justice counseling: Fifth "force" in field. *Counseling Today, 47*, 28–30.

Rogers, C. (1951). *Client centered therapy: Its current practice, implications, and theory.* Boston, MA: Houghton Mifflin.

Rogers, C. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York, NY: Free Press.

Rosensweig, M. R. (1992). Psychological science around the world. *American Psychologist*, 39, 877–884.

Rotter, J. B. (1966). Generalized expectancies of internal versus external control of reinforcements. *Psychological Monographs, 80*, 1–28.

Rubel, D., & Ratts, M. (2011). Diversity and social justice issues in counseling and psychotherapy. In D. Capuzzi & M. Staufer (Eds.), *Counseling and psychotherapy: Theories and interventions* (5th ed., pp. 29–51). Alexandria, VA: American Counseling Association.

Sampson, E. E. (1977). Psychology and the American ideal. *Journal of Personality and Social Psychology, 35*, 767–782.

Santrock, J. W. (2012). *A topical approach to lifespan development* (5th ed.). New York, NY: McGraw–Hill.

Silvestri, A. J., & Joffe, J. M. (2004). You'd have to be sick not to be crazy. *The Journal of Primary Prevention, 24*, 497–511.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64–89.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley and Sons.

Thompson, M., Ellis, R., & Wildavsky, A. (1990). *Cultural theory*. San Francisco, CA: Westview Press.

United States Census Bureau. (2011). *Overview of race and hispanic origin: 2010* (pp. 1–23). Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration.

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*, 253–272. doi: 10.1177/0011000003031003001

Watson, J. B. (1913). Psychology as the behaviorist views it. *Psychological Review, 101*, 248–253.

Weinrach, S. G., & Thomas, K. R. (2004). The AMCD multicultural counseling competencies: A critically flawed initiative. *Journal of Mental Health Counseling, 26*, 81–93.

Whitbeck, L. B., McMorris, B. J., Hoyt, D. R., Stubben, J. D., & Lafromboise, T. (2002). Perceived discrimination, traditional practices, and depressive symptoms among American Indians in the upper Midwest. *Journal of Health and Social Behavior, 43*, 400–418.

Whoriskey, P. (2012, December 26). Antidepressants to treat grief? Psychiatry panelists with ties to drug industry say yes. *The Washington Post*. Retrieved from http://articles.washingtonpost.com/2012-12-26/business/36015527_1_drug-companies-antidepressants-wellbutrin

Worell, J., & Remer, P. (2003). *Feminist perspectives in therapy: Empowering diverse women* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Chapter 3

The Complexities of Identity

Human identity is complex. How people identify themselves is shaped by "individual characteristics, family dynamics, historical factors, and social and political contexts" (Tatum, 2010, p. 5). In other words, people are not the sole determiners of their identities; society plays a role in the construction of identity and our beliefs about human diversity. Tatum (2010) contended that human identity is multidimensional rather than one-dimensional. Race, class, gender, sexual orientation, religion, age, and disability status are separate yet synergistic dimensions of identity that combine to make up the total human being. It is difficult, for example, to understand race without also examining its connection with other dimensions of identity such as class, gender, religion, and sexual orientation. Each dimension of identity influences how other dimensions are experienced. Together, each dimension of identity (race, ethnicity, gender, sexual orientation, economic status, religious status, age, etc.) combines to form a whole where one aspect of identity cannot be fully understood without the other.

The dimensions of identity are social constructs shaped and constructed by the dynamics of power, privilege, and oppression. To make sense of our world, we create social categories such as race, gender, sexual orientation, religion, disability, and class. Everything we do, how we experience the world, and how resources are distributed are based on these social categories. For example, students of color in urban schools tend to receive a lower quality educational experience than students in predominantly White affluent neighborhoods (Kozol, 2005). This experience leads to very different opportunities after graduation.

Counselors who are unaware of how dimensions of identity and oppression influence client experiences may inadvertently label clients with a mental illness when their behaviors are actually normal and healthy responses to a toxic environment. This carelessness on the part of counselors can have grave consequences for clients and their families. Misdiagnosing clients can mean an added financial burden for clients who opt for medication to cope with their "mental illness." Inaccurately labeling client problems can also lead clients to blame themselves for their problems.

In this chapter we highlight the most recent U.S. census data on the diversity of the U.S. population. We then discuss the dimensions of identity that form human identity; explain

oppressor, border, and oppressed group identities; and describe the way in which identity is tangled with interlocking systems of power, privilege, and oppression.

Diversity of the U. S. Population

The U.S. census data reflect the mosaic that makes up the U.S. population (see Table 3.1). The increasing diversity of the U.S. population also affects the counseling profession. Counselors can no longer ignore such important variables as race, ethnicity, gender, sexual orientation, economic class, religious status, and disability status. Both clients and counselors bring with them rich histories and personal experiences that shape the counseling experience.

Whites account for a majority of the U.S. population. However, historically underrepresented racial and ethnic groups are growing at a faster rate than the White population (Humes et al., 2011). Hispanics are the fastest growing population, increasing by 43% between 2000 and 2010.

The U.S. census data on gender suggest that males and females are equally represented. However, the data are misleading because information on transgender individuals is not

Table 3.1 • **Demographic Distribution of the United States**

Demographic Variable	% of the Population
Race (in 2010)	
Native Hawaiian and Other Pacific Islander	0.2
America Indian/Alaskan Natives	0.9
Asian	4.8
Some other race alone	6.2
Two or more races	2.9
Black/African American	12.6
White	72.4
Gender	
Female	50.8
Male	49.2
Poverty level by race (in 2011)	
Asian	12.3
White	12.8
White, not Hispanic	9.8
Hispanic, any race	25.3
Black	27.6
Age (in 2010)	
Under 18 years old	24.0
18–44 years old	36.5
45–64 years old	26.4
65 years old and older	13.0
Same-sex households	1.0
Disability	11.9

Source. Race data are from Karen R. Humes, Nicholas A. Jones, and Roberto R. Ramirez, 2011, *Overview of Race and Hispanic Origin: 2010* (2010 Census Brief, p. 2). Washington, DC: US Department of Commerce, Economics and Statistics Administration, US Census Bureau. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf. Poverty data are from Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica C. Smith, 2013, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. Current Population Report. 2013 (p. 22). Retrieved from http://www.census.gov/prod/2013pubs/p60-245.pdf. Age data are from Lindsay M. Howden and Julie A. Meyer, 2011, *Age and Sex Composition: 2010*. 2010 Census Briefs (p. 22). Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

collected. *Transgender individuals* are those who vary from culturally conventional roles of male or female. They may identify as male, female, transgender, or neither.

Christians make up the largest religious group (78.4%) in the United States. This is followed by unaffiliated (16.1%) and other religions (4.7%).

Blacks and Hispanics/Latinos account for a majority of those living in poverty. Individuals in the 18–44 year age range represent the largest age group. Same-sex households make up 1% of the population. However, the data are misleading because it does not consider lesbian, gay, and bisexual individuals who are single or living alone, which means that this group is much larger. Individuals with disability make up nearly 12% of the population.

Internal, External, and Sociopolitical Dimensions of Identity

Human identity exists on three dimensions: individual, group, and universal (Sue & Sue, 2013). The *individual dimensions of identity* refers to the unique characteristics of each person, such as personality, values, and belief systems. These characteristics and attributes distinguish people on an individual level and make each of us unique. The *group dimensions of identity* refers to the shared experiences people have as a result of being a member of a social group. As human beings we are all members of racial, gender, sexual orientation, social class, religious, and ability social groups. As members of these social groups we share certain things, such as language or a group identity, that shape our lived experiences. The *universal dimension of identity* refers to the universal aspects of human existence. Human beings need food, shelter, water, and safety for survival regardless of cultural background. How we achieve each of these survival resources varies for each person and social group.

People often focus on individual and universal dimensions of identity in the United States more so than group dimensions of identity. However, group dimensions of identity are just as important because they describe shared experiences that individuals have as members of a social group, and they offer explanations for the way in which people experience the world as members of various social groups.

We introduce the dimensions of identity model (see Figure 3.1) to explain group dimensions of identity. Group dimensions of identity are categorized into internal, external, and sociopolitical dimensions. All of these dimensions are linked with one another. Dimensions of identity closest to the center of the circle are those that are most salient for a person (i.e., dimensions that a person tends to be conscious of on a daily basis); they are referred to as the *internal dimensions of identity*. Dimensions of identity that are second furthest from the center of the circle are referred to as the *external dimensions of identity*. What is listed as an internal or external dimension of identity varies for each person depending on the degree of salience of that particular aspect of identity. Some people may list race as an internal dimension of identity. Others may list race as an external dimension of identity because they are not as conscious of their racial identity.

For purposes of illustration in Figure 3.1, we list internal dimensions of identity as age, race, ethnicity, gender, sexual orientation, and physical and mental ability. The circular arrows surrounding the internal dimensions of identity reflect both the forms of oppression related to that aspect of identity and the fluidity of identity and the connection between each dimension of identity and each form of oppression. We provide a more detailed overview of oppression in the section *Dynamics of Oppression*. Here we identify which internal dimensions of identity correspond to which system. (Note that each is associated with individual, social–cultural, and institutional levels of oppression.)

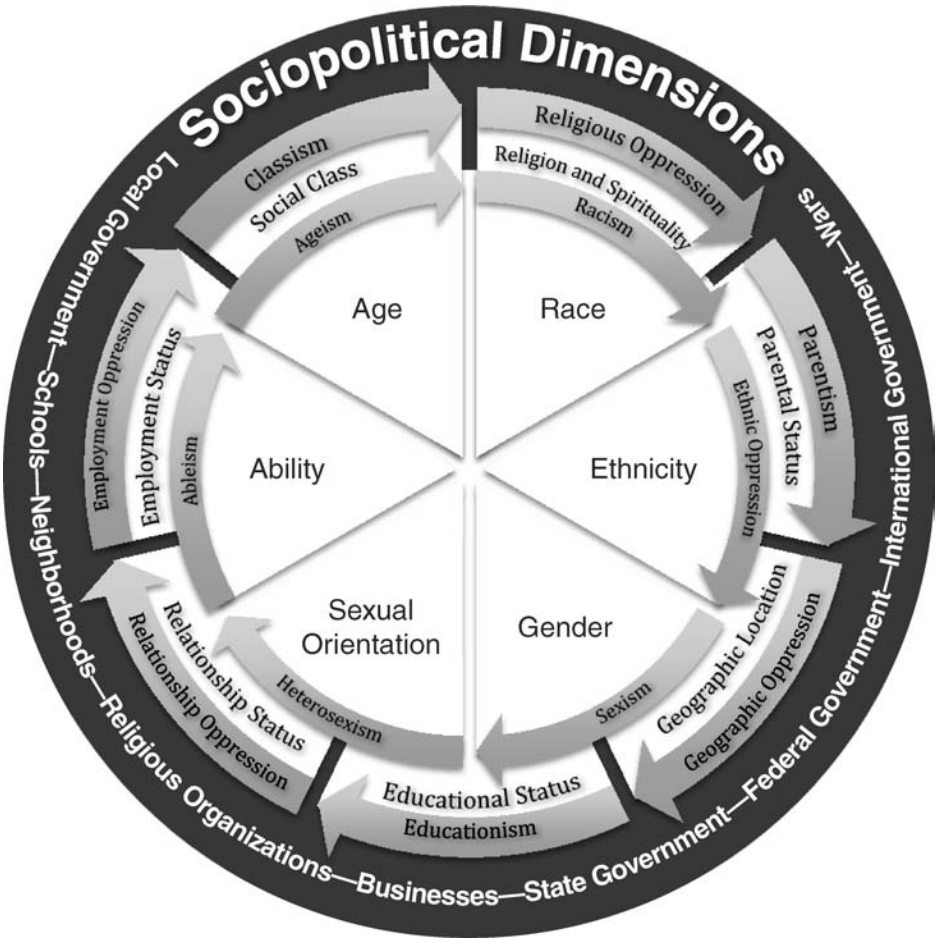


Figure 3.1 • **Dimensions of Identity Model**

Source. Manivong J. Ratts © 2014. Reprinted with permission. For permission to use for research or publication purposes, contact Manivong J. Ratts: vong@seattleu.edu.

- race → racism
- ethnicity → ethnic oppression
- gender → sexism
- sexual orientation → heterosexism
- ability → ableism
- age → ageism

External dimensions of identity are aspects of human diversity that people tend not to be as conscious about as other dimensions. For instance, Whites tend to not be conscious of themselves as being members of a White racial group. For purposes of illustration we list external dimensions of identity as social class, religion and spirituality, parental status, geographic location, educational status, relationship status, and employment status. The arrows surrounding the external dimensions of identity reflect a form of oppression connected to that aspect of identity. Each bullet entry is associated with individual, social–cultural, and institutional levels of oppression.

- religion and spirituality → religious and spiritual oppression
- parental status → parentism
- geographic location → geographic oppression
- educational status → educationism
- relationship status → relationship oppression
- employment status → employment oppression
- social class → classism

The sociopolitical dimension of identity, which is furthest from the center of the concentric circle, is concerned with the social, political, and economic conditions that influence human development. This includes, but is not limited to, local government, schools, religious organizations, businesses, neighborhoods, state government, federal government, wars, and social policies. Each social system influences people's lived experiences and access to resources such as education, health care, and employment. For instance, religious institutions have historically been a barrier for sexual minorities. We see this in the Catholic Church's position against marriage equality. Another example is seen in America's education system where students who attend poor schools are more likely to have a less than ideal educational experience than students who attend well-funded schools. These examples reflect how people influence, and are influenced by, their surroundings.

Internal Dimensions of Identity

Age

Society uses age as a marker of time. Age is often used to determine biological effects of time on a person. It is also used to determine rites of passage in society. For instance, in the United States age 16 is often the marker for when people can legally hold a valid driver's license; at age 18, adolescents are generally viewed as legal adults.

Race

Race is a classification used to connote both biological and social differences in people based on historical geographic origins and physical attributes such as skin pigmentation. According to Pedersen (2000), the Caucasoid, Mongoloid, and Negroid races recognize racial differences among themselves and explain these differences in biological terms. However, this understanding does not explain differences in sociological behavior where patterns cut across racial lines. Race is a social construction with little or no biological basis. The U.S. census uses the following racial categories to distinguish people: American Indian and Alaska Native, Asian, Hispanic or Latino, Native Hawaiian and Other Pacific Islander, Some Other Race, and White.

Ethnicity

Ethnicity refers to an individual's identification with a cultural group and is largely based on culture, nationalism, religion, and citizenship. According to Pedersen (2000), the term *ethnic* is "derived from the social or cultural heritage a group shares that relates to customs, language, religion, and habits passed on from one generation to the next" (p. 54). African American ethnic groups include but are not limited to Nigerian, Kenyan, or Haitian. Asian American ethnic groups include but are not limited to Indonesian, Japanese, Korean, Laotian, Filipino, Taiwanese, Thai, and Vietnamese. Hispanic or Latino ethnic groups include but are not limited to Colombian, Cuban, Dominican, Ecuadorian, Honduran, Mexican, Peruvian, Puerto Rican, and Salvadoran. European American ethnic groups include but

are not limited to British, French, German, Italian, Polish, Spanish, Russian, Swedish, and Ukrainian. Native American ethnic groups are also referred to as *tribes*. There are 562 federally recognized tribes in the United States; the largest tribes are Navajo, Cherokee, Choctaw, Sioux, Chippewa, Apache, Blackfeet, Iroquois, and Pueblo. Pacific Islander ethnic groups include but are not limited to Hawaiian, Samoan, or Chamorro.

Gender

Gender refers to a range of social, behavioral, cultural, and psychological traits used to distinguish between girls–women and boys–men. Gender roles are ascribed within cultures. Society tends to view gender in binary terms, often equating it to either man or woman. This binary thinking of gender does not allow for gender diversity. Cultural practices and standards often determine how gender is viewed in society.

Gender should not be confused with biological sex, which is assigned at birth. Society uses *biological sex* to identify whether people are male, female, or intersex. It is determined by physiological factors such as internal and external sex organs (vulva, clitoris, vagina for assigned females and penis and testicles for assigned males), chromosomes (XX for females; XY for males), and hormones (estrogen and progesterone for females; testosterone for males).

Gender identity refers to whether people identify psychologically as male, female, both, or neither. People's gender identity often matches their assigned biological sex. However, this is not always the case; the gender identity one psychologically identifies with can differ from one's biological sex assigned at birth.

Gender expression refers to how people communicate their gender identity. Gender can be expressed through such things as clothing, hairstyle, or behavior. Cultural standards often influence the way gender is expressed. In Western society, males are expected to express gender in masculine ways (e.g., assertiveness and independence). Females are expected to express gender in feminine ways (e.g., nurturing and cooperation).

Sexual Orientation

A person's sexual orientation is related to, and yet distinct from, gender identity. *Sexual orientation* refers to the emotional, intellectual, physical, sexual, and spiritual attraction to members of a specific gender. Gay and lesbian people are attracted to members of the same gender. Heterosexual individuals are attracted to members of the opposite gender. Bisexual individuals are attracted to both genders. Asexual individuals are attracted to neither gender. It is important to note that the term *sexual orientation* is preferred over the term *sexual preference;* the latter is considered a derogatory term because it implies that being gay, lesbian, bisexual, or heterosexual is a choice, when research supports the claim that it is not.

Ability

According to the World Health Organization (2012), disabilities may be physical, cognitive, mental, sensory, emotional, developmental, or some combination that affects three areas: impairments (bodily functioning or structure), activity limitations (difficulty in executing a task), and participation restrictions (inability to obtain access). Disabilities are both visible and invisible. Visible disabilities are those that are typically noticeable and can be seen. Invisible disabilities are those that may not be readily observable, such as auditory, learning, and mental disabilities.

External Dimensions of Identity

Social Class

Clarifying what class entails requires an understanding of social status. *Social status* refers to the position, whether real or perceived, that society places people in based on economic indicators such as "prestige, power, income, wealth and property, in-group and out-group

behavior, lifestyle, and leisure and consumption behavior" (Liu, 2001, p. 129). The combination of socially determined societal markers (e.g., material possessions, education level) and a person's self-inventory of her or his economic status determines class status. *Class* refers to shared experiences, worldview, and life opportunities among people. Society in the United States is based on class stratification.

Adams, Bell, and Griffin (2007) categorize social class into the following: rich/upper classes, middle class, and working class/poor. Each of these class categories shapes lived experiences, access to quality resources (e.g., education, healthcare, employment), and influences how people are perceived by others. Those in the rich/upper classes are often viewed as being more "capable" than those in the working class/poor.

Religion and Spirituality

Religion is a collection of beliefs and practices of a religious institution. According to Wiggins (2010), "Religion is corporate, cognitive, behavioral, public, ritualistic, external, and institutional. Although 'spirituality' often includes 'religion' the two terms are not identical. In fact, religion may be only one way in which some persons express their spirituality" (p. 76). Many religions use rituals, symbols, and traditions to reflect values, beliefs, and practices. Religious beliefs may influence people's morals, values, and ethics. Life decisions are often guided by religious beliefs and values, which provide purpose and meaning in life.

Parental Status

Parents are caretakers of a child or adult. Everyone has two biological parents, a male and female who reproduce either through sexual reproduction or artificial insemination. Typically, biological parents raise their own offspring. However, children can have caretakers who are not their biological parents (e.g., extended family members, parents of the same sex). State and federal regulations also allow people to become adoptive parents. It is common for same-sex couples to adopt children. It is important for counselors to keep parental status in mind because it influences client's lived experiences. Circumstances often dictate whether children are raised by biological parents, same-sex parents, family members, foster parents, or adoptive parents.

Geographic Location

Geographic location, or where people live, is important to consider as our society continues to become increasingly global. Encompassing many regions, countries, and parts of the world, geographic locations influence the ways people think, feel, and act. For example, people who live in the southeastern part of the United States, also known as the "Bible Belt," are likely to be influenced by conservative political ideologies rooted in Christian values and beliefs. Conversely, those who live in the Pacific Northwest are likely to hold more liberal political ideologies and beliefs that are influenced by regional politics and value systems. People who come from other countries have different perspectives on development issues.

Educational Status

Society often uses education as a formative experience to transmit knowledge and skills from one generation to the next. Education serves the purpose of helping people develop critical thinking and social skills. It is used as a means to determine qualifications and regulate who can enter certain sectors of the work force. Education is often associated with financial benefits, income potential, and increased opportunities.

Relationship Status

Relationship status has to do with whether a person is in an intimate relationship. People can identify as single, divorced, separated, partnered (e.g., married, polyamorous, monogamous), or widowed. The relationships people enter into can be short-term or long-term,

committed or noncommitted, and arranged or unarranged. Culture plays a significant part in the formation of relationships. For instance, arranged marriages are common in South Asia, Africa, and the Middle East. Arranged marriages occur when family members decide that individuals are to wed. People pursue relationships for a variety of reasons, including companionship and financial gain.

Employment Status

Employment is a paid experience that involves a contractual agreement between an employer and an employee. The employer dictates the types of duties required of a particular job, and the employee performs those duties within an agreed upon period of time. The type of work experience people engage in varies from manual labor to highly skilled positions that require the attainment of certifications or education.

Sociopolitical Dimensions of Identity

The social and political landscape must be considered when defining the factors that shape identity. Helping professionals are better able to understand clients when they consider how environmental factors (e.g., local, state, and federal government; businesses; wars; social policies; institutionalized oppression) shape and influence a client's identity and lived experiences. Clients do not exist in a vacuum; we cannot truly understand a client's racial and ethnic identity without also exploring how this aspect of identity is influenced by racial dynamics in society. Similarly, the "coming out" process for lesbian, gay, bisexual, transgender, or queer clients can better be understood by examining how heterosexism influences the coming out experience.

Oppressor, Border, and Oppressed Group Status

An understanding of internal and external dimensions of identity is enhanced by further classifying these dimensions into oppressor, border, and oppressed groups. Oppressor or privileged groups are those who, by virtue of their membership in a social group, have power and unearned privilege in the United States (Adams et al., 2010). According to Adams et al., oppressors appear in any of the following groups:

- *race:* Whites;
- *sex:* cisgender men (*Note:* Cisgender refers to a self-perception that matches the body and the biological sex an individual was born with.);
- *gender:* gender-conforming cisgender men and women;
- *sexual orientation:* heterosexuals;
- *class:* rich, upper class;
- *age:* adults;
- *ability:* temporarily able-bodied; and
- *religion:* Christian.

Border groups are those who experience both privilege and oppression as a result of their social group identity. Adams et al. (2010) identified the following as border groups:

- *race:* biracial and multiracial individuals;
- *sex:* transsexual, intersex;
- *gender:* gender-ambiguous men and women;
- *sexual orientation:* bisexual and asexual;
- *class:* middle class;

- *age:* young adults;
- *ability:* individuals with temporary disabilities; and
- *religion:* Roman Catholics.

Oppressed groups are those in society who are marginalized because of their membership in a social group. They are often placed at a disadvantage because their values, beliefs, and customs are frequently at odds with the oppressor. The different values and beliefs held by individuals from oppressed groups are often viewed as a deviation rather than as a variation in society. Adams et al. (2010) included the following as oppressed groups:

- *race:* people of color (Asian, Latino/a, Black, and Native American);
- *sex:* cisgender women;
- *gender:* transgender, genderqueer (an umbrella term for gender identity that goes beyond traditional notions of man and woman), intersex individuals;
- *sexual orientation:* gay males and lesbians;
- *class:* poor and working class individuals;
- *age:* youth;
- *ability:* people with mental and physical disabilities; and
- *religion:* Jews, Muslims, Buddhists, Mormons, and others.

One's status as a member of an oppressor, border, or oppressed group can influence the counseling relationship. Consider the following examples:

- Victor, a transgender male school counselor, was hired to work in a middle school. Prior to applying for school counseling positions, he changed his name so that search committee members would not be able to Google his name on the Internet and discover his previous transgender advocacy work. After 4 years as a school counselor and earning the School Counselor of the State award, he decided to leave the profession. For 4 years he struggled every day with not being able to be "out" to students, families, and colleagues. After submitting his resignation letter he felt free to be himself again.
- Vu, a Vietnamese American male college counselor working with predominantly White client populations, struggled with issues of confidence. He had a disproportionately high number of "no shows" compared to his White counselor colleagues. He wondered whether his racial identity played a factor in the number of missed appointments. He brought this concern to his White clinical supervisor; she argued that race could not be a factor because of the racial diversity on campus and that the no shows were more likely to be an indication of his inexperience. After 3 years working at the college he decided to leave and work at an Asian counseling agency. The pay was lower, but he was happier than he had been because his racial identity was not a factor in his work with clients.
- Amy, a White female counselor who grew up in an affluent White suburb, was interning at a local mental health agency that served clients who were poor and predominantly people of color. She struggled to connect with clients and wondered whether her racial identity was a factor. Amy never considered herself as part of a White racial group until the internship experience. She noticed that counseling sessions tended to be surface level at best. Clients often did not show up for their second appointment; some requested to see another counselor at the agency. She did not broach the topic of race and poverty with clients because she was afraid to make them uncomfortable.

Dynamics of Power and Privilege Between Client and Counselor

Members of oppressor, border, and oppressed groups interact in counseling in various ways. Understanding these combinations gives insight into how power and privilege influence the client–counselor relationship. These combinations are conceptualized in quadrants with the origin being the center of the quadrant (see Figure 3.2).

Oppressor Client–Oppressed Counselor (Quadrant I). Counselors from oppressed groups who work with clients from oppressor groups are at a disadvantage. On one hand, counselors have power by virtue of their professional title, but this power may be negated because they lack social power and privilege by virtue of their social group status. Oppressed group counselors who work with oppressor group clients must deal with the challenge of how to be taken seriously. For instance, White clients who harbor racist beliefs may undermine an African American counselor's expertise. A gay male school counselor may experience challenges with gaining trust from parents who hold the belief that gay males have pedophile tendencies.

Oppressor Client–Oppressor Counselor (Quadrant II). Both counselors and clients might belong to oppressor groups when they both hold power and privilege in society. As oppressors the assumption may be that cultural diversity and identity politics do not factor into the counseling equation. The dynamics of power and privilege may also not be considered because oppressors are often unaware of their status and dominance. As a result, both counselors and clients may not always realize how privilege can be a burden that can contribute to a client's presenting problem.

Oppressed Client–Oppressor Counselor (Quadrant III). Counselors from oppressor groups hold power and privilege over clients from oppressed groups. Because oppressors are often unaware of their own privileged status, they may use theories and approaches that do not align with the cultural background and worldview of oppressed clients (Sue & Sue, 2013).

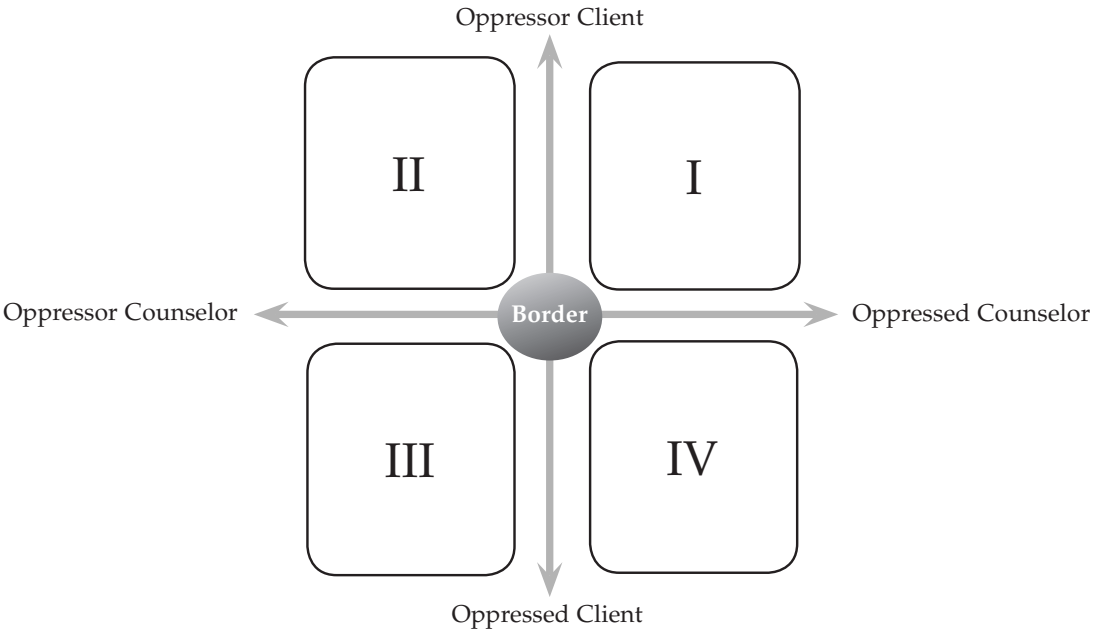


Figure 3.2 • **Oppressor–Border–Oppressed Relationships**

Source. Manivong J. Ratts © 2014. Reprinted with permission. For permission to use for research or publication purposes, contact Manivong J. Ratts: vong@seattleu.edu.

Gaining trust may also be a challenge for counselors from oppressor groups who work with oppressed clients. Oppressed group clients may be hesitant to share because in their view, counselors who belong to oppressor groups represent power and unearned privilege. This perspective holds true regardless of whether counselors are multiculturally competent or identify as change agents. Oppressor group counselors who initiate dialogue about differences in power dynamics can alleviate concerns and ward off potential barriers with oppressed group clients. Such discussions require oppressor group counselors to be comfortable in their own skin and knowledgeable of the ways in which they benefit from privilege.

Oppressed Client–Oppressed Counselor (Quadrant IV). Both clients and counselors may belong to oppressed groups, which means that both lack social power and privilege. Oppressed group counselors who have internalized oppression may perceive clients from oppressed groups as inferior. Conversely, if oppressed group counselors are aware of oppression and its impact, they can be an important resource to oppressed group clients. Such counselors can have a deeper sense of empathy for oppressed group clients because of their shared experiences. They may also be able to connect oppressed clients with important resources in the community. It is also not uncommon for oppressed group clients to seek counselors from the same oppressed group, because they do not want the burden of having to enlighten counselors about oppression. There is also solace in knowing that their counselor is likely to understand their experiences.

Border Groups (the Origin)

Individuals with border group status experience both privilege and oppression, but their identities are not always evident to others. Therefore, the dynamics of privilege and oppression may not be as apparent unless that dimension of identity is shared. For instance, counselors who identify as bisexual and are "out" may experience oppression when working with clients who are homophobic. However, such counselors may experience privilege if they are not "out" to clients. Similarly, clients who identify as bisexual may experience oppression if they are in a gay or lesbian relationship. However, they may experience privilege if they are in a heterosexual relationship. Given the invisible nature of border group identities counselors should refrain from making assumptions about privilege and oppressed group statuses. Counselors who wrongly assume clients' privileged and oppressed group status may offend clients. To the extreme, this inaccurate assumption may lead clients to terminate therapy.

Cycle of Socialization

We learn about ourselves, about others, and about the world through a process referred to as *socialization*. This socialization process occurs throughout the life span. Harro (2010) developed a socialization model, referred to as the *cycle of socialization,* that identifies five key characteristics of the socialization process:

- *Pervasive*: The process is relentless and permeates the individual, social–cultural, and institutional levels.
- *Consistent*: The process is predictable and requires individuals and institutions to play certain roles.
- *Circular*: The process is circular, thereby providing a feedback loop.
- *Self-perpetuating*: The process requires individuals and institutions to work in synchronicity so that it is self-sustaining.
- *Invisible*: The process pervades all aspects of society so thoroughly that we do not notice it.

Harro's (2010) cycle of socialization model is described as a process that works in a symbiotic and systematic fashion. The socialization process is based on the dominant group's perspective, which reinforces the dominant group's explanation of how the world operates. Harro's cycle of socialization model describes the following process:

1. *The beginning:* We are all born as blank slates into a world where certain rules, power structures, laws, and policies are already in place that benefit one group over another. Bias, stereotypes, and prejudices about social groups are already well established before we are born. Through no choice of our own we inherit a world where discrimination and oppression are rampant.
2. *First socialization:* We are socialized from an early age about race, ethnicity, gender, sexual orientation, economic class, religion, and disabilities from those we love and trust the most. This process begins at birth and continues through the life span. The implicit and explicit messages we are taught about the self and about others begin at such an early age that people do not question them. This socialization occurs both "intrapersonally (how we think about ourselves) and interpersonally (how we relate to others)" (Harro, 2010, p. 47). We learn from those we trust about how we should behave and the roles we should play in society. Those closest to us influence our values, our self-concept, and our perception of others. The messages we learn about ourselves and about issues of diversity and social justice can be positive or negative, and they can either be reinforced or contradicted by others.
3. *Institutional and cultural socialization:* The socialization process is multiplied when we begin to interact with institutions and systems outside the immediate family. The messages people learn about themselves, other people, and the way the world works from loved ones are either reinforced or contradicted by schools, places of worship, businesses, media, and Internet sources. People quickly learn the rules of engagement through interaction with social systems: Girls like pink and boys like blue; a healthy family includes a mother and a father; gay men are pedophiles; transgender individuals are mentally ill; poor people are lazy; Asian Americans are sneaky; being White means more opportunities; and success is the result of hard work.
4. *Enforcements:* There is pressure to maintain the social order of things. People are rewarded for maintaining the dominant status quo, and they are punished if they question the way things are done. Those who buck the status quo run the risk of being unpopular. Such individuals are often stigmatized and viewed as troublemakers. Those who help to maintain the status quo are perceived as team players and are often left alone. This type of reward system keeps the status quo in place.
5. *Results:* The impact of socialization results in different experiences for dominant and target group members. Target group members may have a wide range of negative feelings such as anger, dissonance, frustration, dissonance stress, hopelessness, and disempowerment. These feelings often lead to internalized oppression such as low self-esteem, crime, and destructive behavior. Dominant group members experience internalized privilege, guilt, fear of retribution and violence, and stress, and they often become defensive.
6. *Actions and directions for change:* People can choose to do nothing and allow the status quo of oppression to exist, or they can choose to interrupt the cycle of oppression. It is easier to remain quiet than to speak out. Those who choose to remain quiet may do so because they fear retribution from others if they speak out or because they are oblivious to the realities of oppression. Those who speak out do so because they realize that being silent means that they are condoning oppression.

7. *The core of the cycle:* Harro (2010) argued that the combination of fear, ignorance, insecurity, confusion, obliviousness, and powerlessness work to maintain the cycle of socialization.
    - *Fear:* Members of targeted groups fear being labeled as troublemakers, deported, and killed, and so they choose to keep silent. Members of dominant groups fear losing their privilege and being ostracized, so they do not question the status quo.
    - *Ignorance:* Both targeted and dominant group members are unaware that oppression exists and how it works; they may not be aware that they are being socialized.
    - *Confusion:* The complexity of oppression makes it overwhelming to address. People often do not know where to begin and so they choose to do nothing. The fear of doing or saying the wrong thing helps to maintain the cycle of socialization and oppression.
    - *Insecurity:* Many people lack confidence in their ability to address issues of oppression. They lack appropriate training and the knowledge and skills needed to be effective in challenging the status quo.
    - *Power or powerlessness:* Dominant group members hold power and fear losing it. Targeted group members may be overwhelmed by the existing power structure and so choose to do nothing.

Harro's (2010) cycle of socialization model describes how power and privilege are maintained. Moreover, it explains why the dominant status quo is difficult to change. Even when people are aware of the need for change, pressure from individuals and institutions to maintain the system of power and privilege makes change difficult to achieve.

Dynamics of Oppression

The messages we learn about social group identity are often based on stereotypes and prejudice. When left unexamined, stereotypes and prejudice can lead to discrimination and oppression. The link between stereotypes, prejudice, discrimination, and oppression is illustrated and explained in the dynamics of oppression conceptual model (see Figure 3.3).

Research (Katz & Kofkin, 1997; Lewis, 2003; Van Ausdale & Feagin, 2001) indicates that children as young as 6 months begin to recognize difference such as skin color. Children learn about diversity through discussions, observation, modeling, vicarious reinforcement, and imitation of others. Their natural curiosity leads them to ask questions about themselves and the world around them. These experiences lead children to form cognitive schemas, also known as *stereotypes*, about others. *Stereotypes* are mental pictures in our head about people based on their membership in a particular racial, ethnic, gender, sexual orientation, age, economic, disability, or religious group. Stereotypes are often based on half-truths, misconceptions, and misinformation. Stereotypes are harmful because they ascribe negative attributes to a group. Even positive stereotypes are harmful. For example, the stereotype that Asian Americans are the model minority is harmful because it puts undue pressure on Asian Americans to succeed and it pits Asian Americans against other people of color such as Latin@ Americans, American Indians, and African Americans.

When left unchallenged, stereotypes can lead to prejudice. *Prejudices* are preconceived judgments, attitudes, or beliefs about others based on stereotypes. Prejudices are often irrational and are not always based on personal experience. People can be steadfast in their prejudice even when confronted with evidence that contradicts their prejudice. Prejudices are damaging because they lead people to form favorable or unfavorable opinions or attitudes about others. In turn, these preconceived notions lead to discrimination against others.

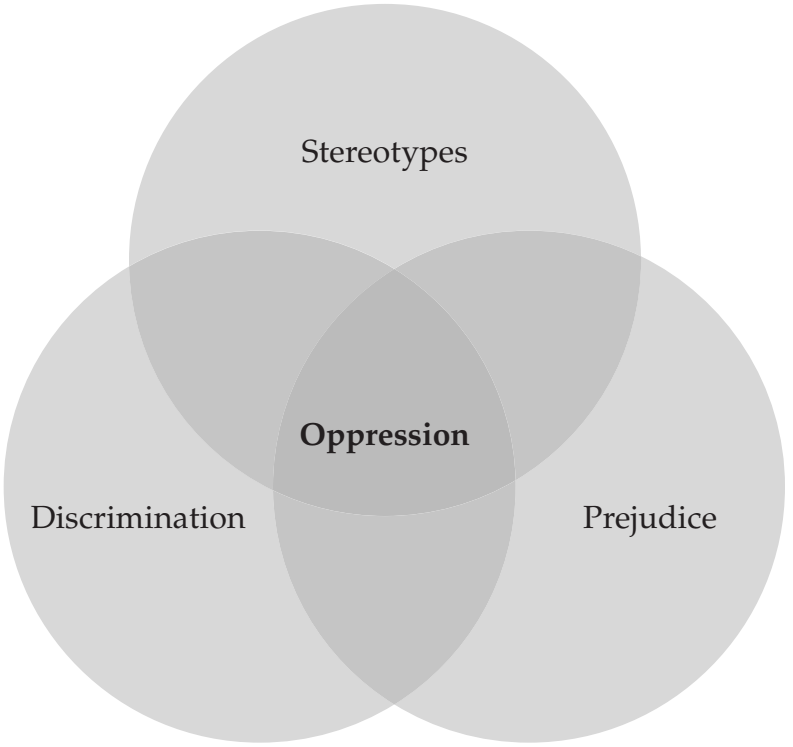


Figure 3.3 • **Dynamics of Oppression**

Source. Manivong J. Ratts © 2014. Reprinted with permission. For permission to use for research or publication purposes, contact Manivong J. Ratts: vong@seattleu.edu.

Discrimination is an unconscious or conscious act against a person based on prejudice. Discrimination occurs when a person treats another person favorably or unfavorably based on such categories as race, ethnicity, gender, sexual orientation, economic status, age, and religion. For example, unconscious discrimination occurs when a White female clutches her purse when an African American male steps into an elevator. A heterosexual counselor who refuses to see lesbian, gay, bisexual, or transgender (LGBT) clients because of his or her religious beliefs is acting on a conscious form of discrimination. Discrimination is harmful because it leads to decisions that are often based on bias rather than on merit or facts.

When those in power participate in discrimination, what results is *oppression*, a complex interlocking system of advantages one group has over another based on the ability, whether intentional or unintentional, to use power to enact one's prejudices. Oppression is "first and foremost a systematic phenomenon that involves ideological domination, institutional control, and the promulgation of the dominant group's ideology of domination and culture on the oppressed" (Hardiman & Jackson, 1982, p. 2). It is a system that operates on the individual, social–cultural, and institutional levels. Individual forms of oppression include individual acts and attitudes directed toward others. Social and cultural forms of oppression occur when dominant cultural norms and practices of a society are used to dehumanize others. Institutional forms of oppression include the structures, laws, regulations, and policies that result in differential access to goods, services, and opportunities in society based on a person's identification with a racial, ethnic, gender, sexual orientation, age, ability, economic, or religious group.

Oppression is based on both prejudice and power. Lukes (2005) conceived of power as control or influence over others. For instance, those in the privileged group have "power

to" institutionalize policies and "power over" those in the target group. Based on this description, everyone has the ability to discriminate against others. However, only those in the privileged group have the power to use their prejudice to oppress. Many people do not understand the distinction between discrimination and oppression; they think that people of color can be racist or that women can be sexist. However, people cannot oppress when they are also victims of that oppression. A female who selects a woman for a job over a male because of gender or people of color who act on their prejudicial attitudes toward other White people are demonstrating discriminatory behavior and not oppressive behavior. On a systemwide scale, males and Whites still hold power and unearned privilege, and they continue to profit from a system that benefits them.

Research continues to demonstrate that oppression is a chronic stressor that can lead to psychological and physical health problems. The prevalence of heterosexism contributes to increased negative psychosocial development for youth who are identified as or perceived to be LGBT or queer (Toomey, Ryan, Diaz, Card, & Russell, 2010). Krieger and Sidney's (1996) research suggested that the combination of racism and the belief that unfair treatment was inevitable correlated with higher levels of blood pressure in African Americans. Women's experiences with sexism have been associated with depression, anxiety, somatization, and low self-esteem (Klonoff, Landrine, & Campbell, 2000). Individuals who experience more than one form of oppression are affected in even more complex ways. For example, research by the Gay, Lesbian & Straight Education Network (2011) found that LGBT and queer youth of color in K–12 schools were at a greater risk for harassment and physical safety than their heterosexual peers.

Conclusion

The mosaic that makes up the United States is diverse, rich, and complex. America's diversity exists in large part because we are a country primarily made up of immigrants and refugees. As a nation, the United States is rich in diversity. Living in a multicultural society affords opportunities to interact with people from all walks of life and to learn about varying perspectives. The nation's diversity also allows America to compete in an increasingly global economy. Our diversity is not the problem. It is our inability to know what to do with America's diversity that creates problems. Using the diversity of our nation, we have set up an invisible and self-perpetuating system that promotes inequities and allows oppression to thrive.

Given the realities of the world our clients live in, counselors must make a commitment to multiculturalism and social justice. Such a commitment begins with an understanding of the various dimensions that make up human identity. This commitment must also include a belief that we live in a world where people are socialized to maintain an invisible system of oppression. Until counseling as a profession is able to recognize the way we are socialized and do something on a systemwide scale to dismantle oppression, the status quo will continue. Those in privileged groups will continue to reap the benefits of their privileged status. Target group members will remain disenfranchised. Border groups will both benefit and be harmed by the system.

References

Adams, M., Bell, L. A., & Griffin, P. (Eds.). (2007). *Teaching for diversity and social justice* (2nd ed.). New York, NY: Routledge.

Adams, M., Blumenfeld, W. J., Castaneda, R., Hackman, H. W., Peters, M. L., & Zuniga, X. (Eds.). (2010). *Readings for diversity and social justice* (2nd ed.). New York, NY: Routledge.

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2013). *Income, poverty, and health insurance coverage in the United States: 2010* (Current Population Report. 2013, p. 22). Retrieved from http://www.census.gov/prod/2013pubs/p60-245.pdf

Gay, Lesbian & Straight Education Network. (2011). *The 2011 national school climate survey.* Retrieved from http://glsen.org/nscs

Hardiman, R., & Jackson, B. (1982). Oppression: Conceptual and developmental analysis. In M. Adams, P. Brigham, P. Dalpes, & L. Marchesani (Eds.), *Social diversity and social justice—Diversity and oppression: Conceptual frameworks* (pp. 1–6). Dubuque, IA: Kendall/Hunt.

Harro, B. (2010). The cycle of socialization. In M. Adams, W. J. Blumenfeld, C. Castaneda, H. W. Hackman, M. L. Peters, & X. Zuniga (Eds.), *Readings for diversity and social justice* (pp. 45–51). New York, NY: Routledge.

Howden, L. M., & Meyer, J. M. (2011). *Age and sex composition: 2010* (2010 Census Briefs, p. 22). Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Humes, K., Jones, N. A., & Ramirez, R. R. (2011). *Overview of race and Hispanic origin, 2010* (2010 Census Brief). Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

Katz, P. A., & Kofkin, J. A. (1997). Race, gender, and young children. In S. S. Luthar & J. A. Burack (Eds.), *Developmental psychopathology: Perspectives on adjustment, risk, and disorder* (pp. 51–74). New York, NY: Cambridge University Press.

Klonoff, E. A., Landrine, H., & Campbell, R. (2000). Sexist discrimination may account for well-known gender differences in psychiatric symptoms. *Psychology of Women Quarterly, 24*, 93–99.

Kozol, J. (2005). *The shame of the nation: The restoration of apartheid schooling in America*. New York, NY: Three Rivers Press.

Krieger, N., & Sidney, S. (1996). Racial discrimination and blood pressure: The cardia study of young Black and White adults. *American Journal of Public Health, 10*, 1370–1378.

Lewis, A. E. (2003). *Race in the schoolyard: Negotiating the color line in classrooms and communities*. New Brunswick, NJ: Rutgers University Press.

Liu, W. M. (2001). Expanding our understanding of multiculturalism. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling* (pp. 127–170). Thousand Oaks, CA: Sage.

Lukes, S. (2005). *Power: A radical view*. New York, NY: Palgrave Macmillan.

Pedersen, P. (2000). *A handbook for developing multicultural awareness*. Alexandria, VA: American Counseling Association.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley and Sons.

Tatum, B. D. (2010). The complexity of identity. In M. Adams, W. J. Blumenfeld, C. Castaneda, H. W. Hackman, M. L. Peters, & X. Zuniga (Eds.), *Readings for diversity and social justice* (2nd ed., pp. 5–8). New York, NY: Routledge.

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46*, 1580–1589.

Van Ausdale, D., & Feagin, J. R. (2001). *The first R: How children learn race and racism*. Lanham, MD: Rowman & Littlefield.

Wiggins, M. I. (2010). Religion and spirituality and the ACA Advocacy Competencies. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA Advocacy Competencies: A social justice framework for counselors* (pp. 75-83). Alexandria, VA: American Counseling Association.

World Health Organization. (2012). *Disabilities*. Retrieved from http://www.who.int/topics/disabilities/en/

Chapter 4

Counselor–Advocate–Scholar Model: Merging Multiculturalism and Social Justice

It is difficult to discuss multiculturalism without also considering the relevance of social justice. Multiculturalism and social justice go hand in hand. They are inextricably linked forces that work in synchronicity. Ratts (2011) referred to multiculturalism and social justice as "two sides of the same coin" (p. 26). He argued that the multicultural counseling force paved the way for the social justice force in counseling. Multiculturalism allows counselors to see the harmful consequences of oppression on human growth and development. Social justice focuses on addressing issues of oppression that affect clients.

Both multicultural and social justice counselors recognize that inequities such as racial profiling, anti-marriage equality laws, anti-Semitic attitudes, and poverty create an environment that dehumanizes and disempowers people. Individuals from marginalized communities are often made to feel responsible for their plight. Moreover, the oppressed are led to believe that it is they who must change and adapt to their oppression. Counselors with a belief in a just world realize that if they do not advocate for change in the environment, no one will. Such counselors recognize that they have the power to create positive changes in systems that affect oppressed clients and communities.

It is inevitable that counselors seek to integrate multiculturalism and social justice, two complementary paradigms (Ratts, 2011). Taking the very best from the multicultural and social justice traditions increases the potential impact that counselors can have on individuals and society. Moreover, it expands the boundaries of what is possible in counseling and psychology. As counselors hear firsthand about the debilitating effects of oppression from clients, they begin to realize that they can have a greater impact if they resort to social justice measures that address changing the systems that oppress clients and communities (Lewis & Arnold, 1998). The seamless connection between individual counseling and systems advocacy creates a natural relationship between these two approaches (Lewis, Toporek, & Ratts, 2010). Thus, determining whether change needs to occur with clients or within the environment becomes the challenge for many multicultural and social justice counselors.

This chapter introduces readers to the counselor–advocate–scholar model, a model that helps counselors determine whether individual counseling or systems-level work is needed. Assumptions about human nature and the tenets inherent in a multicultural-social justice counseling perspective are presented; these assumptions (listed in previous chapters)

are included here to provide context to the model. We also describe one way to operationalize the counselor–advocate–scholar model.

We make the following assumptions about human nature:

- We live in a world in which oppression exists.
- Oppression leads to psychological stress and disorders.
- We are socialized from an early age to uphold the status quo of oppression.
- People are members of privileged, border, and target groups.
- People experience both privilege and oppression.
- Culture influences human development.
- There is complexity in diversity.

We subscribe to the following tenets of multicultural–social justice counseling:

- Counseling is a multicultural and sociopolitical process.
- Client problems can be internally or externally based.
- Power and privilege influence the therapeutic relationship.
- Counseling can be liberating or it can be oppressive.
- Counselors are change agents and advocates for social justice.
- The goal of counseling is to liberate clients from oppression.
- Counseling involves balancing individual and systems work.

Counselor–Advocate–Scholar Model

We synthesize the multicultural and social justice force by introducing readers to the counselor–advocate–scholar model (see Figure 4.1). This model provides a conceptual framework of the different roles professional helpers should play in general and the symbiotic relationship between counseling, advocacy, and scholarship. Moreover, this model expands the traditional counselor role of being strong clinicians by incorporating advocacy and scholarship into this role. We believe the combination of counseling, advocacy, and scholarship is essential to multicultural and social justice praxis; all three are linked to and inform one another.

The counselor–advocate–scholar model is molded after the University of Tennessee Counseling Psychology Program's scientist–practitioner–advocate training model (University of Tennessee Counseling Psychology Program, 2013). Their model is an outgrowth of the scientist–practitioner model that was developed to integrate science with practice (Mallinckrodt, Miles, & Levy, 2014). We, too, believe that research and practice should inform one another. The University of Tennessee Counseling Psychology Program expanded on the scientist–practitioner model by including advocacy as an integral part of counselor training. We find this approach to counselor training to be promising.

We revised the scientist–practitioner–advocate training model to better reflect the philosophical underpinnings of counseling. The term *counselor* is used in place of *practitioner* to stress the importance of clinical skills and the need to take an empowerment-based approach. We avoided the term *practitioner* for another reason: It tends to evoke the medical sciences and seems to imply that counselors are experts. McWhirter (1994) defined an empowerment-based counseling approach:

> Counseling for empowerment is a complex and multifaceted process that requires for some, a radical departure from the traditional conceptualization of the helper's role. Empowerment goes far beyond helping people "adjust to" or "feel better about" their lives. The process of empowerment demands that professional helpers and their clients

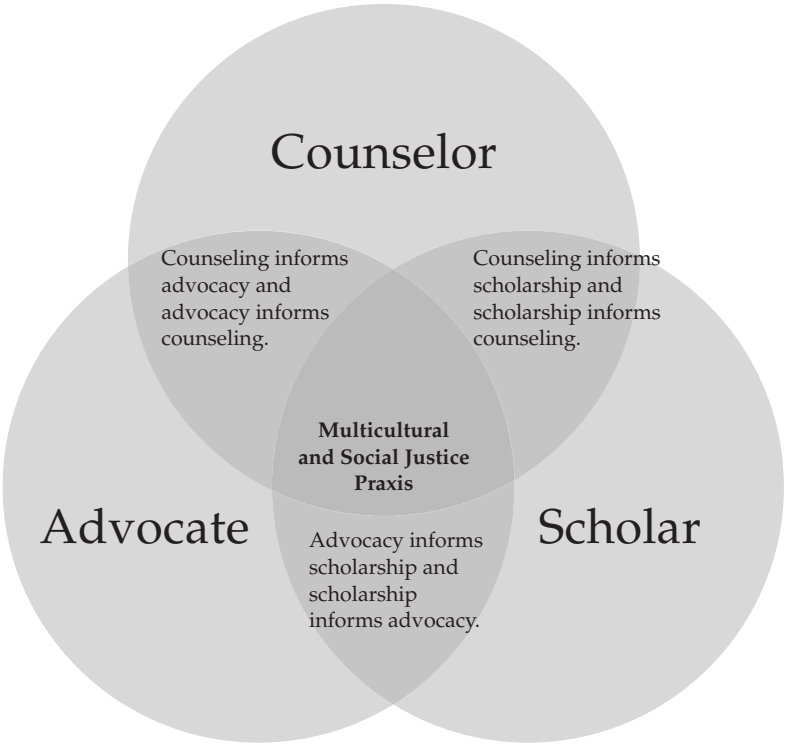


Figure 4.1 • **Counselor–Advocate–Scholar Model**

Note. The Counselor–Advocate–Scholar Model by M. J. Ratts was adapted from *The Scientist–Practitioner–Advocate Model: Addressing Contemporary Training Needs for Social Justice Advocacy* (p. 26) by B. Mallinckrodt, J. R. Miles, & J. J. Levy, 2014, Manuscript submitted for publication. Copyright 2014 by B. Mallinckrodt, J. R. Miles, & J. J. Levy. Adapted with permission of the authors.

> take an active, collaborative approach to identifying problems and goals. Counseling for empowerment also requires that the counseling relationship become a vehicle for fostering critical awareness of the power dynamics influencing the client's life context. It involves working with clients to develop a repertoire of skills that enable more effective self-direction; to develop a sense of collective history, common identity, or community with others; and to help clients to support the empowerment of others. (xiii)

Incorporating advocacy to the counselor role is important because it acknowledges that client problems can sometimes be externally driven and thus there is a need for counselors to intervene in the community realm. Because "counselors are in positions of institutional power and privilege in relation to clients" (Toporek, 2000, p. 6), they can use their positions in society to advocate for systems change. Moreover, counselors are advocates who work in the social milieu to alter oppressive barriers impacting clients. We believe that developing advocacy skills is as important as developing clinical skills. Advocacy is not an "add on" but rather a natural extension of a counselor's daily routine that evolves out of the counseling setting (Lewis, Ratts, Paladino, & Toporek, 2011). The Advocacy Competencies developed by Lewis, Arnold, House, and Toporek (2002) offer a framework from which to advocate with and on behalf of clients.

We use the term scholar instead of scientist. Scholars are seekers of truth. They look at the world through a critical lens. The term *scientist* conjures up the image of a person experimenting in a lab. Clients are not subjects that are to be experimented on like lab animals. In addition, the term scientist has historically implied a preference for quantitative research over qualitative research. We do not share this preference; we see value in

both quantitative and qualitative epistemologies. There is value in statistical data and a place for using community voices to understand and address social issues. To this end, evidence based practices (EBP), action research, and community based research (CBR) are all valuable methodologies in addressing social justice issues. EBP stresses the importance of making decisions based on the best available research evidence available. In contrast, action research is an emergent process whereby social problems are addressed through research. Similarly, CBR involves community members throughout the research process and occurs within the community setting. Whether using quantitative or qualitative methodologies, scholars are committed to the following endeavors:

- advancing a question or social issue through research;
- developing new ways of practicing informed by research;
- discovering new theories and/or models of helping; and
- seamlessly linking theory, practice, and research (Mallinckrodt et al., 2014).

At the center of the counselor–advocate–scholar model is multicultural and social justice praxis. We also add *multicultural* to the center of this model because effective social justice practice cannot be done effectively or ethically without considering cultural factors. Multiculturalism and social justice should inform how the roles of counselor, advocate, and scholar come to fruition. Helping professionals need to have an eye on how cultural factors influence clients and the degree to which social injustices affect clients.

In the following sections we discuss the counselor–advocate–scholar model both conceptually and operationally.

The roles of counselor, advocate, and scholar intersect in the following ways:

- *Counselor–scholar:* Counselors are skilled clinicians and scholars. Counselor–scholars use applied clinical work to create new scholarship ideas that foster multiculturalism and social justice. Counselors, in collaboration with clients, are cognizant of what scholarship is needed and know what questions to ask based on their clinical experiences. They are guided by a well-articulated question that culminates in research, which is then shared with the public. Counselors are also informed by scholarship. They use scholarship to learn about best practices, current trends, conditions, and discoveries. Scholarship allows counselors to determine what problems exist and how to address them most effectively. Counselor–scholars are critical consumers of research and scholarship. They do not take research at face value; they read and question research with a critical eye. They understand that research is flawed, imperfect, and prone to bias.
- *Counselor–advocate:* Counselor–advocates recognize that office-based clinical work can lead to community-based systems work and vice versa. Such counselors are able to seamlessly transition from the clinical realm to the community arena. As counselors work with clients, they become exposed firsthand to the realities of the world. They see how oppression influences clients in the clinical setting. When counselors step into the community arena, they come into contact with structural barriers that hinder clients. These experiences shape counselors' understanding of oppression and provide insight into the type of change required (i.e., individual or systems).
- *Advocate–scholar:* Advocate–scholars recognize that social change is enhanced when it is combined with research and scholarship. Scholarship equips helping professionals with awareness and knowledge to be effective advocates. Through scholarship, counselors develop more accurate and effective advocacy interventions. Scholar-

ship is also informed by advocacy practices. Advocate–scholars are in the frontlines working with individuals and communities. They see what issues clients struggle with and are informed of the problems existing in communities. These advocacy experiences lead helping professionals to scholarly inquiry and research that improves communities.

- *Counselor–advocate–scholar:* At the heart of this model is the multicultural and social justice praxis. Helping professionals have a professional and ethical responsibility to provide culturally and advocacy competent services (Ratts, Toporek, & Lewis, 2010) and to ground their practice with scholarship. Multiculturalism allows counselors to be effective social justice change agents. To this end, counselors should honor diverse voices and should use counseling as a mechanism to create a more humane world that promotes justice for all. This approach requires being open to alternative ways of helping that honor clients' cultural background and being willing to work within the traditional office setting or in the community realm.

Counselor–Advocate–Scholar Model in Action

In this section we describe how the counselor–advocate–scholar model comes to life (see Figure 4.2). It provides a step-by-step process for determining whether to intervene at the individual level or at the systems level. This model combines the best from the multicultural and social justice perspectives into one unifying approach. It demonstrates the seamless transition from office-based clinical work to systems-level work and vice versa.

The symbiotic relationship between counseling, advocacy, and scholarship is powerful. When counselors possess advocacy, scholarship, and counseling skills, they can be more effective clinicians and change agents. Counselor–advocate–scholars are informed by research, and they use clinical and advocacy practices to inform their scholarship. Counselor–advocate–scholars understand that developing clinical and system skills increases their ability to affect clients. They are able to effortlessly intervene at the individual and systems level.

Step 1. Determine the Root of the Client's Problems

Multicultural and social justice praxis requires that counselors take a comprehensive approach, which necessitates that counselors are attuned to the client's culture and that they see the client's issues through a wider lens (Lewis, Lewis, Daniels, & D'Andrea, 2011). One approach is to use a biopsychosocial lens to establish the root of client problems. The biopsychosocial approach informs counselors of whether client problems are biological (e.g., physiological symptoms), psychological (e.g., cognition, affect, and behavior), or sociological (e.g., cultural and structural barriers). Seeing client issues through a wide-angle lens is in contrast to the narrower lens prevalent in counseling and psychology. The biopsychosocial lens helps counselors understand that different approaches are possible depending on the origin of client problems. Moreover, knowing whether client problems are biological, psychological, or sociological (or a combination of these) informs counselors whether individual counseling or systems work is needed.

The biopsychosocial approach in counseling merges the fields of biology, psychology, and sociology. This approach allows for a more holistic understanding of client problems. When counselors explore the degree to which biological, psychological, or sociological factors influence clients, they are able to determine with precision the origin of client problems. The following questions can be important in ascertaining client issues from a biopsychosocial context.

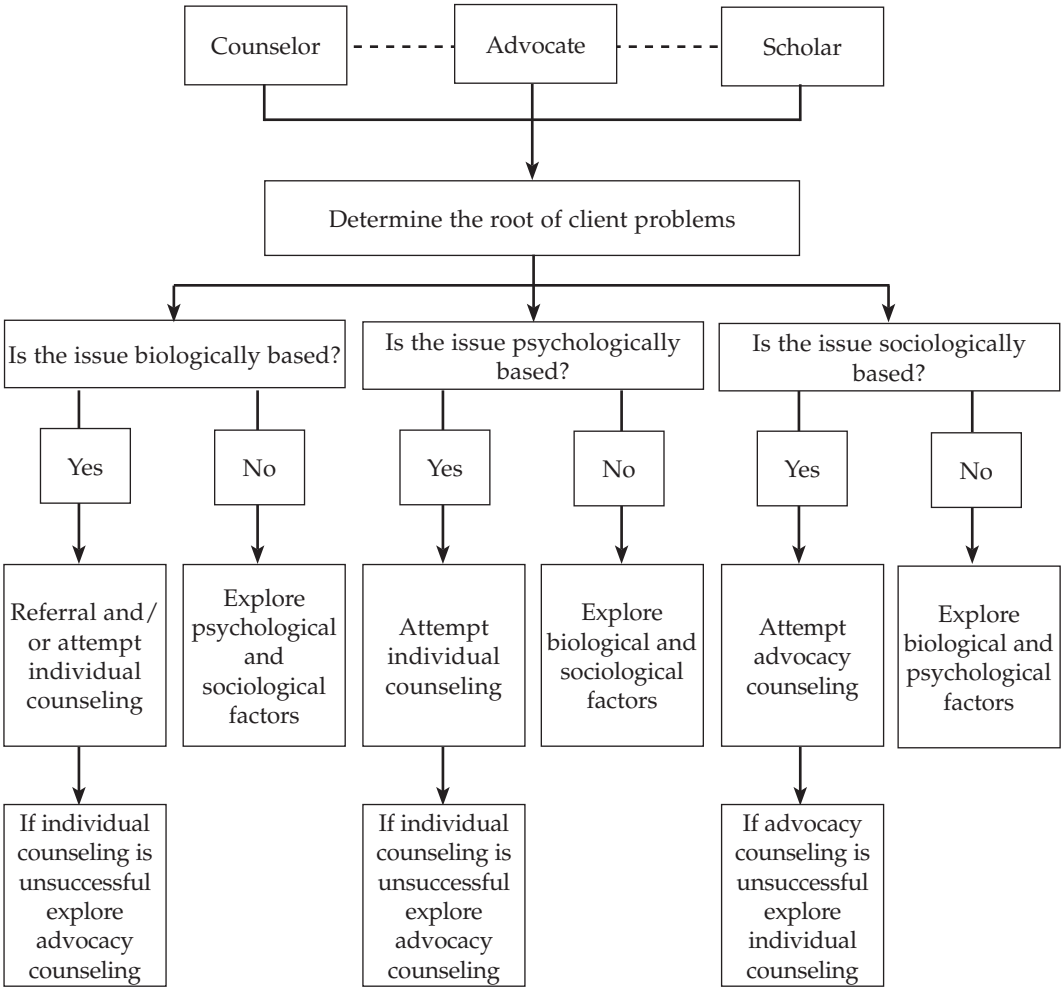


Figure 4.2 • **Operationalizing the Counselor–Advocate–Scholar Model**

Source. Manivong J. Ratts © 2014. Reprinted with permission. For permission to use for research or publication purposes, contact Manivong J. Ratts: vong@seattleu.edu.

Biological

- What physiological symptoms does the client present?
- Are client problems biologically based?
- Will addressing physiological symptoms alleviate client problems?
- Is consultation with medical professionals needed given a client's physiological symptoms?
- How might biological symptoms influence psychological and sociological factors?

Psychological

- What cognitive, affective, and behavioral issues does the client present?
- Are client problems psychologically based?
- Will addressing psychological factors alleviate client problems?
- How might psychological symptoms influence biological and sociological factors?

Sociological

- What cultural or sociological symptoms does the client present?
- Are client problems culturally or sociologically based?
- How does oppression influence client problems?
- Will addressing sociological conditions alleviate client problems?
- How might sociological symptoms influence biological and psychological factors?

Step 2. Determine Whether Individual Change or Systems Change is Required

Determining the root of client problems helps counselors decide whether referrals, individual counseling, systems work, or a combination of the three is needed. We explore this process in further detail.

Biologically Based Problems

If client problems are biologically based, individual counseling or referral to a medical provider may be necessary. Referral to a physician is dependent on the extent of the client's physiological symptoms. If client problems are not biologically based, counselors should explore the extent to which problems are psychologically or sociologically based. As counselors work with clients, they may realize that individual counseling is unsuccessful. If this occurs, counselors should explore whether systems-level change is needed.

Psychologically Based Problems

Counselors should explore the degree to which client problems are rooted in psychology. If client problems are not psychologically based, counselors should explore the influence of biological and sociological factors. If, however, client problems are psychologically based, counselors should attempt individual counseling. Through individual counseling, counselors may realize that client problems are more systemically based. If this occurs, the focus of counseling should be on environmental change.

Sociologically Based Problems

Counselors should explore whether client problems are rooted in the environment. If client problems are not environmentally based, counselors would do well to examine how biological and psychological variables contribute to client problems. A focus on altering the social context should occur if client problems are systemic. This counseling approach requires counselors to address environmental barriers with, and on behalf of, clients. Altering systemic variables occurs at the individual, social, cultural, and institutional levels. Individual-level advocacy involves working to change individual attitudes and behaviors. For example, school counselors may address a teacher's attitude of low expectations for students of color that permeates throughout the class. Advocacy at the social and cultural level may involve addressing dominant norms and values that are deeply entrenched in society that hinder client development. For instance, counselors may address heterosexual norms that obstruct the development of a healthy sexual identity for lesbian and gay clients. Institutional-level advocacy focuses on altering oppressive social structures, policies, and laws. This approach may involve working with agencies, businesses, schools, and the government to address unjust policies, rules, laws, and statutes. If systems-level work is not effective, counselors should explore whether individual counseling may benefit clients instead.

Conclusion

Should counselors focus their efforts on individual change or environmental change? This question is fundamental to multicultural and social justice work. Establishing the need for individual change or systems change (or both) is in stark contrast to predominant ways of helping. Most counselors rely on individual counseling regardless of clients' presenting concerns. This approach is due in part to tradition (Ratts & Wood, 2011). There is danger in relying solely on one approach to helping. Relying on individual counseling alone limits the type of impact counselors can have on clients and communities. Clients may walk away from counseling feeling better. However, their happiness is likely to be short-lived because the root of their problems has not been completely addressed. Counseling interventions serve only as a Band-Aid when counseling fails to get at the origin of client problems.

References

Lewis, J. A., & Arnold, M. S. (1998). From multiculturalism to social action. In C. C. Lee & G. R. Walz (Eds.), *Social action: A mandate for counselors* (pp. 51–65). Alexandria, VA: American Counseling Association.

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. (2002). *ACA advocacy competencies* (pp. 1–2). Retrieved from http://www.counseling.org/knowledge-center/competencies

Lewis, J. A., Lewis, M. D., Daniels, J. A., & D'Andrea, M. J. (2011). *Community counseling: A multicultural-social justice perspective* (4th ed.). Belmont, CA: Brooks/Cole.

Lewis, J. A., Ratts, M. J., Paladino, D. A., & Toporek, R. L. (2011). Social justice counseling and advocacy: Developing new leadership roles and competencies. *Journal for Social Action in Counseling and Psychology, 3*, 5–16.

Lewis, J. A., Toporek, R. A., & Ratts, M. J. (2010). Advocacy and social justice: Entering the mainstream of the counseling profession. In M. J. Ratts, R. A. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (pp. 239–244). Alexandria, VA: American Counseling Association.

Mallinckrodt, B., Miles, J. R., Levy, J. J. (2014). *The scientist–practitioner–advocate model: Addressing contemporary training needs for social justice advocacy*. Manuscript submitted for publication.

McWhirter, E. H. (1994). *Counseling for empowerment*. Alexandria, VA: American Counseling Association.

Ratts, M. J. (2011). Multiculturalism and social justice: Two sides of the same coin. *Journal of Multicultural Counseling and Development, 39*, 24–37.

Ratts, M. J., Toporek, R. L., & Lewis, J. A. (Eds.). (2010). *ACA advocacy competencies: A social justice framework for counselors*. Alexandria, VA: American Counseling Association.

Ratts, M. J., & Wood, C. (2011). The fierce urgency of now: Diffusion of innovation as a mechanism to integrate social justice in counselor education. *Counselor Education and Supervision, 50*, 207–223.

Toporek, R. (2000). Developing a common language and framework for understanding advocacy in counseling. In J. Lewis & L. Bradley (Eds.), *Advocacy in counseling: Counselors, clients, and community* (pp. 5–14). Greensboro, NC: CAPS.

University of Tennessee Counseling Psychology Program. (2013). *Scientist–practitioner–advocate training model*. Retrieved from http://psychology.utk.edu/spa_model.php

Chapter 5

Worldview and Identity Development

Manivong J. Ratts, Paul B. Pedersen, and Alexa Wayman

Scholars and practitioners use identity development theories to explain human growth and to describe developmental challenges that clients experience throughout the life span (Wijeyesinghe & Jackson, 2012). These challenges are often shaped by sociopolitical events of the times. For example, the struggle for marriage equality is a human development issue that affects individuals from all walks of life. Poverty is a challenge that affects millions of people around the world. These human development issues are complex and ever changing.

Early theories of identity development frequently did not take into account the significance of social influences and social identities in the definition of the self (Briggs & Pepperell, 2009; Gilligan, 1993). Erikson's (1968) seminal work on stages of psychosocial development continues to be popular today even though it applies less accurately to people of color and women. Although Erikson emphasized the importance of autonomy and initiative development during the childhood years in his classic model of identity, it is also true that his psychosocial concepts defined the individual self in the context of the dominant group's values, norms, and social roles. Whereas Erikson's model favors the individualistic worldview and the more masculine roles, the notion of a separated self is now replaced with a notion of self-in-relationship, in which the sense of self reflects the relationships among people (Gilligan, 1993).

This chapter provides an overview of social identity development theories that examine racial, ethnic, gender, and sexual orientation identity development. Social identity development theories evolved out of the civil rights movement of the 1960s. Liberation movements for women, people of color, people with disabilities, the elderly, and other oppressed client populations in the 1960s and 1970s gradually adopted the idea that judging all populations by a narrow standard did more harm than good. Oppressed client populations began to develop their own separate criteria for group identity. The goal of these social identity development theories is to explain the experience of oppressed groups living within a dominant group culture.

Worldview

The process of identity development is essentially linked to the concept of *worldview*, which refers to the way each person sees the world (Koltko-Rivera, 2004). The concept of worldview has been studied for centuries and has been defined in various ways. Koltko-Rivera (2004) defined *worldview* in the following terms:

> [It is a] way of describing the universe and life within it, both in terms of what is and what ought to be. A given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle), what objects or experiences are good or bad, and what objectives, behaviors, and relationships are desirable or undesirable. A worldview defines what can be known or done in the world, and how it can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals should be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system. (p. 4)

Ibrahim (1991) described *worldview* as how people view human nature (e.g., inherently good, inherently bad, or a combination of good and bad), social relationships (e.g., lineal–hierarchical, collateral–mutual, and individualistic), nature (e.g., control nature, live in harmony with nature, or nature over people), time orientation (past, present, or future oriented), and activity orientation (e.g., being, being-in-becoming, and doing).

Sue (1977) developed a two-dimensional model of worldview, matching locus of control with locus of responsibility (see Figure 5.1). This model is divided into four quadrants. Quadrant I matches internal control and internal responsibility (IC–IR), describes dominant culture values, and is achievement oriented. Quadrant II matches external control and internal responsibility (EC–IR), where self-hatred and marginality are problems for individuals in oppressed groups. Quadrant III connects external control and external responsibility (EC–ER); the system is blamed for any and all failures and people must learn appropriate coping skills. Quadrant IV connects internal control with external responsibility (IC–ER); people have the power to change if given the chance, but their typical response is to attack the system and challenge the value of counseling.

The concept of worldview is important to comprehending the various stages of social identity development that will be introduced in this chapter. By understanding worldview it allows for a deeper appreciation of the various stages of development inherent in many identity development theories.

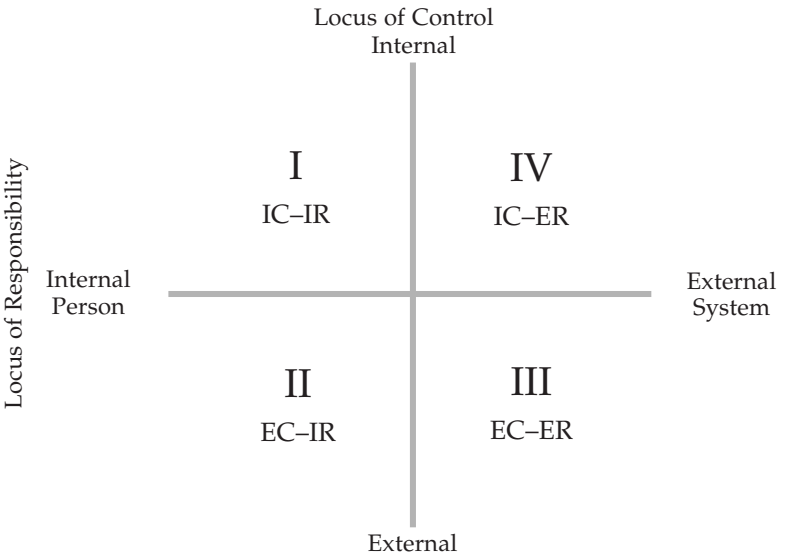


Figure 5.1 • **Control and Responsibility**

Note. Roman numerals are added to facilitate discussion of the quadrants. IC = internal control, IR = internal responsibility, EC = external control, ER = external responsibility. From "Barriers to Effective Cross-Cultural Counseling," by D. W. Sue, 1977, *Journal of Counseling Psychology, 24,* pp. 420–429. Copyright 1977 by the American Psychological Association. Reprinted with permission.

Social Identity Development

Social identity development theories describe how people come to understand their own social group identities and how these identities influence lived experiences (Wijeyesinghe & Jackson, 2012). These theories differ from earlier models of human development because they take into consideration a person's surroundings, including oppression. Our understanding of race, ethnicity, gender, sexual orientation, age, disability status, religious status, and economic class are influenced by the self, others, the environment, and our understanding and experience of oppression. This explains why Asian Americans in predominantly White schools can have different experiences from Asian Americans who attend schools where students of color are the majority. It also explains why people act one way when they are among their own group members and another way when they are surrounded by individuals from other social groups.

Social identity development is dynamic and is often described as a process that occurs in a sequential stagelike manner. Nevertheless, it is possible for individuals to be in more than one stage of identity development at the same time and to skip earlier stages of development. Within each stage of development, characteristics and qualities are shared among individuals within a particular social group. Each stage of identity development reflects how people see themselves in relation to their world and how they understand and experience the world. Although theories of identity development identify the highest or final stage of identity development in different ways, there is general uniformity in the way they identify the lowest stage (as one in which people are oppressed). Individuals from oppressed groups experience internalized oppression, and individuals from dominant groups experience internalized privilege. At the lowest stage of development the criteria for normal behavior, personal beauty, and competence are based on characteristics associated with the dominant group. For example, with respect to racial identity development Whites are the standard by which all racial groups are compared. Similarly, heterosexuals are the normative group for sexual identity development.

Key Assumptions

Social identity development theories all share several key assumptions (Adams, Bell, & Griffin, 2007):

1. Individuals of all social groups are influenced by pervasive and interacting multiple oppressions and may respond to situations differently, depending on their consciousness levels and worldview.
2. Manifestations of social identity respond in different ways to interpersonal, organizational, and/or social contexts and also reflect psychosocial and cognitive development.
3. Social identity development theory provides a way of tracking one's progress away from internalized subordination or internalized domination toward a liberated social identity.
4. Interpersonal interactions within groups as well as between groups are influenced by developmental differences and different levels of conscious awareness of oppression.
5. Developmental terms such as stage, phase, or worldview provide convenient metaphors for differentiating levels of consciousness or experiences of identity. (p. 17)

Jackson and Hardiman's Social Identity Development Model

Jackson and Hardiman (2012) developed a generic model of social identity development to illustrate how various forms of oppression (e.g., racism, sexism, heterosexism, classism, ageism, anti-Semitism, ableism) affect members of dominant and target groups across the life span. Their social identity development model evolved out of Jackson's (1976) work

on Black identity development and Hardiman's (1982) White identity development theory. Jackson and Hardiman's (2012) social identity development model includes five stages; people can be in more than one stage simultaneously.

Stage 1: Naïve or No Social Consciousness

During the formative years (from birth to early childhood), children from dominant and target groups are unaware of themselves as members of social groups and the behaviors assigned to social groups. They are naïve about societal rules of social group membership and the boundaries of what is appropriate and inappropriate. Whereas children recognize differences among people, they do not necessarily place a positive or negative value judgment on social group differences. Young children are naturally curious about and interested in others and their surroundings. Because they have not learned societal rules of engagement, they may ask questions that are considered taboo by adults (e.g., "Why is her skin dark?"; "Why does Raul have two dads?"). As children grow older, they quickly learn (through socialization from parents or guardians, teachers, friends, family, and religious institutions) the rules, laws, and types of behaviors permitted in society.

Stage 2: Acceptance

In the acceptance stage, individuals internalize the dominant group's ideology and worldview. This stage includes active acceptance and passive acceptance. Individuals in the active acceptance stage are more overt and intentional in their support of the dominant group's perspective. In contrast, those in the passive acceptance stage are more covert and unaware of how their attitudes, beliefs, and behaviors support the dominant group's worldview.

Individuals in the dominant group have internalized their privilege. At the active acceptance stage they may hold beliefs that stereotype nondominant group members (e.g., Blacks are lazy, gay people are sinners), or they may join organizations that support the dominant group's supremacy. If these attitudes are learned early and are not questioned, they may lead a person to believe that the dominant status quo is normal and healthy. In the passive acceptance stage, dominant group members tend to be well-intentioned yet unaware of how their attitudes and behaviors support oppression. A woman may believe that she is not racist because she has friends of color. Yet she may clutch her purse tightly when an African American male enters the elevator. Similarly, individuals may support gay and lesbian relationships only to the extent that their own children are not involved in such relationships.

Target group members have internalized their oppression. They believe in the superiority of the dominant group and in the inferiority of their own group. Such individuals may not question their support of the status quo. They may look down on target group members and often adopt the dominant group's worldview as their own. At the active acceptance stage, people of color may not support affirmative action policies. Gay and lesbian individuals may be unwavering in their lack of support for marriage equality. At the passive acceptance stage, individuals are unaware of how their attitudes and behaviors support dominant ideology. For example, persons of color may not seek counselors of color because of their belief that counselors of color are inferior to White counselors.

Stage 3: Resistance

The resistance stage is characterized by an increased awareness and understanding of oppression. Both dominant and target group members begin to question and resist dominant ideology and worldviews. A new worldview is constructed that names the dominant group as responsible for oppression. Persons in the active resistance stage may openly question

oppressive attitudes, behaviors, and policies. In contrast, people in the passive resistance stage may challenge and question oppressive attitudes and behaviors only when there is little to no risk to their personal and professional well-being. Target group members may experience mixed feelings of emotions and may surround themselves only with people from their own social group for support. Dominant group members may experience shame and guilt for being responsible for oppression and for having unearned privileges. They seek ways to avoid and actively reject the privileges gained from an oppressive system.

Stage 4: Redefinition

In the redefinition stage, individuals seek to formulate their own identity free from the dominant group's definition. For dominant group members this process involves forming an identity that is free from oppression and that does not blame or stereotype target groups. Target group members focus on reclaiming their identity and cultural heritage. Both dominant and target group members develop a sense of pride in their own groups. They begin to see the good in all social groups and to internalize the belief that no group is better than another. The anger directed at dominant group members in previous stages has subsided.

Stage 5: Internalization

Both dominant and target groups begin to integrate their new identities into other aspects of their identity. They seek to work in collaboration to address issues of oppression. Addressing oppression also becomes more spontaneous and natural at this stage. Target group members seek to become allies to other target groups. For example, heterosexual women may advocate for marriage equality to support lesbian, gay, and bisexual (LGB) couples.

In the following sections we explore racial and sexual orientation identity development models. These models of social identity development are important because they help provide a framework for understanding how racism, sexism, and heterosexism affect the individual's sense of self in relation to the world.

Racial Identity Development Models

Despite the advances made in the civil rights movement, Dr. Martin Luther King, Jr.'s dream of racial equality has yet to become a reality. Racism creates profoundly different experiences that influence self-concept and mental health for Whites and people of color in the United States. People continue to live in racially segregated communities that fall along class lines. Within the same city, middle and upper class White Americans continue to have access to higher quality education, health care, and food simply because they can afford to live in neighborhoods that have better resources. White women who work are paid 77 cents for every dollar paid to men, but this disparity is much worse for women of color. According to the National Partnership for Women and Families (2011), "African American women are paid only 64 cents and Latina women are paid just 55 cents for every dollar paid to non-Hispanic White men" (para. 2).

Racial identity is an important element of both individual and group identity (Wijeyesinghe & Jackson, 2012). Models of racial identity development have existed for some time in the counseling and psychology literature. Racial identity development models were developed to explain the integration of race into an individual's sense of self (Sue & Sue, 2013). Helms (1993) described racial identity as "a sense of group or collective identity based on one's perceptions that he or she shares a common racial heritage with a particular racial group" (p. 3). Racial identity development models grew out of the limitations inherent in Erikson's (1968) work on psychosocial development.

Most racial development models suggest that individuals experience three to four phases or stages of racial identification. First, there is identification with the dominant culture in a pre-encounter, conformity, or traditional stage. Second, there is an awakening to the impact of racism in a transitional encounter or dissonance stage. Third, there is identification with one's own racial group. Fourth, there is an internalization and integration of one's own racial group with the dominant racial group.

Many models of racial identity development exist that explain the process of racial identity for people of color. These models of racial identity refer to people of color in the United States. Individuals of color from other countries may find that these models do not reflect their experiences in the United States. In this chapter we present five models of racial identity, each of which illustrates the racial identity for specific racial minority groups:

- Atkinson, Morten, and Sue's (1998) racial-cultural identity development model;
- Cross and Fhagen-Smith's (2001) Black identity development model;
- Kim's (1981, 2001, 2012) Asian American identity development model;
- Ferdman and Gallegos's (2001, 2012) Latino/a American identity development model; and
- Horse's (2012) Native American identity development model.

We also highlight White racial identity development, which explains how living in a predominantly White society affects White Americans. Two White racial identity development models are summarized:

- Hardiman's (1982) White identity development model, and
- Helms's (1984, 1993, 1995) White identity development model.

A new development in the literature includes explanations of multiracial and biracial identity development for people who come from more than one race. We highlight Wijeyesinghe and Jackson's (2012) model that describes racial identity for multiracial individuals.

Racial–Cultural Identity Development Model for People of Color

Atkinson, Morten, and Sue's (1998) five-stage minority identity development model, which was later revised and labeled the *racial/cultural identity development model*, was one of the first to focus on the collective racial identity of people of color (i.e., African Americans, Asian Americans, Latino/a Americans, and Native Americans). It is considered the foundational racial identity model that examines the experiences of people of color. The following summary provides an overview of each of the five stages:

1. *Conformity.* Individuals in this stage have internalized racism. They idealize White culture at the expense of their own racial identity. Negative stereotypes about their racial group and other minority racial groups have been internalized. Persons in this stage lack a desire to learn about or maintain their own cultural heritage.
2. *Dissonance.* Personal experiences lead individuals to question their once unwavering commitment to the White dominant culture's worldview. Individuals begin to take an interest in their own racial or ethnic group.
3. *Resistance and immersion.* Individuals begin to reject White cultural worldviews and immerse themselves in their own racial or ethnic identity. There is increased interest in learning about one's own racial or ethnic identity, which leads to the formation of a new identity.

4. *Introspection.* Individuals begin to seek ways to integrate their new identity into the dominant culture without sacrificing their own racial or ethnic identity.
5. *Synergistic articulation and awareness.* Individuals are able to balance their new identity with other aspects of their identity. There is an appreciation for all groups and a full acceptance of oneself.

Cross and Fhagen-Smith's Black Identity Development Model

Many models of Black identity development exist (Helms, 1993; Jackson, 2012; Thomas, 1971). Cross's (1991) *nigrescence model* is arguably one of the most well known. The term *nigrescence* is a French term meaning the "process of becoming Black" (Cross, 1991, p. 147). Cross's early descriptions of Black identity development were "convergent," moving from a broad to a narrow focus in Black identity development and included five stages. Cross revised his 1991 model (Cross & Fhagen-Smith, 2001) to move from a broad focus to a narrow convergent focus midway in the Black identity development process and then toward a broader divergent focus at the highest stages. This revised model included four stages and introduced three key concepts that define Black racial identity: (a) *personal identity*, the traits and characteristics that make up an individual's personality; (b) *reference group orientation*, how a person sees the world and the values a person holds; and (c) *race salience*, the degree to which race is important in a person's life.

Cross and Fhagen-Smith (2001) elaborated on the nigrescence model by integrating a life span perspective that considers Black racial identity development from infancy to adulthood. They referred to Black racial identity as sectors rather than stages. This particular model of Black identity identified three key patterns: (a) *Nigrescence Pattern A*, which describes how individuals form a Black racial identity as a result of interaction with family, friends, and significant others throughout the life span; (b) *Nigrescence Pattern B*, the development of a healthy Black racial identity in later adulthood even when individuals lacked the opportunity to develop a Black racial identity in the formative years; and (c) *Nigrescence Pattern C*, the development of a more complex Black racial identity that evolves during later adulthood.

The Cross and Fhagen-Smith's (2001) model of Black racial identity includes six sectors that incorporate all three nigrescence patterns.

- *Sector 1: Infancy and childhood in early Black identity development.* Black racial identity is formed early in life through interaction with family, friends, school, church, and community events. Just as influential in the development of a Black racial identity are cultural traditions and class status of the family (Cross & Fhagen-Smith, 2001).
- *Sector 2: Preadolescence.* Low race salience, high race salience, and internalized racism emerge depending on how youth are socialized at home and in their community. Youth with low race salience have little to no interactions with parents or guardians about race and therefore do not attach significance to being Black. Youth with high race salience perceive being Black as important to their identity because pride in their race was instilled in them by their parents or guardians. High-race-salience youth are likely to develop a positive self-concept in later adulthood. Internalized racism occurs when Black youth develop hatred of themselves and their racial group as a result of seeing and experiencing negative messages about being Black within their own family unit. Fully developed Black racial identity does not develop until the adolescence stage.

- *Sector 3: Adolescence.* During a period of exploration and reflection, Black adolescents begin to form their own personal beliefs about their racial identity. This process involves reflecting on whether their understanding of their racial identity was formed based on their own beliefs or on other people's beliefs. Those with low race salience or internalized racism patterns maintain beliefs related to these patterns if their beliefs and assumptions are not challenged. Black adolescence with low race salience seek to understand the nonrace aspects of their identity. Those who have internalized racism continue to hold negative beliefs and stereotypes of their own racial group.
- *Sector 4: Early adulthood.* Individuals with high race salience have an established reference group orientation that values Black culture. Those who developed a low race salience do not see race as significant to their life as adults; they see other aspects of their identity as more important. Young African American adults with low internalized racism continue to maintain negative beliefs of their racial group held earlier in their lives.
- *Sector 5: Adult nigrescence.* This sector incorporates Cross's (1991) original model of nigrescence and consists of four stages:

    1. *Preencounter:* Individuals with low race salience assimilate into mainstream culture whereas those with internalized racism hold anti-Black sentiments.
    2. *Encounter:* Individuals experience an event that causes them to question previously held beliefs about their racial identity.
    3. *Immersion-emersion:* Individuals begin this stage by completely immersing themselves in the Black community without a clear understanding of the Black identity they want to assume; they come out of this stage with a more balanced perspective of their racial identity.
    4. *Internalization:* Individuals develop a more defined and secure sense of Black racial identity. They either develop a Black nationalist identity (being Black is the most important identity and they promote causes that support the Black community); a bicultural identity (individuals integrate their Black identity with their dominant group identity into one identity); or a multicultural identity (being Black is just one of many aspects of their identity).

- *Sector 6: Nigrescence recycling.* Throughout adulthood African Americans encounter personal and professional events or situations that cause them to reflect and question their Black racial identity. These situations can lead individuals to reach a complex understanding of their racial identity.

Kim's Asian American Identity Development Model

Racial identity models pertaining to Asian Americans are not as well known as those relating to Black identity (Sue & Sue, 2013). In a review of the literature, we noticed that Asian American identity development models tended to describe both the ethnic and racial identity experiences of specific Asian American groups such as Japanese Americans. This seems to suggest how intertwined race and ethnicity are to the Asian American experience. Whereas each of these Asian ethnic groups may have similar racial experiences, their ethnic cultures are vastly different from one another. Caution should be taken when examining particular Asian American identity development models so that generalizations are not made to other Asian American ethnic groups such as Vietnamese Americans, Laotian Americans, and Filipino Americans.

Kim's (1981, 2001, 2012) qualitative research on Japanese American women led to a five-stage model of Asian American racial identity development. Kim described an Asian

American identity development model in which conflict is resolved in a five-stage progression from a negative self-concept and identity confusion to a positive self-concept and positive identification with being Asian American. In her most recent model Kim (2012) found the following factors to be influential to Asian American racial identity development:

- *social environment:* family, school, social political movements, campus politics, Asian American community;
- *critical factors:* participation in ethnic activities, contact with Whites, awareness of racism and political consciousness, immersion in Asian American experience, clear and firm Asian American identity;
- *self-concept:* positive, neutral, or negative self-concept;
- *ego identity:* participation leads to a clear or unclear sense of their Asian heritage;
- *primary reference group:* family, Whites and dominant society, people with similar political views, and Asian Americans at similar stages of racial identity development; and
- *hallmark of the stage:* major themes within each stage of identity.

The salience of racial and ethnic identity is based on social context and can be explained in five stages (Kim, 2012):

1. *Ethnic awareness.* This stage begins at around 3 to 4 years of age where interaction with family first forms the individual's sense of ethnic identity.
2. *White identification.* This stage is often linked to the time when children begin attending school. A sense of being different tends to alienate Asian children from their own ethnic background. Peer influence leads individuals to develop negative views of their own racial group.
3. *Awakening to social political consciousness.* Increased political awareness leads to the realization that discrimination exists and that it is a result of societal infrastructures. Individuals shed previously held identification with White culture as they begin to understand oppression and its impact on oppressed groups. During this stage, individuals begin to form their racial identity.
4. *Redirection.* A sense of racial pride develops as individuals reconnect and recommit to their Asian heritage and culture. Individuals find support from their family, friends, and the Asian community. The belief that Whites and White supremacy are responsible for racism leads to negative attitudes toward White people.
5. *Incorporation.* Individuals have developed a positive Asian American identity and self-concept. There is also increased respect for other racial groups, including Whites. Being Asian is just one of many aspects of identity.

Ferdman and Gallegos's Latino/a American Identity Development Model

Ferdman and Gallegos (2001, 2012) developed a racial identity development model that described the process of Latino and Latina racial identity development. Their first model of Latino/a identity development (2001) focused on race in the United States. This model also focused on how Latino/a individuals perceived themselves in relation to others. The most current model incorporates the concept *ethnoracial* to emphasize the importance of both racial and ethnic identity development for Latino and Latina Americans. Their new model also examines how social context plays a role in the development of a Latino and Latina racial identity.

Instead of referring to stages of racial identity, Ferdman and Gallegos (2001, 2012) identified six orientations that serve as a lens to describe the process of achieving a healthy

Latino/a racial identity. Each orientation is influenced by the context and the particular situation. Each orientation is influenced by the following factors:

- *lens:* how one views identity,
- *identity (self):* how individuals identify themselves,
- *view of Latino/as :* how Latino/as are seen as a group,
- *view of Whites:* how Whites are seen as a group,
- *framing of race:* how race is understood,
- *key challenges:* main challenge(s) to be addressed,
- *most adaptive for:* what environments or situations are best situated for each orientation,
- *behavioral manifestations:* how a person lives his or her daily life, and
- *limitations:* the limitations inherent within each orientation.

The six orientations are summarized in the following list:

- *Latino integrated:* Being Latino/a is just as important as other dimensions of identity. Individuals have a good understanding of how race, gender, sexual orientation, class status, disabilities, and religion are socially constructed. They also stand up against social injustices.
- *Latino identified:* Individuals hold a pan-Latino/a identity. As a group Latino/as are seen as a unified racial group regardless of ethnic background. There is an emphasis on developing unity and connection among various Latino/a groups.
- *Subgroup identified:* Persons identify solely within their Latino/a subgroup (Puerto Rican, Mexican, Cuban, etc.) and may view other Latino/a subgroups as inferior. There is a strong connection with one's country of origin. Ethnic group identity is more important than racial group identity.
- *Latino as other:* Individuals see themselves as Latino/as but do not really understand what it means to be a person of color in a predominantly White society. They lack a deep understanding of their cultural heritage.
- *Undifferentiated/denial:* Individuals are indifferent to issues of race and tend not to see cultural or ethnic differences. Latino/as at this orientation have a color-blind view of the world in which race is not a factor in interactions with others. There is a lack of connection with other Latino/as .
- *White identified:* Latino/as are assimilated into dominant White culture and ideology. Individuals see themselves as White and view the world through the White cultural lens. They view their racial group and other people of color as inferior to the White racial group.

Horse's Native American Identity Development Model

Horse (2012) identified three labels commonly used to refer to aboriginal peoples of America: Native American, Indian, and Indian American. Each of these descriptors is used interchangeably in the literature. Horse (2001) identified five psychosocial influences that affect American Indian consciousness:

- knowledge of one's native language and culture,
- the validity of one's genealogical heritage as Indian,
- adoption of an Indian worldview that respects Native traditions and philosophies,
- the degree to which a person identifies as Indian, and
- one's status as a member of an officially recognized Indian tribe.

Horse (2012) believed that the need to maintain an Indian identity is becoming increasingly important because Native elders are dying and the multicultural and technological world is rapidly changing. Both the past and the present inform and influence American Indian identity. Horse highlighted five areas of consciousness that are expected to influence American Indian identity in the 21st century:

- *Eras of change in Indian consciousness.* American Indian consciousness is shaped by tribal histories and cultures, and it is indelibly connected to their past (Horse, 2012). American Indian cultures can be understood through different eras: (a) the first era or epoch, when Indians were free and before non-Indians came to North America, (b) the second era, beginning with the U.S. Declaration of Independence and westward expansion, (c) the third era covered the latter part of the nineteenth century, when the U.S. government declared Indians as "domestic dependent nations" (Horse, 2012, p. 110), and (d) the new era which encompasses the twenty-first century, where American Indians strive for more independence from the U.S. government.
- *Orientation to race consciousness.* Race did not enter the minds of American Indians until White explorers came to America. Individual, social–cultural, and institutional forms of racism hindered American Indian development. Many American Indians view themselves as "the people" (Horse, 2012, p. 111) rather than as a race.
- *Orientation toward political consciousness.* The U.S. federal government recognizes American Indian tribes as sovereign nations with the right of self-governance. Being aware of the political struggles Indian tribes experience is important to understanding current political events. Understanding the political history of American Indians and relations with the U.S. government helps explain why American Indians mistrust the U.S. government.
- *Orientation toward linguistic consciousness.* The ability to speak their native language allows American Indians to connect to their past and to maintain their cultural heritage. The struggle for new generations of American Indians is to maintain their native language. Most native speakers are middle-aged or older and many do not hold academic degrees. As elders pass, so too will their native language; it may in fact become extinct.
- *Orientation toward cultural consciousness.* Language and culture are intertwined; both shape American Indian identity. Maintaining cultural traditions in an ever-changing world will be the challenge for new generations of American Indians.

Hardiman's White Identity Development Model

Hardiman (1982) examined race and gender issues in the context of social identity theory in a five-stage White identity model. She was one of the first to examine White identity development and White privilege in the United States. Social identity includes conscious or unconscious membership that contributes to a person's conception of herself or himself. Hardiman looked at gender, occupation, religion, and White racial identity as contributing to that self-perception. She drew on the autobiographies of four White females and two White males to develop her White racial identity development model:

Stage 1: No Social Consciousness

In the first stage (birth to about age 4 or 5 years), individuals operate naively from their own needs and do not recognize or accept the restrictions of any particular social role; they can be presumed to act spontaneously or independently.

Stage 2: Acceptance
This transition period (which lasts until adulthood) is one of acceptance and role learning; the person is suddenly aware of her or his social role based on the White dominant culture's worldview and conforms to that role.

Stage 3: Resistance
This stage results in critical analysis of restrictions imposed by the social role resulting in rebellion and some rejection of social pressure to conform from others who share the same social role. Individuals resist the "myths" they had learned and experience an emotionally painful reaction to their own "Whiteness."

Stage 4: Redefinition
The rules of the person's social role are adapted to fit the circumstances and rediscover the importance of that social role in this new personalized context. This stage involves redefining one's White identity in a more positive direction, acknowledging both strengths and limitations.

Stage 5: Internalization
The individual integrates insights from the previous four stages into a newly defined social role or identity. White individuals in this stage have internalized and established this new identity as their own.

Helms's White Identity Development Model

Helms's (1984, 1993, 1995) model of White identity development is more widely known in the counseling and psychology literature than Hardiman's (1982). Helms's White identity model is also one of the most robust models because it has gone through empirical testing (Helms & Carter, 1990). Like Hardiman's model, Helms's White identity development model was constructed to understand how White Americans maintain racism.

Helms's (1984, 1993, 1995) White identity model includes six statuses and two phases. (Rather than use the term *stage*, Helms decided to use *statuses* to imply that racial identity did not occur in a stagelike linear fashion.) Her original model referred to the process of White racial identity development as stages. Helms believed White individuals develop a healthy racial identity when they move through two phases: (a) the abandonment of racism phase, the process of moving from being unaware of their role in racism to becoming cognizant of how Whites as a group are responsible for racism; and (b) the evolution of a nonracist White identity phase, during which White individuals spend time reflecting on whether it is possible to be White without being racist. White individuals attempt to construct a racial identity that is more positive and that is free of racism.

The following are the six statuses of Helms's White identity development model:

1. *Contact status.* White people are oblivious to race and issues of racism. As a result of limited exposure to people of color, White individuals believe that all people are treated equally, that society is color-blind, and that all people can succeed if they work hard enough. There is a conscious and unconscious belief that racial differences do not exist and a naïve acceptance of White dominant group ideologies that view people of color as inferior.
2. *Disintegration status.* Inner turmoil is common because of unresolved racial dilemmas and conflicting beliefs about race and White privilege. For example, individuals may believe they are not racist while at the same time assume that a group of Black males

are athletes. Individuals begin to recognize themselves as part of a White racial group and the benefits they receive as a result of White privilege. This realization often leads to feelings of guilt and helplessness. To deal with these feelings, White individuals avoid interacting with people of color, attempt to avoid discussions about race, and seek reassurance from others that White people are not responsible for racism.

3. *Reintegration status.* Individuals believe in White superiority when the guilt and self-blame they experienced turns into anger and aggressiveness. Persons idealize White culture to the point where they view White individuals as superior to people of color. This attitude leads to intolerance toward people of color; it might be expressed as "I am successful because of hard work and people of color can become successful too if they just stop complaining and work hard."
4. *Pseudoindependence status.* Individuals make an effort to define a nonracist White identity. Responsibility for racism is acknowledged and an alternative nonracist identity is sought out. People enter this status because of encounters that propel them from the reintegration status. White individuals recognize that people of color are often unfairly treated, and they feel discomfort because they are White and have unearned privilege. This attitude leads White individuals to have more interactions with people of color and less interaction with other White individuals.
5. *Immersion–emersion status.* Individuals engage in the hard work of developing a new identity and gathering accurate information on what it means to be White. Individuals explore what it means to live in a predominately White society and the various ways one benefits from White privilege. Confronting one's own biases as well as other people's prejudices is common during this time.
6. *Autonomy status.* Individuals experience less White guilt and have a firm awareness and understanding of what being White means. There is knowledge of racism and a natural tendency to combat racism in all of its forms. The end goal is openness and flexibility through self-actualization.

Multiracial Identity Development Models

The scholarly literature on biracial and multiracial identity development is leaner than the literature on other racial identity development models. Poston (1990) and Root (1990) developed the first publications on healthy biracial identity development (Renn, 2008). Both models were significant because they addressed prevailing attitudes that biracial and multiracial people were not able to develop a healthy self-concept. Biracial and multiracial individuals were viewed as "confused, distraught, and unable to fit in anywhere in the American racial landscape" (Wijeyesinghe, 2001, p. 131).

Wijeyesinghe (2012) identified the following core characteristics important to understanding multiracial theory:

- *Emergence: When and why.* Research on multiracial people emerged in the late 1980s and early 1990s (Wijeyesinghe, 2012). In terms of intersectionality of identity, scholars did not consider how race, class, and gender merged at the time even though multiracial people existed.
- *Identity: Holistic and multiply influenced.* Early beliefs about multiracial people discussed how they had an "either–or" (Wijeyesinghe, 2012, p. 85) experience in which they had to choose among their identities. Multiracial theory gave way to a new more holistic identity that allowed for the integration of all dimensions of their iden-

tity. Individuals encompass identities of both power and marginalization; they can be members of both dominant and target groups. For example, a Black–White biracial person can experience both oppression and White privilege.

- *Identity: Fluid and changing over time.* Identity is a dynamic process that continually evolves over time. Sociopolitical factors often influence the salience of identities at different periods in a person's life.
- *Whose voices and how to hear them.* Qualitative research allows for the voices and lived experiences of multiracial individuals to be heard.
- *Linking theory to social change.* The literature on multiracial and intersectionality changes society's understanding of multiracial people, which in turn, can lead to important education, advocacy, and social policies that support multiracial people.

The factor model of multiracial identity (FMMI; Wijeyesinghe, 2001; Wijeyesinghe & Jackson, 2012) is centered on the assumption that people make a choice when they determine their identity. The choice made by multiracial people regarding their identity is also influenced by the social and political landscape. A light-skinned person with blonde hair may identify as Native American whereas society perceives the person as White. The FMMI model identifies seven factors that affect choice of racial identity. Each of these factors is defined individually, but they are all interrelated.

- *Racial ancestry.* Individuals of multiracial descent may determine their racial identity according to their family racial ancestry.
- *Early experiences and socialization.* Early life experiences and interactions with family and friends provide multiracial people with overt and covert messages regarding their racial identity. These messages can be a combination of positive and negative messages about their racial identity.
- *Cultural attachment.* Being exposed to cultural traditions and practices can influence multiracial people's choice of racial identity.
- *Physical appearance.* Physical appearance influences how multiracial peoples choose their racial identity. Wijeyesinghe and Jackson (2012) argued that

> skin color and tone, hair color and texture, eye color and shape, size and shape of facial features, and body structure are used by the general public and society to make assumptions about people's racial ancestry, racial group membership, and racial identity. (p. 89)

  Physical appearance can be used to help determine a person's racial identity, or it can serve as a barrier to a person's choice of racial identity. For example, people who fit into society's image of what an Asian person looks like may have less difficulty identifying with being Asian than a person who identifies as Asian but has blonde hair.
- *Political awareness and orientation.* Awareness and experiences with issues of race and racism can also influence a person's choice of racial identity. Sometimes multiracial people choose a particular racial identity for political purposes.
- *Other social identities.* Other dimensions of identity such as gender, class, sexual orientation, religion, age, and disability status also influence a person's racial identity. For some, racial identity may not be as salient as gender based on personal experiences and circumstances.
- *Spirituality.* People who are spiritual may use their spirituality to help them understand issues of race, racism, and racial identity.

Sexual Identity Development Models

Sexual identity development models evolved out of the research on racial identity development. Theories of sexual identity development examine how living in a predominantly homophobic and heterosexual world affects the development of one's sexual identity. Most sexual identity development models describe the process of lesbian and gay identity development. The first two sexual identity development models presented in this section focus on the experiences of gay men and lesbian women rather than bisexual individuals; we discuss the latter group separately because the group faces unique challenges. It is important to note that these models on sexual identity development refer to adults and not youth.

Lesbian and Gay Identity Development Models

The Cass Model

Australian psychologist Vivienne Cass (1979, 1984) was one of the first to publish studies about lesbian and gay identity using her clinical work with lesbian women and gay men. Cass's work was significant because it viewed lesbian and gay identity as a normal aspect of human growth and development. The common belief at the time, reflected in the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952), was that lesbian women and gay men were mentally ill.

Cass (1979, 1984) believed lesbian and gay identity to be a developmental process that was acquired based on the interaction of individuals and their environment. She proposed a six-stage model for the coming out process where individuals fully integrate a positive lesbian or gay identity into their self-concept:

1. *Identity confusion.* In this stage, individuals experience a sense of dissonance and confusion as they begin to question whether they are gay or lesbian. For the first time, they are aware that they have gay or lesbian thoughts, feelings, and attractions. This awareness often causes inner turmoil and confusion. Questions such as "Who am I?" and "Am I gay or lesbian?" surface during this stage of development as individuals attempt to understand their experiences.
2. *Identity comparison.* Individuals begin to realize that they might be gay or lesbian; they compare their experiences with those in the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) and heterosexual communities. Social alienation is common in this stage of development.
3. *Identity tolerance.* Individuals begin to tolerate but not fully accept their LGBTQ identity. Activities in this stage promote decreasing social isolation by immersing oneself in lesbian and gay communities. They may still view lesbian or gay individuals negatively because they have internalized homophobic attitudes; individuals may be "out" in their private life but not in their public life.
4. *Identity acceptance.* Individuals fully identify as LGBTQ; their private and public identities are increasingly congruent. Contact with and immersion within the lesbian and gay community continues to increase.
5. *Identity pride.* Dichotomous thinking is prevalent. Heterosexuals are viewed as the root cause of homophobia, biphobia, and heterosexism. This belief leads to an "us versus them" mentality that may seem to be militaristic by others. Anger is directed toward the heterosexual community and to those who do not support LGBTQ causes. Individuals have a strong desire to be "out" in both their private and personal lives.

6. *Identity synthesis.* Individuals integrate their sexual identity with other aspects of their identity. Being LGBTQ is viewed as only one aspect of the self.

Ritter and Terndrup's Phase Model

In order to simplify the various sexual identity models, Ritter and Terndrup (2002) identified key concepts from the Cass (1979), Coleman (1982), Grace (1992), and Troiden (1989) models and combined them into a single model having five phases:

1. *Phase 1: sensitization* (Troiden); pre-coming out (Coleman); emergence (Grace). This first phase involves dealing with client feelings of "estrangement, isolation, loneliness, and fear" (Ritter & Terndrup, 2002, p. 169). This includes treating depression, illness, suicidal ideation, isolation, and acting-out behaviors through interventions and other alleviation methods.
2. *Phase 2: identity confusion* (Cass, Troiden); identity comparison (Cass); coming out (Coleman); acknowledgement (Grace). Psychotherapeutic techniques more specifically begin to foster LGBTQ identity through challenging heterosexist assumptions that others hold in a client's life as well as those that have been internalized by the client. This stage lays the groundwork for approaching and unpacking Warner's (2002) concept of heteronormativity as it influences the client's life and well-being. At this stage, clients begin to accept the idea that they might identify as LGBTQ rather than as heterosexual.
3. *Phase 3: identity tolerance* (Cass); identity assumption (Troiden); exploration (Coleman); finding community (Grace). Through psychotherapeutic care and individual growth and exploration, clients are able to tolerate their new identity and accept themselves as probably LGBTQ. Clients are able to work with the counselor to explore past sexual encounters and attach LGBTQ meaning to these encounters.
4. *Phase 4: identity acceptance* (Cass); commitment (Troiden); first relationships (Coleman, Grace). Clients are supported in their engagement with and participation in LGBTQ subcultures and are referred to as *lesbian*, *gay*, *bisexual*, *transgender*, or *questioning*, which supports the development and consolidation of a healthy new identity.
5. *Phase 5: identity pride/synthesis* (Cass); integration (Coleman); self-definition and reintegration (Grace). Counselors and psychologists patiently guide any clients who are driven to act out in aggression against heterosexism in society, severing ties with the sexual majority, to a less hostile position. Counselors can work with clients to allow them to see that not all heterosexual individuals are against them and guide them to healthy participation in society.

Bisexual Identity Development Model

Bisexual individuals experience discrimination on all fronts. Heterosexuals and those in the lesbian and gay community often misunderstand the bisexual experience. Weinberg, Williams, and Pryor (1994) were the first to develop a model on bisexual identity based on interviews with bisexual individuals in the San Francisco area. Those interviewed indicated that they initially identified as heterosexuals and that over time they developed a bisexual identity. For men, having sex was more of a priority than falling in love; women reported the opposite priority.

Weinberg et al. (1994) conducted interviews that led to the creation of a four-stage bisexual identity development model. This model described bisexual individuals as being in a perpetual state of confusion over their bisexuality. Brown (2002) built on Weinberg et al.'s (1994) model by elaborating on the experiences of bisexual females and males. Brown's model of

bisexuality includes four stages. The first three stages are directly from Weinberg et al.'s model, and the fourth stage, "identity uncertainty," was renamed "identity maintenance":

1. *Initial confusion.* This stage can last for years if not a lifetime. Bisexual males experience conflict between gender roles and sexual feelings. Same-sex attractions may lead to anxiety because of the belief that their masculinity is being questioned. Bisexual women may feel intense emotional feelings for other women, but they may not act on these feelings in a sexual way. Both men and women fear that attraction to one sex will lead to un-attraction for the other sex. Self-identifying as heterosexual or as gay or lesbian rather than bisexual can lead to confusion. Difficulty acknowledging one's same-sex attraction can also lead to anxiety and further confusion.
2. *Finding and applying the label.* Individuals eventually explore their bisexuality either through intimate relationships with others or through connections with the bisexual community. Such experiences can lead individuals to accept or reject their bisexuality. Those who experience support are more inclined to identify as bisexual. Bisexual women might self-label as bisexual for political reasons and may be involved in romantic relationships with only one sex. Some bisexual women might identify as either lesbian or heterosexual to avoid labels of bisexuality because they fear stigmatization and rejection. Bisexual men might reject their bisexual identity because of threats to their masculinity and manhood.
3. *Settling into the identity.* People at this stage are more comfortable with their bisexual identity because of a strong support network. Individuals at this stage question whether bisexuality is a phase or a transition period. They also actively seek out relationships. Bisexual women seek emotional relationships with others whereas bisexual men will seek physical relationships with others.
4. *Identity maintenance.* Initially referred to as the "continued uncertainty" stage by Weinberg et al. (1994), individuals begin to engage in behaviors throughout the life span that help maintain a bisexual identity. Bisexual women may have "concomitant or serial relationships with members of both sexes" to maintain their bisexual identity (Brown, 2002, p. 84). Bisexual men may act upon their bisexual tendencies with members of both sexes before identifying themselves as bisexual. The lack of accurate knowledge regarding the bisexual experience and the complexity that comes with being in a relationship (e.g., jealousy and misunderstandings) can often lead to continued uncertainty for bisexual individuals at this stage.

Heterosexual Identity Development Model

When people think about sexual orientation, they tend to automatically think about LGB people first instead of heterosexuals, in part because heterosexuality is considered the norm in society. Heterosexual values, behaviors, and ideologies are so ingrained into the fabric of everyday life that they are rarely examined. As a result, heterosexuality and heterosexual privilege are rendered invisible. Research on heterosexual identity development is limited; thus, helping professionals have little to no understanding of heterosexual identity formation and its implication for counseling.

Models of heterosexual identity development evolved out of racial identity and LGB identity literature. Heterosexual identity development models explain how living in a predominantly homophobic and biphobic society influences the formation of a heterosexual identity. Such models are also useful because they shed light on heterosexual privilege and the development of heterosexual sexual identity (Worthington & Mohr, 2002).

Worthington, Savoy, Dillon, and Vernaglia (2002) developed a multidimensional model of heterosexual identity development built on earlier identity development models. Worthington et al.'s model considers biopsychosocial influences on sexual development and distinguishes between *sexual orientation* as "one's sexual predisposition" (p. 497) and *sexual identity* as "one's recognition and identification with such predispositions" (p. 497). Sexual orientation is something other than a choice, and sexual identity is something people "adopt" (Worthington et al., 2002, p. 497).

Worthington et al. (2002) identified the following biopsychosocial influences on heterosexual identity development:

- *Biology.* Sexual health, development, desire, behavior, reproduction, and orientation are all influenced to varying degrees by biological processes.
- *Microsocial context.* The values held by family, peers, coworkers, and neighbors provide the context in which identity is developed.
- *Gender norms and socialization.* Men and women are socialized to fulfill gender roles in society.
- *Culture.* Cultural context gives meaning to sexuality.
- *Religious orientation.* For many people, religious beliefs can influence sexual identity development.
- *Systematic homonegativity, sexual prejudice, and privilege.* Stereotypes, discrimination, and oppression combine to dehumanize LGB individuals and serve to benefit heterosexuals.

In Worthington et al.'s (2002) multidimensional model of heterosexual identity, individuals go through two processes: (a) an internal process that involves awareness and acceptance of one's "sexual needs, values, sexual orientation and preferences for activities, partner characteristics, and modes of sexual expression" (p. 510); and (b) an external process of developing a social identity where one begins to see oneself as a member of a heterosexual group that also shares similar attitudes about LGB individuals.

Worthington et al.'s (2002) multidimensional model of heterosexual identity model includes five identity developmental statuses that affect both internal and external processes. These statuses are also experienced in a circular fashion in that a status can be revisited at different points in a person's life.

1. *Unexplored commitment status.* People develop a heterosexual identity with very little if any conscious thought as a result of socialization from family and society. Heterosexuality is accepted as the norm. There is no conscious recognition of one's dominant status as heterosexual. At the group level, individuals conform to the heterosexual norms established in society. This means having negative attitudes and beliefs about LGB people.
2. *Active exploration status.* This involves intentional cognitive and behavioral "exploration, evaluation, or experimentation of one's sexual needs, values, orientation, and/or preferences for activities, partner characteristics, or modes of sexual expression" (Worthington et al., 2002, p. 516) at the individual identity level. Heterosexual norms are often questioned during this time. At the group level, individuals become aware of their unearned heterosexual privilege and either (a) question the fairness of this privileged status or (b) exercise their "rights" to this privilege. As individuals exit the active exploration status, they enter either the deepening commitment status or the diffusion status.

3. *Diffusion status.* Individuals do not involve themselves in exploration or commitment. Diffusion occurs because of a crisis and is connected to intense psychological distress. There may be active rejection of a heterosexual identity without much intentionality or thought into the consequences of one's actions. The pathway out of diffusion is active exploration.
4. *Deepening commitment status.* Individuals have a deeper understanding of their individual and group sexual identities. A more meaningful understanding of oneself as heterosexual develops. There is also an awareness of homophobia, biphobia, and heterosexism. Attitudes toward LGB individuals vary from supportive to unsupportive. Upon exiting this status, individuals enter either the synthesis, active exploration, or diffusion status.
5. *Synthesis status.* There is congruence between individual, group, and attitudes toward sexual minorities. This synergy of identities and attitudes converges as individuals form a holistic self-concept. There is a heightened level of maturity within this status.

Transgender Identity Development Model

Western medicine and psychology continue to pathologize transgender individuals as people with "mental illnesses and biological maladies" (Bilodeau, 2005, p. 30). The American Psychiatric Association (2013) recently addressed concerns that gender variant individuals were labeled as sick by changing some of the diagnostic criteria and renaming "gender identity disorder" to "gender dysphoria" in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.); nevertheless, this diagnostic classification still considers the individual and not the environment as the problem.

Models of transgender identity development, which describe the process individuals go through to identify as transgender, are in their infancy when compared with sexual identity development models. Renn and Bilodeau (2005) proposed that the process to fully developing a transgender identity is similar to the coming out process for LGB individuals. For gender-conforming people, developing a gender identity is a normal and often unconscious process because they conform to what is considered the norm in society. The process of gender identity development for gender variant people is one that has many challenges because of the lack of family and social support.

Bilodeau's (2005) transgender identity development model was built on D'Augelli's (1994) model of identity development and sexual orientation. Bilodeau's model describes transgender identity as a process that can be described in six categories (Process 1, Process 2, and so on). Having a supportive environment, being politically conscious, and being able to access community resources are important to developing a fully integrated transgender identity.

1. *Process 1: Exiting a traditionally gendered identity.* This involves being cognizant of one's gender and experiences with gender. Individuals identify as transgender and recognize that exiting a traditional gender identity is a lifelong process.
2. *Process 2: Developing a personal transgender identity.* Having positive role models and supportive people helps to foster a transgender identity. Interacting with other transgender individuals can help clarify questions about gender identity and nurture a deeper understanding of one's gender.
3. *Process 3: Developing a transgender social identity.* Surrounding oneself with a supportive group of people who know and accept the person's transgender identity is important during this time. Transgender resources and organizations in the community can be helpful in developing a support network.

4. *Process 4: Becoming a transgender offspring.* Transgender persons recognize that their gender identity may lead to isolation and to a mix of reactions from family. Some families support a person's transgender identity and some are unsupportive, which results in distant family relationships.
5. *Process 5: Developing a transgender intimacy status.* Being intimate with others is an important process to further understanding one's gender identity and sexual orientation. Individuals may experience either synergy or conflict with their gender identity and sexual orientation depending on their partner's support or lack thereof.
6. *Process 6: Entering a transgender community.* This process involves being committed to addressing societal barriers on the transgender community. Involvement in social advocacy can occur on an individual level or with organizations.

Intersection of Identities

A limitation of the models of identity development described in the preceding sections is that they examine only one dimension of identity. Race and sexual orientation are viewed through a single lens separate from other dimensions of identity. Compartmentalizing one dimension of identity while disregarding other equally important identity dimensions gives only a partial picture of a person. Another limitation is that identity development models are too linear and restrictive. People do not experience the world in a stagelike fashion. Human development issues are too complex to categorize into tightly packaged stages. Some may not identify with a particular stage within a particular model.

In this section we discuss the intersection of identities. We examine theories that explore how race, ethnicity, gender, sexual orientation, ability status, religion, and economic class converge at different points in a person's life. Being able to see when different dimensions of identity intersect allows one to see the relationship between each facet of identity.

Jones and McEwen's (2000) research on college women evolved out of the limitations they believed to be inherent in predominant identity development models. They argued that major identity development models were too linear and overly simplistic and that they did not fully capture all dimensions of human identity. Most models explored only one dimension of human diversity, such as race, which does not provide a comprehensive understanding of individuals. The dimensions that form human identity are not separate and disconnected parts (Jones & McEwen, 2000); rather, they are all interconnected and combine in equally meaningful ways to make up the whole person.

Jones and McEwen's (2000) research on the intersection and salience of identities led to the development of a nonlinear model of multiple dimensions of identity. Their research supported earlier identity development theories regarding the fluidity of identity and the influential role social context plays in identity development. In their research Jones and McEwen concluded that the salience of identity is dependent on whether an individual is a member of an oppressed group or whether he or she experiences being different among a group. For example, women and people of color tend to be more conscious of their gender and racial identity than White men. Being in settings where a particular dimension of identity is different from the crowd can also make that dimension of identity salient at that moment in time. For instance, a White individual may become conscious of being White if he or she is the only White person in a room of people of color.

Jones and McEwen (2000) created an atomlike conceptual illustration of the intersection and salience of the dimensions of identity.

- The nucleus of the atomlike structure, referred to as the *core*, represents a person's values, beliefs, and characteristics. This core is a participant's "inside self" or "inner identity" (p. 408), the dimensions of identity that others are not readily able to see or notice.
- Surrounding a person's core are "outside identities" (p. 408) such as race, class, gender, culture, and sexual orientation. Outside identities are essentially social constructs people use to categorize and label others. Participants found less meaning in their outside identities because they rarely addressed the true essence of their sense of self.
- The various dimensions of identity surrounding the core suggest that no one aspect of identity can be understood without the other. For example, race cannot be fully understood without also considering a person's ethnicity, gender, sexual orientation, religion, and class status.
- The placement of the various dimensions of identity around the core represents the salience of identity in a given situation. Dimensions of identity closest to the core represent aspects of identity a person is conscious of at that moment in time. Those furthest from the core reflect a dimension of identity a person is least conscious of at a given moment in time.
- The various dimensions of identity orbiting the core move around the nucleus to represent the dynamic nature of identity and how the salience of identities varies from one social setting and situation to the next.
- Surrounding the dimensions of identity is the social context. Identity is both internally defined by the individual and externally defined by society.

Conclusion

Theories of identity development have long established the importance of sociocultural contexts in identify formation. Early measures of identity were defined by the dominant culture, with oppressed populations having to either adapt to dominant group characteristics or suffer the consequences. The research on racial, ethnic, gender, and sexual orientation identity development has made a significant contribution to research on identity development generally. Although there are many differences across the various research models studying racial, ethnic, gender, and sexual orientation identity development, the general patterns apply across the various models.

First, there is a clear differentiation between lower and higher levels of development regarding the person's identity. This development is usually related to intentional or unintentional, conscious or unconscious, or articulate or inarticulate aspects of identity. In some cases, the lower levels of development correlate with measures of illness or personal inadequacy whereas higher levels of development correlate with healthy competent functioning.

Second, it is clear that culture relates to the process of personal identity development in profoundly meaningful ways. Culture, broadly defined, describes the significant experiences that lead the person to defined roles. It should be clear to the reader that measures of identity development that disregard cultural aspects are likely to be inaccurate and inadequate.

Oppressed client populations from at least the last 200 years in the United States began the process of reflecting on culture and identity issues in social, political, and economic situations. In most cases, these persons were not counselors or psychologists, although the implications of their ideas were certainly psychological. As we examine racial, ethnic, gender, and sexual orientation identity development as a process, it is

important to recognize that these ideas have a history that goes far beyond the last several decades.

The next section of the book explores practical ways counselors can develop into multicultural and social justice competent helping professionals. We discuss the importance of using appropriate terminology in counseling. We also introduce two inventories that can help counselors develop both multicultural and advocacy competence and discuss ways in which counselors can address any potential pitfalls with doing multicultural and social justice work.

References

Adams, M., Bell, L. A., & Griffin, P. (Eds.). (2007). *Teaching for diversity and social justice* (2nd ed.). New York, NY: Routledge.

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Arlington, VA: Author.

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

Atkinson, D. R., Morten, G., & Sue, D. W. (1998). *Counseling American minorities*. Boston, MA: McGraw Hill.

Bilodeau, B. (2005). Beyond the gender binary: A case study of two transgender students at a Midwestern research university. *Journal of Gay and Lesbian Issues in Education, 3*, 29–44.

Briggs, C. A., & Pepperell, J. L. (2009). *Women, girls, and addiction: Celebrating the feminine in counseling treatment and recovery*. New York, NY: Routledge.

Brown, T. (2002). A proposed model of bisexuality identity development that elaborates on experiential differences of women and men. *Journal of Bisexuality, 2*, 67–91. doi: 10.1300/J159v02n04_05

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*, 219–235.

Cass, V. (1984). Homosexual identity formation: Testing a theoretical model. *Journal of Sex, 20,* 143–167.

Coleman, E. (1982). Developmental stages of the coming out process. *Journal of Homosexuality, 9,* 105–126.

Cross, W. (1991). *Shades of Black.* Philadelphia, PA: Temple University Press.

Cross, W. E., & Fhagen-Smith, P. (2001). Patterns in African American identity development: A lifespan perspective. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 243–270). New York: New York University Press.

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 312–333). San Francisco, CA: Jossey-Bass.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York, NY: Norton.

Ferdman, B. M., & Gallegos, P. I. (2001). Racial identity development and Latinos in the United States. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 32–66). New York: New York University Press.

Ferdman, B. M., & Gallegos, P. I. (2012). Latina and Latino ethnoracial identity orientations. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed., pp. 51–80). New York: New York University Press.

Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
Grace, J. (1992). Affirming gay and lesbian adulthood. In N.J. Woodman (Ed.), *Lesbian and gay life-styles: A guide for counseling and education* (pp. 33–47). New York, NY: Irvington.
Hardiman, R. (1982). *White identity development: A process oriented model for describing the racial consciousness of White Americans* (Unpublished doctoral dissertation). University of Massachusetts, Amherst.
Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *Counseling Psychologist, 12*, 153–165.
Helms, J. (1993). *Black and White racial identity: Theory, research and practice.* New York, NY: Greenwood Press.
Helms, J. E. (1995). An update of Helms's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–191). Thousand Oaks, CA: Sage.
Helms, J. E., & Carter, R. T. (1990). Development of the White racial identity attitude inventory. In J. E. Helms (Ed.), *Black and White racial identity: Theory, research, and practice* (pp. 67–80). Westport, CT: Greenwood Press.
Horse, P. G. (2001). Reflections on American Indian identity. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 91–107). New York: New York University Press.
Horse, P. (2012). Twenty-first century Native American consciousness. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity: Integrating emerging frameworks* (2nd ed., pp. 108–120). New York: New York University Press.
Ibrahim, F. A. (1991). Contribution of cultural worldview to generic counseling and development. *Journal of Counseling & Development, 70*, 13–19.
Jackson, B. (1976). Black identity development. In L. Golubschick & B. Persky (Eds.), *Urban social and educational issues* (pp. 158–164). Dubuque, IA: Kendall-Hall.
Jackson, B. W. (2012). Black identity development: Influences of culture and social oppression. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed., pp. 33–50). New York: New York University Press.
Jackson, B. W., & Hardiman, R. (2012). Hardiman-Jackson model of social identity development. In M. Adams, L. A. Bell, & P. Griffin (Eds.), *Teaching for diversity and social justice* (Appendix 2A). New York, NY: Routledge.
Jones, S. R., & McEwen, M. K. (2000). A conceptual model of multiple dimensions of identity. *Journal of College Student Development, 41*, 405–414.
Kim, J. (1981). *A process of Asian American identity development: A study of Japanese American women's perceptions of their struggle to achieve positive identities as Americans of Asian ancestry* (Unpublished doctoral dissertation). University of Massachusetts, Amherst.
Kim, J. (2001). Asian American identity development theory. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: A theoretical and practical anthology* (pp. 67–90). New York: New York University Press.
Kim, J. (2012). Asian American identity development theory. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed., pp. 138–160). New York: New York University Press.
Koltko-Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology, 8*, 3–58.
National Partnership for Women and Families. (2011). *Facts: Women and the wage gap*. Retrieved from http://www.nationalpartnership.org/

Poston, W. S. C. (1990). The biracial identity development model: A needed addition. *Journal of Counseling & Development, 69,* 152–155.

Renn, K. A. (2008). Research on biracial and multiracial identity development: Overview and synthesis. In K. A. Renn & P. Shang (Eds.), *Biracial and multiracial students: New directions for student services* (pp. 13–21). San Francisco, CA: Jossey-Bass.

Renn, K. A., & Bilodeau, B. (2005). Queer student leaders: An exploratory case study of identity development and LGBT student involvement at a Midwestern research university. *Journal of Gay and Lesbian Issues in Education, 2*, 49–71.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: Guilford Press.

Root, M. P. P. (1990). Resolving "other" status: Identity development of biracial individuals. *Women and Therapy, 9*, 185–205.

Sue, D. W. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*, 420–429.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley and Sons.

Thomas, C. (1971). *Boys no more*. Beverly Hills, CA: Glencoe Press.

Troiden, R. R. (1989). *Gay and lesbian identity: A sociological analysis*. New York, NY: General Hall.

Warner, M. (2002). *Publics and counterpublics.* New York, NY: Zone.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality*. New York, NY: Oxford University Press.

Wijeyesinghe, C. (2001). Racial identity in multiracial people: An alternative paradigm. In C. Wijeyesinghe & B. W. Jackson (Eds.), *New perspectives on racial identity: A theoretical and practical anthology* (pp. 129–152). New York: New York University Press.

Wijeyesinghe, C. (2012). Integrating multiracial identity theories and intersectional perspectives on social identity. In C. Wijeyesinghe & B. Jackson (Eds.), *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed., pp. 81–120). New York: New York University Press.

Wijeyesinghe, C., & Jackson, B. (Eds.). (2012). *New perspectives on racial identity development: Integrating emerging frameworks* (2nd ed.). New York: New York University Press.

Worthington, R. L., & Mohr, J.J. (2002). Theorizing heterosexual identity development. *The Counseling Psychologist, 30*, 491–495.

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individuals and social identity. *Counseling Psychologist, 30*, 496–531.

Section II.

Developing Multicultural and Social Justice Competence

Chapter 6

Using Appropriate Terminology

Terminology is both simple and complex. We use terminology to communicate ideas, express concepts, and refer to others and ourselves. Terminology is complex because it continually changes and can have overt and covert meanings, which can lead to confusion and misunderstanding. There are also many ways to refer to others, which further complicates our use of terminology. Terms are important because they provide the context and meaning to help us understand the world and those around us. The use of appropriate terminology by counselors can help create an affirming clinical setting for clients. When used inappropriately, terminology can cause unintended harm and hurt feelings.

The terminology people use to refer to others is a barometer of the social, political, economic, and cultural climate of the times. Terminology evolves over time and eventually becomes dated. Nieto and Bode (2011) offered an example of how the term *colored* evolved to *Negro* to *Black* to *Afro-American* and the term currently used, *African American*. Nieto and Bode argued that changes in terminology are often deliberate attempts to be more precise and respectful of a particular group. For instance, the term *Asian American* (to refer to people of Asian descent) replaced *Oriental*, a term that is now considered offensive because it implies that Asian Americans are foreigners (Takaki, 1998). *Asian American* is the preferred terminology because it acknowledges a person's bicultural identity.

Counselors can become overly cautious when referring to clients for fear of saying the wrong thing and being perceived as bigots. This fear often arises in part because counselors lack the vocabulary to engage with clients and the larger community. As a result, counselors often choose to sidestep the issue by not asking clients how they prefer to be called; the unasked question becomes the elephant in the room.

In this chapter we explore the importance of language and the use of appropriate terminology to describe others. What we say, how we conduct ourselves, and the manner in which the counseling process unfolds depends on our ability to use terminology that affirms clients. An agreed-upon terminology can go a long way in providing multiculturally responsive counseling and bringing about social change. Being grounded in a shared terminology allows counselors to create a welcoming and inclusive therapeutic environment.

The Rules of Terminology

The rules of terminology are merely suggestions based on a combination of usage as reflected in the literature and our experiences with diverse communities. We discuss the rules of terminology knowing that terminology is dynamic; what is in print today is obsolete tomorrow. We caution readers to keep in mind that usage is likely to change over time, to differ from one individual to another, and to change from one geographic location to another.

Nieto and Bode (2011) recommended asking oneself two questions when determining how to refer to individuals:

- Is the terminology current with the times and geographic location?
- How does the individual want to be called?

We believe that Nieto and Bode offered sound guidance for determining how to refer to others. That said, their approach might not be applicable in all situations.

People-First Language

It is important to use people-first language when referring to others. People-first language is a sentence arrangement or way of saying things that names the person first and their identity second. Examples include using *people of color, people with disabilities,* and *person with schizophrenia* instead of *colored people, disabled people,* or *schizophrenic person*. Using people-first language conveys information about a person but does not define the person by that information. Moreover, people-first language acknowledges that people are human beings first and eliminates opportunities for stereotyping.

Inclusive Language

Using inclusive or nonsexist language is key to creating a welcoming clinical environment. Moreover, inclusive language can go a long way in helping clients feel affirmed. *Inclusive language* refers to terminology, phrases, and expressions that do not exclude groups of people. Using gender-specific language or masculine pronouns is rarely necessary and may be offensive to clients. Counselors should instead use gender-neutral language (e.g., *human beings* rather than *men*; *fireperson* rather than *fireman*).

Occasionally, it can be a challenge to write in gender inclusive ways. For example, people often use *her/him* or *he/she* in a sentence to be gender inclusive. This tactic can sometimes be distracting to read; we suggest using the plural *they* or *them*.

Race and Ethnicity

The term *people of color* is used to refer to African American, Latino/a American, Asian American, and Native American individuals as well as individuals of biracial and multiracial backgrounds (Nieto & Bode, 2011). *People of color* is used primarily in the United States and is interchangeable with *persons of color* or *individuals of color*. These terms evolved from *communities of color*. Occasionally, individuals refer to people of color along with their professional roles, such as *counselors of color* or *psychologists of color*. The acronym ALANA (which stands for African American, Latino/a American, Asian American, and Native American) is also used interchangeably with the term *people of color*.

Use of the term *people of color* is preferable to *non-White* or *minority* for several reasons (Nieto & Bode, 2011). The term is a shift away from using Whites as the reference point to which other racial groups are compared. Rarely do people use the phrase *nonpeople of color*

or *non-Black*. The term *minority* is never used when referring to White ethnic groups such as Russian Americans that are in the minority (Nieto & Bode, 2011). Using *people of color* conveys that a group of people has a common experience with racism.

African American and *Black* are often used interchangeably; these terms are preferred over *Negroid* and *Negro*. People may also prefer to be identified by their African heritage (e.g., Ethiopian). It is also common to hear the *n-word* used by segments of the Black community to refer to one another. This term has different connotations for different generations of African Americans (Kennedy, 2003): Younger generations of African Americans perceive the n-word to be a term of endearment and empowerment, and some use a variation of the word to give it a different meaning. For older generations of African Americans the n-word has very negative connotations: It is a term that White people have used to degrade and dehumanize them, and it reminds them of slavery and segregation. We strongly advise those who are not African American to refrain from using this term in any context.

The term *Asian American* refers to people of Asian descent who live in the United States. Asian Americans have a broad cultural heritage spanning Asian ethnic groups including Indian, Cambodian, Chinese, Japanese, Laotian, Thai, and Vietnamese. Use of the term *Oriental* to refer to people of Asian heritage is considered derogatory in the United States; it implies that Asian Americans and Pacific Islanders are foreign to the United States even if they were born in the country (Takaki, 1998). Some individuals of Asian heritage who identify strongly with their bicultural identities may refer to themselves as *Filipino American* or *Cambodian American*.

Latino/a is a term used to refer to people of Latin American and Caribbean heritage (Nieto & Bode, 2011). Sometimes people will use the term *Latino* to refer to both genders. To address the masculine pronouns in the Spanish language, some people use *Latin@* or *Latina/o*. We believe use of the terms Latin@ or *Latino/a* is appropriate. Sometimes Latino/a individuals prefer to be identified by their ethnic identity (such as *Mexican* or *Puerto Rican*) or their bicultural identity (e.g., *Mexican American* or *Puerto Rican American)*.

Native American, American Indian, and *Indian* are interchangeable terms used to refer to the indigenous people of North America. American Indians may also identify by their tribal affiliations, such as *Coeur D'Alene* or *Cowlitz*. The use of Indian and tribal names is an attempt by Native Americans to regain their cultural heritage. The struggle to maintain their cultural heritage is a challenge for many American Indians.

European American is a term used to describe individuals whose roots are in European countries (e.g., Sweden, Holland, England, Ireland, and Germany). This term refers to White Americans in the United States. Nieto and Bode (2011) noted that because many White Americans are unaware of their ethnic identity, they use *European American* as a way to encourage White Americans to think about their ethnic identity.

Biracial refers to people who come from two different racial groups; whereas, *multiracial* refers to people of who identify with more than two racial groups. *Multiracial* is a term that encompasses biracial people as well. The terminology used to refer to *biracial* and *multiracial* people varies. For example, *Hapa* is a term that means different things depending on geographic location. In Hawaii, it is used to refer to people of different ethnic heritages. In California, this same term is used to refer to individuals who are part White and part Asian. Using slang such as *mutt, half-breed, mixed, mulato, zambo,* and *mestizo* is inappropriate and should be avoided.

People With Disabilities

When interacting with people with disabilities it is important to use people-first language (e.g., *person with paraplegia* and not *paraplegic*). Avoid the use of negative labels and phrases such as *disabled*, *retarded, wheel chair bound, handicapped*, *sick, crippled, afflicted with, suffering from, victims of, lame,* and *sickly*. If you so happen to use one of these terms, apologize and promptly correct yourself.

Lesbian, Gay, Bisexual, Transgender, and Questioning Populations

The abbreviation *LGBTQ* refers to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals. Sometimes people will add an "I" to the acronym to include intersex people (individuals who are born with ambiguous sex characteristics). *Lesbian* is a term that refers to females who are emotionally, physically, and sexually attracted to other females. The term *gay* has more than one meaning. It is sometimes used to refer to gay males, and it can be used as an umbrella term to refer to the sexual orientation of lesbian, gay, and bisexual individuals. Bisexual individuals are emotionally, physically, and sexually attracted to members of both genders. *Transgender* refers to the identification of a person with a gender that differs from the one at birth. (Note that one should use the adjective *transgender* rather than the verb *transgendered*.) *Queer* is an umbrella term referring to all LGBTQ people. This term originally was used in a derogatory manner toward LGBTQ people, and some still view it in this manner. However, some within the LGBTQ community regard it as a positive term.

The use of gender-appropriate pronouns is also important to creating an affirming environment. A male-identified person may prefer masculine pronouns such as *him, he,* and *his*. Female-identified persons might prefer the use of feminine pronouns such as *she* and *her*. Transgender-identified individuals may use either male or female gender pronouns or gender-neutral pronouns such as *ze, sir, sie,* and *hir*. Clinicians should ask clients which gender pronouns to use to refer to them.

Using terminology such as *sexual preference* and *lifestyle* when discussing a person's sexual orientation or sexual identity is derogatory and creates a hostile clinical environment. Both terms imply that one's sexual orientation and sexual identity are matters of choice. The research on sexual orientation is inconclusive. Perrin (2002) argued that sexual orientation is not determined by one factor but by a combination of genetic, hormonal, and environmental factors.

Conclusion

A commitment to using respectful and inclusive language when referring to clients can go a long way in helping them feel accepted. Grounding in basic terminology conveys respect for clients and communities. This commitment conveys the message that counselors care about clients' well-being. Using the wrong terminology when referring to a client can lead clients to terminate therapy. Clients may walk away with the belief that their counselor is unaware of the issues they experience. We encourage the practice of respectful and inclusive language in one's personal and professional lives. Using appropriate terminology in one's personal life can strengthen what one does in the clinical setting and vice versa.

References

Kennedy, R. (2003). *Nigger: The strange career of a troublesome word*. New York, NY: Vintage.

Nieto, S., & Bode, P. (2011). *Affirming diversity: The sociopolitical context of multicultural education* (6th ed.). Upper Saddle River, NJ: Pearson.

Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York, NY: Kluwer Academic/Plenum Publishers

Takaki, R. (1998). *Strangers from a different shore: A history of Asian Americans* (Rev. ed.). New York, NY: Little, Brown.

Chapter 7

Developing Multicultural Competence

Developing multicultural competence is not an end in itself but rather a means toward increasing one's power, energy, and freedom of intentional choice in a multicultural world. Multicultural competence increases a person's intentional and purposive decision-making ability by accounting for the many ways that culture and diversity influence different perceptions of the same solution.

Multicultural competence occurs in a global context. Technological advances such as the Internet increase the rate of globalization. The Internet has made us more connected than ever before. As a result of technology, people are able to learn about world events in a matter of minutes if not seconds. Social media such as Facebook, Twitter, and online blogs allow people to communicate with a wider range of people all over the world. We need to develop multicultural awareness on a globalized scale to respond appropriately to the problems and opportunities of globalization.

Culture is not only external but also "within the person," and it is not separate from other learned competencies. Developing multicultural competence is therefore a professional and ethical obligation as well as an opportunity for the adequately trained counselor. Millions of people today live and work in a culture other than their own. People who live in an unfamiliar culture are likely to become more multiculturally competent in their awareness of alternative values, habits, customs, and lifestyles that were initially strange and unfamiliar. Sometimes they learn to adjust even more profoundly and effectively than they themselves realize. They learn to respond in unique ways to previously unfamiliar situations and to come up with the right answers without always being aware of their own adjustment process.

In this chapter, a culture-centered approach is described in a three-stage developmental sequence: from multicultural awareness, to knowledge and comprehension, to skills and applications. First, auditing the assumptions being made by counselors and increasing the level of cultural self-awareness by both the provider and the consumer of counseling services challenges the culturally encapsulated conventions about health and illness. Second, documenting facts and knowledge for increased comprehension is essential to meaningful understanding of a presenting problem in its cultural context and provides or constructs a receptive site for research, training, and direct intervention. Third, generating appropriate intervention skills for bringing about appropriate and effective change matches the

skill to the cultural context. The same shared positive values and expectations—common ground—may be expressed differently in each cultural context. By developing multicultural awareness, counselors are able to interpret client's behavior in the cultural context in which that behavior was learned and is displayed.

The three-stage developmental sequence of awareness, knowledge, and skills is based on the work of D. W. Sue, Arredondo, and McDavis's (1992) multicultural counseling competencies (MCC). Developing equal emphasis on the combination of awareness, knowledge, and skills is critical to developing multicultural competence. Underemphasizing or overemphasizing one of these three areas of multicultural competence can impede counselors' ability to deliver culturally competent counseling (D. W. Sue & Sue, 2013). Counselors who lack awareness will find it difficult to develop knowledge and culturally appropriate interventions and skills. Similarly, an overemphasis on awareness in the absence of knowledge and skill can lead to awareness becoming an end in itself, which is nonproductive. There is also a danger when counselors overemphasize obtaining knowledge and facts to the point where they are not able to connect their gained knowledge with awareness and skills to see how all the information is relevant. Just as risky is when counselors attempt to develop skills without the necessary awareness and knowledge needed to determine whether their skills make things better or worse. For instance, without adequate awareness or knowledge about clients' cultural background, counselors may inaccurately diagnose their behavior as abnormal when in actuality it is a culturally appropriate behavior in the clients' culture. For these reasons, we recommend a three-stage developmental sequence from awareness to knowledge to skills.

It is difficult to know the culture of others until and unless one has an awareness of the culturally learned assumptions that govern one's life. Many counselors in training skip over the primary stage of developing multicultural awareness about their own underlying assumptions. People want to learn about how to work with specific client populations and sometimes do not realize that learning about others must begin with examining their own assumptions. We dare not assume that we, or our colleagues, have already achieved a high level of cultural self-awareness because this is an ongoing, incomplete developmental process. The importance of identifying these unexamined underlying assumptions is frequently underestimated. Individuals who have achieved some degree of self-awareness and can perceive themselves as others do are ready to move to the second level.

The second level involves accumulating information that results in comprehension. Increased awareness helps counselors ask the right questions about the facts and information they need to assist clients. Increased awareness also helps counselors find the similarities and differences between and among the populations being served. When counselors have gained cultural self-awareness and accumulated the facts, information, and knowledge necessary for that comprehension, they are ready to identify the appropriate skills needed that also take into consideration the client's cultural background.

The third level involves developing culturally appropriate skills. The same skill that is appropriate in one culture may be completely inappropriate in another culture. Because every test and theory was developed in a specific cultural context, it is likely to reflect assumptions implicit in that context and, to a greater or lesser extent, to be biased. Culture-centered skills enable counselors to use data from culturally biased tests or theories and still apply them appropriately, meaningfully, and helpfully in a variety of other cultural contexts.

The Developmental Sequence

The three-stage developmental sequence that is described in this section provides a convenient structure to organize the elements needed to develop multicultural competence as counselors. As noted previously, this three-step approach is rooted in the MCC (D. W. Sue

et al., 1992). Both the American Counseling Association and the American Psychological Association have endorsed the MCC of awareness, knowledge, and skills as the most articulate examples of assessing counseling competencies.

Awareness

Awareness provides the basis for accurate opinions, attitudes, and assumptions. It is essential to first become aware of implicit priorities given to selected attitudes, opinions, and values. Awareness presumes an ability to accurately compare and contrast alternative viewpoints, relate or translate priorities in a variety of cultural settings, identify constraints and opportunities in each cultural context, and have a clear understanding of one's own limitations. A well-defined awareness becomes essential for counseling, research, training, direct service, and consultation. If the awareness stage is overlooked in multicultural counseling development, then the knowledge and skills, however accurate and effective, may be based on false assumptions. If, however, multicultural development does not go beyond awareness objectives, clients see the problems but are not able to do anything to change their situation, which causes frustration.

Knowledge

Knowledge provides the documentation and factual information necessary to move beyond awareness toward effective and appropriate change in multicultural settings. Through accumulated facts and information based on appropriate assumptions, it is possible to understand cultures on their own terms. The facts and information about cultures are available in the people, the literature, and the products of each culture at the local, national, and regional levels. The second stage of gaining knowledge helps people access those facts and information, directs people to where the knowledge can be found, and identifies reliable sources of information to better understand the unfamiliar culture. If the knowledge stage is overlooked, then the cultural awareness and skill, however appropriate and effective, lack grounding in essential facts and information about the multicultural context, and the resulting changes may be inappropriate. If, however, multicultural development does not go beyond the collection of facts and information about other cultures, clients become overwhelmed by abstractions that may be true but are impossible to apply in practice.

Skills

The ability to build on awareness and apply knowledge toward effective change in multicultural settings is a skill that counselors cultivate. Multiculturally competent counselors are skilled in planning, conducting, and evaluating the multicultural contexts in which they work. They assess the needs of other cultures accurately. They work with interpreters and cultural informants from other cultures. They observe and understand behaviors of culturally diverse clients. They interact, counsel, interview, advise, and manage their tasks effectively in multicultural settings.

The American Counseling Association has proposed a revised set of competencies based on the counselor's (a) being aware of his or her own assumptions, values, and biases; (b) understanding the worldview of the culturally different client; and (c) developing appropriate intervention strategies and techniques. These competencies are described in D. W. Sue et al.'s (1992) article on MCC. We discuss these competencies in the order in which they are presented in that article as the most promising competency guidelines available for developing multiculturally skilled counselors.

Multicultural Counseling Competencies

The first step in developing multicultural skills requires that counselors develop an awareness of the culturally learned starting points in their own thinking. This foundation of

multicultural awareness is important because it controls the counselor's interpretation of knowledge and use of skills. The need for multicultural awareness is seldom addressed in the generic training of counselors, and counseling skills are generally assumed to be uniform in the literature about counseling and counselor education. The multiculturally skilled counselor does not take awareness for granted. The sections that follow describe competencies for attitudes, beliefs, knowledge, and skills (D. W. Sue et al., 1992).

Attitudes and Beliefs

Culturally competent counselors have moved from being culturally unaware to being aware of and sensitive to their own cultural heritage and to valuing and respecting differences. Culturally skilled counselors are aware of how their own cultural backgrounds, experiences, attitudes, values, and biases influence psychological processes. These counselors are able to recognize the limits of their competencies and expertise. They are comfortable with differences that exist between themselves and clients in terms of race, ethnicity, culture, and beliefs.

Knowledge

Culturally competent counselors have specific knowledge about various aspects that shape their own identity and cultural heritage and how it personally and professionally affects their definitions of normality–abnormality and the process of counseling. These counselors possess knowledge and understanding about how various forms of oppression, discrimination, and stereotyping affect them personally and affect their work with clients. This understanding allows them to acknowledge their own racist, sexist, heterosexist, and classist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism (White identity development models). Culturally skilled counselors possess knowledge about their social impact on others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with minority clients, and how to anticipate the effect it may have on others.

Skills

Culturally competent counselors seek out educational, consultative, and professional development experiences to improve their understanding and effectiveness in working with culturally diverse populations. Being able to recognize the limits of the competencies, they (a) seek consultation, (b) seek further training or education, (c) make referrals to more qualified individuals or resources, or (d) engage in a combination of these. Culturally skilled counselors constantly seek to understand themselves as racial and cultural beings and actively seek a nonracist identity.

Pope-Davis and Dings (1995) were among the first to provide the best discussion of the research to measure and validate the multicultural competencies. Worthington, Soth-McNett, and Moreno (2007) conducted a 20-year content analysis of empirical studies on the MCC (pp. 353–354); they categorized the empirical research on the MCC as shown in the following list. (The number of studies in each category and the percentage of those studies as part of the whole are provided within parentheses.)

- Scale development/instrument validity (11, 14.7%): studies that measure the validity of the instrument.
- Client perceptions (26, 34.7%): studies addressing client perceptions of counselor credibility, counselor MCC, effectiveness, and general counseling competencies.

- Client outcomes (6, 13.3%): studies focused on client satisfaction, self-disclosure, and attrition.
- Objective ratings of trainee or counselor MCC (9, 12.0%): studies rating the multicultural case-conceptualization ability of MCC.
- Multicultural counseling training interventions (8, 10.7%): studies focused on counselor training to promote multicultural competencies.
- Intrapersonal correlates of counselors' MCC (43, 57.3%): studies addressing the correlates of counselors' MCC: (a) demographics, (b) attitudes, (c) personality, (d) identity, (e) theoretical orientation, (f) multicultural counseling training, (g) cross-cultural contact, (h) clinical experience, and (i) social desirability.
- Counseling process (4, 5.3%): studies focused on the process of counseling.
- Other (2, 2.7%): studies that do not fit any of the content categories described above.

Worthington et al. (2007) concluded that there continues to be a paucity of research on the MCC. Most of the literature on the MCC consists of conceptual articles, which are important in providing a framework to understand abstract concepts. Worthington et al. argued that research on the MCC must match the level of empirical data needed to sustain the multicultural counseling perspective.

Toward Multicultural Competence: A Four-Step Process

Multicultural competence, as presented in this book, is a continuous learning process based on three stages of development. The awareness stage emphasizes assumptions about cultural differences and similarities of behavior, attitudes, and values. The knowledge stage expands the amount of facts and information about culturally learned assumptions. The skills stage applies effective and efficient action with people of different cultures and identities on the basis of the participants' clarified assumptions and accurate knowledge. Multicultural counselors need to be trained to develop the awareness, knowledge, and skills required for multicultural competency. The following four-step process provides guidelines that help professionals develop into multiculturally competent counselors (Center for Applied Linguistics, 1982; Pedersen, 1983). The Multicultural Competencies Self-Assessment (MCSA) Survey (see Appendix 7.1) developed by Ratts (2013) is a way to measure one's level of multicultural awareness, knowledge, and skills. The MCSA Survey can aid counselors in completing the four-step process to develop multicultural competence.

Step 1: Assess Your Needs

The first step in developing multicultural competence as a counselor is to assess awareness, knowledge, and skill needs. Assessing one's level of awareness is an important first step; otherwise one is likely to "scratch where it doesn't itch." One's level of awareness, knowledge, and skill will differ based on the cultural group. The MCSA Survey in Appendix 7.1 offers a way to assess one's level of multicultural awareness, knowledge, and skills.

The MCSA Survey (Ratts, 2013) consists of 45 items that are derived from and structured around the three areas of D. W. Sue et al.'s (1992) MCC: (a) counselors' awareness of their own assumptions, values, and biases; (b) counselors' understanding of their client's worldview and culture; and (c) counselors' ability to use culturally appropriate interventions strategies and skills. These items were developed to help practitioners reflect on their level of competence around each of the three areas of the MCC.

The first area of the MCSA Survey explores counselors' awareness of their own assumptions, values, and biases. Counselors who are aware of their "hot buttons" can use this

awareness to address issues that may impede their ability to work with culturally diverse clients. This area also explores counselors' awareness of themselves as cultural beings. Moreover, multicultural awareness is the ability to accurately judge a cultural situation from both one's own and the other's cultural viewpoint. A counselor should be able to describe a situation in each culture so that a member of that culture can agree with the counselor's perception. Such an awareness requires counselors to demonstrate the following qualities:

- ability to recognize direct and indirect communication styles,
- sensitivity to nonverbal cues,
- awareness of cultural and linguistic differences,
- interest in the unique experiences of the culturally diverse client,
- sensitivity to the myths and stereotypes of the culturally diverse client,
- concern for the welfare of the culturally diverse,
- ability to articulate elements of his or her own aspects of identity,
- appreciation of the importance of multicultural teaching,
- awareness of the relationships between culturally diverse groups, and
- accurate criteria for objectively judging "goodness" and "badness" in other culturally diverse groups.

The second area of the MCSA Survey assesses counselors' knowledge of their own as well as their client's worldview and culture. Assessing one's level of knowledge becomes important when counselors possess a certain degree of awareness judged to be adequate. If awareness helps counselors to ask the "right questions," then knowledge provides access to the "right answers." The increased knowledge and information should clarify the alternatives and reduce the ambiguity in a counselor's understanding about the culturally diverse client. For example, learning the language of another culture is an effective way to increase one's information. Counselors can also learn a great deal by immersing themselves in the lesbian, gay, bisexual, transgender, and questioning community. Anticipating preconceptions and stereotypes from another culture's viewpoint requires knowledge about the myths and widely "understood" perceptions of that culture. It is also important to know the right way to get more information about the culture in question so that clinical interventions are culturally appropriate.

A great deal of information is necessary before counselors can be expected to understand another culture. The second area of the MCSA Survey helps assess counselors' level of knowledge prior to working with a particular cultural group so they can fill in any gaps with accurate factual information they need to proceed with an accurate and comprehensive understanding of their client. The following questions can also help increase counselor's level of knowledge about culturally diverse clients and client populations:

1. Do I have specific knowledge about the culturally diverse group's historical experiences, adjustment styles, roles of education, socioeconomic backgrounds, preferred values, typical attitudes, honored behaviors, inherited customs, slang, learning styles, and ways of thinking?
2. Do I have information about available resources for learning about the culturally diverse client population?
3. Do I know about the culturally diverse client in relation to other culturally diverse client populations?

4. Do I have professional expertise in an area valued by persons in the other culture?
5. Do I have information about resources regarding the other culture, and do I know where those resources are available?

The third area of the MCSA Survey examines counselors' ability to use culturally appropriate intervention strategies and techniques in counseling. Counselors can use their awareness of their own values, biases, assumptions, and knowledge of clients' worldviews and cultures to design interventions and techniques that align with clients' cultural backgrounds. Counseling interventions and techniques that align with clients' worldviews and cultural heritages can be helpful in ensuring that client problems are not inappropriately addressed.

Assessing one's skill level becomes important when one's informed awareness is supplemented with factual data about the other culture. Skill becomes the most important stage of all and therefore requires a great deal of preparation in learning about awareness and knowledge. By learning a skill, counselors enable themselves to do something that they could not do before. It is possible to measure the things a counselor can now do effectively that he or she could not do prior to learning the new skill. Skill requires counselors to do the right thing at the right time in the right way and provides the final test of whether counselors have been effective after all.

Skills are difficult to evaluate. Sometimes the suggested solution is not credible to all persons in the other culture. Skill is demonstrated when counselors present a solution in the client's language and cultural framework; when counselors test stereotypes against real and present situations and modify them accordingly; and when counselors seek agreement on evaluation criteria and implement change that will cause an improvement. In a needs assessment to determine counselors' level of skill development, it is important for counselors to consider the following questions:

1. Do I have culturally appropriate techniques to work in another culture?
2. Do I have a counseling style that is appropriate in the other culture?
3. Do I have the ability to establish empathic rapport with persons from the other culture?
4. Am I able to receive and accurately analyze feedback from persons of the other culture?
5. Do I have the creative ability to develop new methods for work in the other culture that go beyond what I have already learned?

The MCSA Survey takes about 15 minutes to administer and score. Each item requires that respondents select one of the following answers: "Almost Never," "Sometimes," or "Almost Always."

Step 2: Define the Objectives

After counselors have established and analyzed their needs, the second step is to design appropriate objectives for a multiculturally competent counselor. In identifying objectives it is important that there is a connection linking awareness needs to knowledge or information needs and finally to skill needs. These objectives are likely to differ from person to person because each of us has different levels of awareness, knowledge, and skill. The relative emphasis on awareness, knowledge, or skills also depends on the results of the needs assessment (Step 1). When clearly stated objectives are identified, it is useful to critically analyze the awareness aspect, the knowledge aspect, and the skill aspect of each objective. One may, therefore, imagine a matrix in which the same objective has an awareness aspect, a knowledge aspect, and a skill aspect. Asking the following questions can be helpful:

1. Are there patterns that emerge in the objectives?
2. What seems to be missing in the objectives?
3. Is each objective measureable?
4. Are the objectives attainable?
5. Are the objectives relevant?
6. Is there a time frame in which objectives will be accomplished?

The awareness objectives focus on changing counselors' attitudes, opinions, and personal perspectives about themselves and the other culture so that these elements are in harmony with one another. The primary emphasis should focus on identifying stereotypical attitudes and opinions. Usually, the awareness objectives focus on a person's unstated assumptions about another culture or about the person in relation to the other culture. Specific objectives might be based on several important elements of awareness:

1. Are you aware of differences in cultural institutions and systems?
2. As a counselor, are you aware of the stress resulting from functioning in a multicultural situation?
3. Do you know how rights or responsibilities are defined differently in different cultures and communities?
4. Are you aware of differences in verbal and nonverbal communication styles?
5. Are you aware of significant differences and similarities in practices across different cultures and between dominant and target groups?

The knowledge component for developing multicultural competence focuses on increasing the amount of accurate information available about another culture. Having developed a correct and accurate awareness of the other culture, counselors enrich that awareness by testing attitudes, opinions, and assumptions against the body of factual information they now control. A counselor's level of awareness is certain to increase in direct proportion to the extent of their knowledge about the other culture. Specific objectives for developing multicultural competence might be based on several knowledge perspectives:

1. Do you know the client's social group's historical background?
2. Do you know about social services in the community and how they are delivered to vulnerable and underserved populations?
3. Do you know about the theory of culture shock and stages of cultural adaptation as they relate to specific culturally diverse client groups?
4. Do you know how the client's culture interprets its own rules, customs, and laws?
5. Do you know patterns of nonverbal communication and language usage within the client's culture?
6. Do you know how differences and similarities are patterned in the client's culture and how priorities are set in different critical situations?

The skills objective for developing multicultural competence focuses on what counselors can do, given an appropriate level of awareness and knowledge. If the previous assessment about one's own awareness and knowledge is missing or inadequate, counselors have difficulty making right decisions in multicultural communication. If awareness has been neglected, counselors may develop a plan grounded in fallacy and wrong assumptions. If knowledge has been neglected, they describe the cultural situation inaccurately.

If skill has been neglected, they may well change a client's situation in counterproductive directions. Specific objectives for developing multicultural competence for skills might be based on several important perspectives:

1. Are you able to gain access to social services and resources in the community?
2. Are you able to cope with stress and manage difficulties in the client's culture?
3. Are you able to understand consequences of behavior and choose wisely among several options that culturally diverse clients present?
4. Are you able to use the client's language to react appropriately to others from that cultural group?
5. Are you able to function comfortably in the client's culture without losing your own cultural identity?

These are a few examples of skills objectives that must be assessed to ensure that counselors are able to communicate in the other culture. Many additional skills can be developed for each specific situation.

Step 3: Design a Plan to Meet the Objectives

The third step in developing multicultural competence is to design a meaningful plan that illustrates how the identified objectives are carried out in such a way that the identified needs are met. Techniques can be matched with awareness, knowledge, or skill objectives in various ways, as shown in the following examples.

The following techniques can be used to stimulate awareness:

- Join an organization focused on a specific cultural group.
- Visit establishments owned and frequented by culturally diverse clients in the community.
- Interview an individual from a particular cultural group.
- Develop genuine friendships with individuals from other culturally diverse groups and initiate conversations about cultural differences between you and them.
- Identify critical incidents about the problems that come up across culturally diverse client groups.
- Volunteer your time to an organization focused on a specific cultural group.
- Choose to live in the community in which culturally diverse groups reside.

Learning about a culture should extend beyond readings and the classroom environment. Developing increased multicultural awareness relies on having daily experiences that require authentic and genuine multicultural interaction. (If they are not authentic and genuine, they are pointless.) Through personal interactions we learn about the nuances of a culture that cannot be learned through a textbook or a class discussion. Almost any approach that challenges one's basic assumptions, tests prevailing attitudes, and elicits implicit opinions about a particular culturally diverse group increases one's level of awareness.

The following techniques can be used to increase knowledge:

- Read books to increase knowledge about specific culturally diverse groups.
- Attend community town hall meetings, lectures, and community forums to learn about the issues of culturally diverse groups.
- Watch movies detailing the worldview of culturally diverse groups.

- Attend community events that focus on culturally diverse groups.
- Attend conferences that focus on culturally diverse groups.

The increase of multicultural knowledge frequently relies on books, movies, lectures, conferences, community forums, and workshops. Each of these mediums is an effective way to increase one's knowledge. Attending lectures about other cultures allows one to absorb more information relevant to their particular situation. Movies also provide valuable knowledge about a group. Going to conferences and workshops fills in gaps where accurate information might otherwise be impossible to secure. Simply observing persons from culturally diverse groups in their daily activities is an important means for learning about a particular client group, provided the counselor knows what to look for.

Increasing knowledge about multicultural skills takes many forms. Modeling and demonstrating a skill is an effective means of developing one's skill. When available, recording counseling sessions with client permission provides important feedback to counselors both about how the skill is performed within a particular culture and about how they are doing in modeling that skill. Supervising counselors' work with culturally diverse clients provides a valuable ongoing means of assessing developing levels of skill. The opportunity to practice new skills and behaviors enables counselors to improve their skill in a variety of situations.

The following techniques can be used to develop skills:

- Watch video demonstrations of culturally appropriate counseling.
- Work with cultural brokers to identify culturally relevant techniques.
- Role-play with colleagues to develop culturally appropriate skills and techniques.
- Ensure that clinical supervision focuses on culturally appropriate techniques.
- Use video and media resources for feedback to and from other culturally diverse groups.
- Practice a new behavior pattern to target intentional change.

The increase of multicultural skills is often premature before counselors have acquired competence in awareness and knowledge. The standard counseling skills are very relevant when they are based on a foundation of multicultural awareness and knowledge in sequence. It is important to realize that "one size does not fit all" and that each skill must be adapted and adjusted to each cultural context.

Step 4: Evaluate Your Success in Meeting the Objectives

The last step of developing multicultural competence as a counselor involves being able to evaluate whether you have met your objectives in awareness, knowledge, and skill. Evaluation is key to determining the degree to which you are culturally competent with clients. Evaluating oneself is important because it means being accountable for counseling services. Accountability is especially important during times of tight fiscal restraints. Evaluations should occur consistently, and they should also be measureable. Clients should be active participants in evaluations. Evaluations can be both formative and summative. Formative evaluations focus on the process of counseling and allow counselors to build on previous work. Summative evaluations, which are long-term and much more complicated, are used to determine whether counseling objectives are appropriate and meet long-term needs of the target group. Both formative and summative evaluations offer counselors different ways to assess their progress or lack thereof.

Evaluation methods may also range from informal discussions with supervisors and colleagues to formal written evaluations using rubrics that measure changes in productivity. However you proceed, you should allow room for evaluation of your counseling. The following behaviors can be used to evaluate counselor awareness:

- appropriately recognize the valued priority they give to basic attitudes, opinions, and assumptions;
- accurately compare their own cultural perspective with that of the culturally diverse client;
- sensitively articulate their professional role in relation to the culturally diverse client;
- appropriately estimate constraints of time, setting, and resources in the other culture; and
- realistically estimate the limits of their own resources in the other culture.

Counselors are trained to increase their knowledge so that they can demonstrate the following behaviors:

- understand the process of institutional change for culturally diverse clients at local, state, regional, and national levels;
- cite the relevant literature as it relates to culturally diverse client populations;
- identify similarities and differences between their own identities and those of the culturally diverse client;
- identify culturally appropriate referral resources; and
- select key resource persons from culturally diverse populations for guidance and mentorship.

Counselors are trained to increase their skill so that they can demonstrate the following behaviors:

- efficiently plan, conduct, and evaluate training about culturally diverse clients;
- accurately assess the needs of culturally diverse clients;
- use the talents of interpreters and cultural informants in the community;
- observe, understand, and accurately report about culturally learned behaviors of culturally diverse client populations; and
- interact, advise, and appropriately manage their assigned task in the setting of the culturally diverse client population.

Multicultural competence development is presumed to proceed from an awareness of attitudes, opinions, and assumptions; to knowledge of facts and information; and finally to skill in taking the appropriate action. Most people in training, however, are at different stages of development. Some counselors require more emphasis on awareness, some more emphasis on knowledge, and others can proceed directly to skill development.

Conclusion

Just as culture is complex but not chaotic, the process involved in developing multicultural competence should be similarly organized. Multicultural competence must begin with helping professionals. It requires intentionality and a well thought out plan. Developing

multicultural counseling competence and communication should include any and all methods relevant to the multicultural context in terms of that culture. It should be a process guided by a sequence of learning objectives that reflects the needs of the client and the multicultural context. Interventions and techniques must be comprehensive enough to include both culture-general and culture-specific perspectives. The developmental sequence from awareness to knowledge to skill provides an eclectic framework for organizing the content of multicultural development.

References

Center for Applied Linguistics. (1982). *Providing effective orientation: A training guide*. Washington, DC: CAL Refugee Services Report.

Pedersen, P. (1983). The transfer of intercultural training skills. *Interventional Journal of Psychology*, *18*, 333–345.

Pope-Davis, D. B., & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287–311). Thousand Oaks, CA: Sage.

Ratts, M. J. (2013). *Multicultural Competencies Self-Assessment Survey*. Unpublished instrument.

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

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: John Wiley and Sons.

Sue, S. (1998). In search of cultural competencies in psychology and counseling. *American Psychologist*, *53*, 440–448.

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology, 54*, 351–361.

Appendix 7.1 • **Multicultural Competencies Self-Assessment Survey**

Directions: To assess your own competence and comfort with multiculturalism, respond to the following statements as honestly and accurately as possible. See pages 103–104 for scoring.

Statements	Almost Always	Sometimes	Almost Never
1. I am unaware of the different aspects that shape my identity.			
2. I am knowledgeable of my cultural and racial identity.			
3. I seek out educational, consultative, and training experiences to enrich my understanding and effectiveness in working with culturally diverse populations.			
4. I am aware of my negative emotional reactions toward various culturally diverse populations that may prove detrimental to clients in counseling.			
5. I possess knowledge and information about the particular social group I am working with in counseling.			
6. I am familiar with relevant research regarding mental health and mental disorders of various culturally diverse populations.			
7. I respect people's religious beliefs and values about what they consider to be healthy physical and mental functioning.			
8. I am aware of how predominant counseling theories clash with the cultural values of various cultural groups.			
9. I am skilled at engaging in culturally appropriate verbal and nonverbal helping responses.			
10. I am unaware of how my own cultural background and experiences influence my attitudes, values, and biases about psychological processes.			
11. I am knowledgeable of how my cultural identity and racial identity influence how I define normality and abnormality in counseling.			
12. I recognize that there are limits to my competence and know when it is appropriate to refer to more qualified individuals/ resources.			
13. I am able to contrast my own beliefs and attitudes with those of my client in a nonjudgmental fashion.			
14. I am aware of my clients' life experiences, cultural heritage, identity development, and their historical background.			
15. I am familiar with the latest research findings regarding mental health and mental disorders of various culturally diverse populations.			
16. I respect people's spiritual beliefs and values about what they consider to be healthy physical and mental functioning.			
17. I am aware of the institutionalized barriers that impede on oppressed group's access to mental health services.			
18. I am skilled at helping clients determine whether their problems are rooted in oppression so that they do not blame themselves for their predicament.			
19. I am unaware of my limits to multicultural competence and expertise.			

(Continued)

Appendix 7.1 • **Multicultural Competencies Self-Assessment Survey**

Statements *(Continued)*	**Almost Always**	**Sometimes**	**Almost Never**
20. I possess knowledge of how oppression in all its forms affects me both personally and professionally.			
21. I actively seek to understand myself as a racial and cultural being.			
22. I am aware of the stereotypes I hold toward various culturally diverse clients.			
23. I understand how race, sex, gender, sexual orientation, religion, class, culture, and other identity variables may affect personality formation, career choices, and the manifestation of psychological disorders.			
24. I seek out educational experiences that enrich my knowledge, understanding, and cross-cultural skills.			
25. I respect other culture's indigenous helping practices.			
26. I am aware of the potential biases inherent in assessment instruments.			
27. I take responsibility for interacting in the language requested by clients. In situations where I am unable to do so, I am able to identify a translator with cultural knowledge or refer the client to a culturally competent bilingual counselor.			
28. I recognize the sources of my discomfort when interacting with culturally diverse clients.			
29. I understand how I directly or indirectly benefit from individual, institutional, and cultural forms of oppression.			
30. I actively seek an identity that is free from oppression (e.g., non-racist, non-sexist, non-heterosexist, non-classist, etc.)			
31. I am aware of the preconceived notions I hold toward various culturally diverse populations.			
32. I understand and have knowledge of the sociopolitical influences that affect the lives of culturally diverse clients.			
33. I am actively involved with culturally diverse clients outside the counseling setting (community events, social and political functions, celebrations, neighborhood groups, etc.).			
34. I believe that community-based help-giving networks are important.			
35. I am knowledgeable of the values and hierarchies of families of color.			
36. I work at eliminating my personal biases, prejudices, and discriminatory practices.			
37. I am comfortable with differences that exist between others and myself in regard to cultural differences and beliefs.			
38. I am knowledgeable of my social impact on others (e.g., communication style differences)			
39. I recognize when it is appropriate to seek out further education or training and when it is appropriate to refer a client to more qualified individuals or resources.			

(Continued)

Appendix 7.1 • **Multicultural Competencies Self-Assessment Survey**

Statements *(Continued)*	**Almost Always**	**Sometimes**	**Almost Never**
40. I am aware of the prejudices I hold toward particular culturally diverse client populations.			
41. I am knowledgeable of how various forms of oppression and powerlessness impact clients and their influence on the counseling process.			
42. I engage in activities to learn more about culturally diverse client populations that go beyond an academic or helping exercise.			
43. I don't view clients who are unable to speak the English language as an impediment to our communication.			
44. I am knowledgeable of discriminatory practices at the social and community level that affect the psychological well-being of culturally diverse clients.			
45. I take responsibility in educating culturally diverse clients about the process of counseling (e.g., goals, legal rights, expectations, and how my theoretical orientation aligns or does not align with their worldview).			

Directions for scoring: **Score numbers 1, 10, and 19 first**, and then record the score next to the corresponding number below:

Almost Never = 4 points Sometimes = 2 points Almost Always = 0 points

Then score the remaining items by recording the score next to the appropriate number.

Almost Always = 4 points Sometimes = 2 points Almost Never = 0 points

Total the number of points earned for each domain. Then, add the total scored earned for the 9 domains below to determine your multicultural competence rating.

Domain 1: Counselor Awareness of Own Assumptions, Values, and Biases

1. _____
10. _____
19. _____
28. _____
37. _____

Total: _____

Domain 2: Counselor Knowledge of Own Assumptions, Values, and Biases

2. _____
11. _____
20 _____
29. _____
38. _____

Total: _____

Domain 3: Counselor Skills Around Own Assumptions, Values, and Biases

3. _____
12. _____
21. _____
30. _____
39. _____

Total: _____

Domain 4: Counselor Beliefs and Attitudes of Client's Worldviews

4. _____
13. _____
22. _____
31. _____
40. _____

Total: _____

Domain 5: Counselor Knowledge of Client's Worldviews

5. _____
14. _____
23. _____
32. _____
41. _____

Total: _____

Domain 6: Counselor Skills Around Client's Worldviews

6. _____
15. _____
24. _____
33. _____
42. _____

Total: _____

Domain 7: Counselor Beliefs and Attitudes of Culturally Appropriate Intervention Strategies

7. _____
16. _____
25. _____
34. _____
43. _____

Total: _____

Domain 8: Counselor Knowledge of Culturally Appropriate Intervention Strategies

8. _____
17. _____
26. _____
35. _____
44. _____

Total: _____

Domain 9: Counselor Skills Around Culturally Appropriate Intervention Strategies

9. _____
18. _____
27. _____
36. _____
45. _____

Total: _____

(Continued)

Appendix 7.1 • **Multicultural Competencies Self-Assessment Survey**

Scoring: indicates

144–180 points	You're on your way to becoming a culturally competent counselor. Based on the self-assessment results it seems that you have a solid foundation that will help you in working with culturally diverse client populations. Given that cultural competence is a lifelong endeavor, it is always helpful to identify your strengths and areas for further growth. What strengths do you possess that allow you to be a culturally competent counselor? What are areas where you feel further growth is needed? Are there specific cultural groups where further growth is needed?
126–143 points	It appears that you have some areas of growth that need attention in order to achieve cultural competence. Identify areas needing attention and develop a concrete plan that will help you attain cultural competence. The goals you develop should be specific, measureable, attainable, realistic, and timely (S.M.A.R.T.).
125 points or less	You may need to rethink your commitment and readiness to working with culturally diverse client populations. Your score suggest you are seriously lacking in specific areas. Look at the concepts being measured: (1) counselor attitudes and beliefs, (2) counselor knowledge, and (3) counselor skills, and identify what area(s) are lacking. It may be helpful to seek consultation and supervision to identify areas of growth. Professional development workshops can also help increase one's level of cultural competence.

Chapter 8

Developing Advocacy Competence

Serving as client advocates both inside and outside the traditional therapy setting is a process that requires counselors to develop advocacy competence (Ratts, Toporek, & Lewis, 2010). Counselors who are competent advocates are positioned to be agents for social change. Counselors who are competent advocates are able to see the world as historically oppressed client groups see it, which in turn allows them to identify whether client problems are internally driven or systemically based and to address such issues appropriately. Moreover, when counselors are competent advocates, they are able to identify whether client problems are biologically, psychologically, or sociologically based. This recognition allows counselors to realize that individual counseling alone cannot eliminate the systemic barriers that contribute to client problems. Individual counseling, even when combined with multicultural counseling, is limited because this type of counseling does not fully address problems that are systemic in nature (Vera & Speight, 2003). We refer to this approach to counseling as *advocacy counseling* and to such counselors as *social advocates*.

Advocacy counseling requires a unique set of knowledge and skills that many counselor education programs do not emphasize. Counselor education programs tend to stress the development of clinical skills over advocacy skills when preparing emerging counselors for the field (Chang, Crethar, & Ratts, 2010). Thus, graduates of counseling programs are unprepared for the realities of the profession. This chapter provides an outline of the skills required for advocacy competence; it is intended only as an introduction. We illustrate a three-stage developmental sequence that offers helping professionals a means to advocate with, and on behalf of, clients. This developmental sequence is based on the various levels of advocacy illustrated in the ACA (American Counseling Association) Advocacy Competencies developed by Lewis, Arnold, House, and Toporek (2002).

Levels of Advocacy Competencies

The Advocacy Competencies (see Figure 8.1) are organized around the degree of client involvement and the level of counselor intervention (Toporek, Lewis, & Ratts, 2010). The process of advocacy may require counselors to work with or on behalf of clients. Advocacy with clients requires that counselors and clients work in collaboration with one another toward a common goal. This involves working closely with clients to identify the issue,

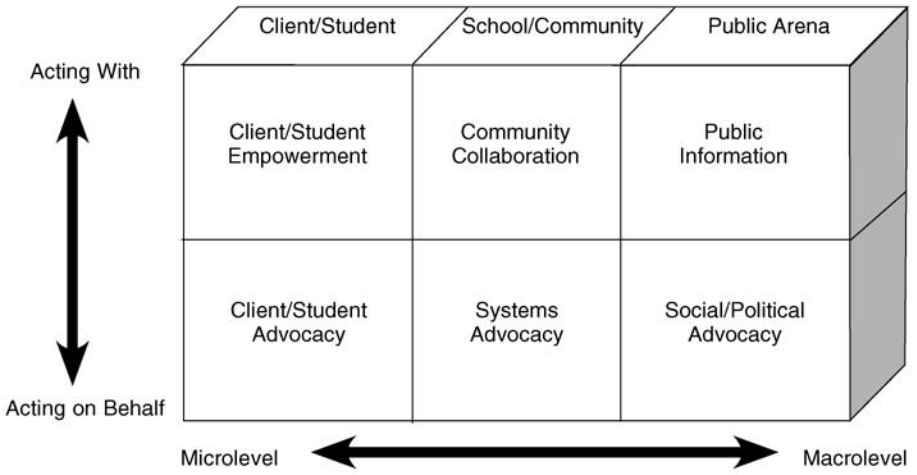


Figure 8.1 • **ACA Advocacy Competency Domains**

Note. The ACA (American Counseling Association) Advocacy Competencies were endorsed by the ACA Governing Council, March 20–22, 2003. From *ACA Advocacy Competencies,* by J. A. Lewis, M. S. Arnold, R. House, and R. L. Toporek, 2002. Available at http://www.counseling.org/knowledge-center/competencies. Copyright 2002 by the American Counseling Association. Reprinted with permission.

possible solutions, and consequences and to execute the advocacy plan (Toporek et al., 2010). For example, counselors may use role-playing in therapy to help clients develop self-advocacy skills they can use to confront their oppressor outside the counseling realm. Collaborating with clients might also involve working together to address issues of bullying in schools.

Other situations may require that counselors, because of the position they hold in society, advocate on behalf of clients. This form of advocacy does not always directly involve clients. Depending on the issue, counselors may be required to write legislative leaders to vote against an anti-gay bill, lead community rallies to address racial profiling within the police department, reach out to community leaders to address gang violence, or create a blog to bring a social justice issue to the public. Although such advocacy efforts occur outside the office setting, they complement what counselors do in the office setting because they directly address the root of client problems.

The level of counselor involvement ranges from interventions that occur in the office setting to those that require counselors to venture outside the traditional office environment. The various levels of counselor involvement are categorized into microlevel, mesolevel, and macrolevel interventions, each of which includes two domains.

Microlevel

Counselor involvement at the microlevel includes the Client Student Empowerment and the Client/Student Advocacy domains, and counselor participation tends to occur within the office setting. In terms of client empowerment, counselors help clients recognize signs that "irrational" cognitions and behaviors may actually be healthy responses to oppression; in other words, their problems might be externally driven. Counselors help clients externalize their oppression by using individual counseling strategies to identify client strengths and resources. Helping clients to develop self-advocacy skills is also an important counseling intervention within the client empowerment domain.

At the Client/Student Advocacy domain counselors negotiate for relevant services for clients, help clients gain access to resources, identify potential allies, and collaborate with clients to develop and carry out an action plan to confront systemic barriers. In schools this

may require school counselors to work with students to advocate for the development of gay–straight alliances in their districts to support lesbian, gay, bisexual, and transgender youth. Likewise, mental health counselors may be called to help clients identify necessary resources (e.g., lawyers, child advocates, cultural agencies) to address systemic barriers. Working to identify allies for clients can also help clients expand their support system.

Mesolevel

Advocacy work at the mesolevel falls in either the Community Collaboration or Systems Advocacy domains, and counselors work both within and outside the office setting. At the Community Collaboration domain counselors form important alliances with groups to foster social change. They also use their understanding of oppression to notify relevant groups that share similar concerns for social justice. At the Systems Advocacy domain, counselors identify environmental barriers that affect client development and use data to demonstrate the urgency for change. Counselors operating at this level also work with others to identify resistance to change and develop concrete strategies to address such issues with clients.

Macrolevel

Counselor involvement at the macrolevel encompasses the Public Information and the Social/Political Advocacy domains. Advocacy at this level often involves working outside the office setting to bring awareness about oppression and to address inequitable social and political structures. At the Public Information level, counselors bring awareness of the social injustices experienced by clients. For example, school counselors may need to use data to highlight unfair testing practices that disproportionately place first-generation students in special education classes. Likewise, mental health counselors may be called to develop websites to address unfair labor practices in their community.

The Social/Political Advocacy domain encompasses efforts to alter unfair structures and policies. For instance, school counselors can use advocacy to ensure that transgender youth are able to use bathrooms that align with their gender identity in schools. Mental health counselors can work with legislators to advocate for the creation of a comprehensive antidiscrimination bill in their state. All of these efforts are achieved when counselors recognize that client problems are rooted in larger systemic issues.

Competence Assessment

Counselors seeking to develop advocacy competence need to be capable of advocating with and on behalf of clients using a variety of methods. Specifically, advocacy-oriented counselors need to know when client issues call for individual counseling or advocacy counseling. The microlevel, mesolevel, and macrolevel advocacy strategies described in the preceding sections provide a structure to organize the necessary elements needed to develop advocacy competence as counselors. This framework is based on the Advocacy Competencies developed by Lewis et al. (2002).

Developing advocacy competency skills requires that helping professionals are aware of their strengths and areas of growth as advocates. The Advocacy Competencies Self-Assessment (ACSA) Survey (see Appendix 8.1) is a self-assessment instrument developed by Ratts and Ford (2010) to help counselors assess their level of competence as advocates and to identify whether they tend to focus on microlevel, mesolevel, or macrolevel advocacy interventions when working with clients. Counselors may find the survey useful in helping them to become more well-rounded advocates.

The ACSA Survey is a 30-item self-administered instrument that takes approximately 15 minutes to complete. Each item on the survey was derived from the list of competency

statements in the Advocacy Competencies. The survey was reviewed by Drs. Judy Lewis and Rebecca Toporek and piloted by two counselor education programs. Revisions were then made to the survey based on user feedback. As with any survey instrument, honesty in answering each item on the survey can help respondents gain a more accurate understanding of their competence as advocates. Honest responses will lead to more accurate determination of relative strengths and areas of growth as advocates. Respondents can determine whether they need to focus more on microlevel, mesolevel, or macrolevel advocacy interventions when working with clients.

Toward Advocacy Competence: A Four-Step Process

Competent advocates are those who are knowledgeable and skilled with microlevel, mesolevel, and macrolevel advocacy strategies (Ratts et al., 2010). Effective counselors should be able to use an array of strategies ranging from office interventions to community-based work. Counselors who are competent at the microlevel use strategies that empower clients. Mesolevel competence involves being able to effectively collaborate with schools and organizations to address systemic barriers. Competence at the macrolevel allows counselors to successfully alter systemic barriers that impede client development.

The four-step process used to develop multicultural competence (described in Chapter 7) can also be used as a guideline for advocacy competence.

Step 1: Assess Your Needs

The first step in developing advocacy competence as a counselor is an assessment of one's ability to help clients at the microlevel, mesolevel, and macrolevel. Assessing competence around these three levels of advocacy is an important first step; the ACSA Survey can be used for that purpose. Table 8.1 lists the skills that counselors should have at the microlevel, mesolevel, and macrolevel and the questions they can ask to assess their competence level.

Microlevel advocacy strategies are designed to empower clients. At this level, counselors recognize that client problems are best understood when social, political, and economic conditions are factored in. Helping clients understand their lives in context and develop the skills they need to advocate for themselves is key.

Mesolevel advocacy occurs when counselors work in collaboration with others to address issues of oppression. Counselors in this role serve largely as allies by using their interpersonal communication skills to build alliances across groups to affect social change. Counselors understand that working with other allies can go a long way in making sustainable changes in communities. Collaborating with others helps build support systems that can prevent burnout.

Counselors who advocate at the macrolevel use their energy to change systemic barriers that hinder human development. Bringing attention to issues of oppression and working with community leaders, policymakers, and community leaders is an important aspect of advocacy at this level.

Using the ACSA Survey, in combination with the self-assessment questions listed in Table 8.1, can help counselors develop advocacy competence at the microlevel, mesolevel, and macrolevel. Being able to identify one's strengths and areas of growth at each level can help counselors develop meaningful objectives to achieve advocacy competence.

Step 2: Define the Objectives

When needs have been established and analyzed, the second step is to design appropriate objectives that allow one to develop competence as an advocate. In identifying objectives,

Table 8.1 • **Skills Required for Microlevel, Mesolevel, and Macrolevel Counselor Advocacy Competence**

Level (Goal) and Skills	Questions to Ask
Microlevel (empower clients)	Does my counseling approach identify client's strengths?
Identify the strengths and resources that clients/students bring to the counseling process.	Do I possess the ability to determine whether social, political, and cultural factors influence client's presenting problems?
Identify the social, political, economic, and cultural factors that affect the client/student.	Do I have the ability to determine whether client problems are a result of biological, psychological, or sociological factors?
Recognize the signs indicating that an individual's behaviors and concerns reflect responses to systemic or internalized oppression.	Do I possess the ability to help clients develop self-advocacy skills?
At an appropriate developmental level, help the individual identify the external barriers that affect his or her development.	Do I possess the skills to explore an advocacy plan to address external barriers with clients?
Train students and clients in self-advocacy skills.	
Help students and clients develop self-advocacy action plans.	
Assist students and clients in carrying out self-advocacy action plans.	
Negotiate relevant service and education systems on behalf of clients and students.	
Help clients and students gain access to needed resources.	
Identify barriers to the well-being of individuals and vulnerable groups.	
Develop an initial plan of action for confronting these barriers.	
Identify potential allies for confronting the barriers.	
Carry out the plan of action.	
Mesolevel (work in collaboration with others to address issues of oppression)	Am I knowledgeable of community groups that need to be alerted about the client issue?
Identify environmental factors that impinge on students' and clients' development.	Do I possess the ability to form alliances with school and community groups that share common concerns?
Alert community or school groups with common concerns related to the issue.	Do I know how to use my counseling skills to better understand the oppressed group's concerns?
Develop alliances with groups working for change.	Do I know how to collaborate with stakeholders to develop a vision for change?
Use effective listening skills to gain understanding of the group goals.	Am I knowledgeable about who is in power and has social influence in the community?
Identify the strengths and resources that the group members bring to the process of systemic change.	Do I possess the ability to address any potential resistance?
Communicate recognition of and respect for these strengths and resources.	Do I possess the ability to bring the client's issue to the public eye without breaching confidentiality so that others are aware of the issue?
Identify and offer the skills that the counselor can bring to the collaboration.	Do I possess the technology skills to develop websites that will inform others in the community about the issue?
Provide data to show the urgency for change.	Do I possess the ability to inform media so they may bring the issue to the community's awareness?
In collaboration with other stakeholders, develop a vision to guide change.	Do I have the ability to use data to demonstrate the need for change?
Analyze the sources of political power and social influence within the system.	Do I have the ability to connect with local, state, and federal legislators?
Develop a step-by-step plan for implementing the change process.	
Develop a plan for dealing with probable responses to change.	
Recognize and deal with resistance.	
Macrolevel (change systemic barriers that hinder human development)	
Recognize the impact of oppression and other barriers to healthy development.	
Identify environmental factors that are protective of healthy development.	
Prepare written and multimedia materials that provide clear explanations of the role of specific environmental factors in human development.	
Disseminate information through a variety of media.	
Distinguish those problems that can best be resolved through social/political action.	
Identify the appropriate mechanisms and avenues for addressing these problems.	
Seek out and join with potential allies.	
Support existing alliances for change.	
With allies, prepare convincing data and rationales for change.	
With allies, lobby legislators and other policymakers.	

Note. For further information, see Ratts et al., 2010, pp. 246–248.

it is important to connect microlevel needs to mesolevel and macrolevel needs. These objectives are likely to differ for each individual because developmental levels differ. The relative emphasis on microlevel, mesolevel, or macrolevel needs is determined by the survey results. When clearly stated objectives are identified, it is useful to critically analyze the microlevel, mesolevel, and macrolevel aspect of each objective. One may, therefore, imagine a matrix in which the same objective will have a microlevel, mesolevel, and macrolevel aspect. Asking the following questions can be helpful:

- Are there patterns that emerge in the objectives?
- What seems to be missing in the objectives?
- Is each objective measureable?
- Are the objectives attainable?
- Are the objectives relevant?
- Is there a time frame in which objectives will be accomplished?

Exhibit 8.1 lists possible objectives for each level of advocacy competency. The microlevel objectives focus on exploring whether client problems are internally or externally based, identifying client strengths, and helping clients develop self-advocacy skills. The primary emphasis is to help determine the root of client problems and the extent to which clients are able to address their oppression. Microlevel objectives should therefore focus on clients in the context of their environment.

The mesolevel component for developing advocacy competence focuses on increasing collaboration with others. By building alliances with others who share similar concerns, counselors can better influence change at the systemic level. Collaborating with others can also help counselors and clients avoid the pitfalls of burnout that often come with advocacy work. Counselors who possess competence at the microlevel are able to ascertain the degree to which clients may benefit from collaboration with other individuals and organizations.

The macrolevel objective for developing advocacy competence focuses on what counselors can do at the systemic level, given what may need to occur at the microlevel and mesolevel. If any of the previous assessments about one's competence at the microlevel and mesolevel is inaccurate, it may negatively affect counselor's advocacy work at the mesolevel and macrolevel. If microlevel interventions have been neglected, counselors may develop advocacy plans grounded in fallacy and wrong assumptions. If mesolevel inter-

Exhibit 8.1 • **Objectives for Developing Advocacy Competence**

Microlevel	Mesolevel	Macrolevel
Are you aware of how client problems may be externally based?	Are you familiar with individuals and organizations in the community that share similar concerns about oppression?	Are you able to use technology to help bring the issue to the public's awareness?
As a counselor are you cognizant of how issues of oppression influence human growth and development?	Do you know how to involve others who share similar concerns about oppression?	Are you familiar with how media works in your community?
Are you aware of the strengths the client possesses?	Are you able to make a seamless transition from individual counseling to working in the community?	Are you able to alter systemic barriers that impact clients?
What self-advocacy skills does the client need to develop?	Have you developed alliances with individuals and organizations that can effect change?	Are you able to identify community and political leaders who can help address systemic barriers affecting clients?
Is there an advocacy plan developed?	Have you used data to help address the urgency for change?	Are you able to address client problems at the macrolevel and connect it with microlevel and mesolevel interventions?
	Are you aware of potential resistance that may occur as a result of your advocacy work with others?	

ventions have been neglected, they will lead to inappropriate collaborations with others. If macrolevel interventions have been neglected, it may lead to counseling interventions that do not adequately address systemic barriers that influence clients.

The questions in Exhibit 8.1 may help in designing objectives. More meaningful questions may arise based on each individual's personal assessment.

Step 3: Design a Plan to Meet the Objectives

The third step in developing advocacy competence is to design a meaningful plan that illustrates how the identified objectives can be carried out in such a way that the identified needs are met. There are many different ways to match techniques with microlevel, mesolevel, and macrolevel objectives. Exhibit 8.2 lists some approaches.

Developing microlevel competence requires grounding on theories of justice that extend beyond what is available in the scholarly counseling literature. Counselors would do well to become familiar with social justice-oriented literature by Paulo Freire, bell hooks, Cornel West, and other social justice-minded scholars. A solid foundation in social justice theories can help counselors better understand the needs of clients from oppressed groups. Given that counselor training is often limited to doing advocacy work, counselors should consider obtaining additional training.

Developing competence at the mesolevel requires that counselors use their communication skills to develop alliances with others. Collaboration with others in the community can go a long way to addressing social justice issues. One of the benefits to joining forces with others to address social justice issues is that it can also help ward off potential burnout that may arise from doing social justice work alone.

Macrolevel advocacy interventions require counselors to alter systemic barriers that hinder client development. A considerable amount of macrolevel advocacy work does not typically involve individual counseling. Rather, it requires counselors to do out-of-office

Exhibit 8.2 • **Strategies for Developing Microlevel, Mesolevel, and Macrolevel Advocacy Competence**

Microlevel	Mesolevel	Macrolevel
Become familiar with counseling theories that focus on client strengths such as relational–cultural theory or narrative therapy.	Visit social justice-oriented community agencies and schools to gain familiarity with the organization's initiatives.	Take a class or workshop on web development to learn how to develop websites to address a social justice issue that affects clients.
Become familiar with multicultural and feminist theories that address clients in context of living in an oppressive environment.	Reach out to individuals in community agencies and schools who share similar concerns to develop potential alliances.	Enroll in a media relations class or workshop to develop media communication skills to effectively communicate about social inequities in the community.
Read about theories of justice within other professions in addition to counseling.	Visit neighborhoods in which clients reside to collaborate with community members on social justice initiatives and projects with clients.	Identify social justice initiatives to support at the local, state, and national levels.
Obtain additional training on advocacy by attending workshops dedicated to advocacy and community-based work.	Invite school personnel and community agencies to collaborate on social justice initiatives in the community.	E-mail and call legislative leaders about social justice initiatives to garner their support.
Obtain a certificate, degree, or additional training in social justice work.	Contact community agencies and schools with clients about potential advocacy initiatives and collaboration opportunities.	Organize a day with a state counseling association to visit state legislative leaders to lobby for social justice initiatives that need support.
	Collaborate with clients on social justice initiatives in their community.	Reach out to city council members to address local initiatives that affect clients.
	Visit clients' homes and neighborhoods to do advocacy work as part of the counseling session.	

work. Because many counselors may not consider macrolevel advocacy work as part of the counselor role, it is likely that this work is not built into the weekly work schedules. For this reason, a certain amount of time in the weekly schedule should be devoted to macrolevel advocacy work. Considering the amount of time devoted to microlevel, mesolevel, and macrolevel advocacy work can help counselors become more intentional with their time. It can also help counselors to avoid burnout.

Step 4: Evaluate Your Success in Meeting the Objectives

The last step of developing advocacy competence as a counselor involves being able to evaluate whether microlevel, mesolevel, and macrolevel objectives have been met (see Exhibit 8.3). Evaluation is key to determining the degree to which counselors are competent advocates. Conducting an honest evaluation can help counselors identify their strengths and areas of growth as advocates. Evaluations also help counselors determine professional development opportunities. When counselors recognize areas that need further development, they have an ethical responsibility to seek out training opportunities to develop competence.

Evaluations should involve input from others such as counselors, clients, and supervisors. Each of these three constituent groups provides important feedback that may not be attainable through self-evaluations. Counselors can help provide input on such matters as confidentiality and professionalism within the context of advocacy work. Client feedback is also important because recipients of services provide insights into the counseling process. Clients can help counselors determine what is working and what is needed as it relates to advocacy. Supervisors who are trained in advocacy can provide the structure and support counselors need as advocates.

Counselors should evaluate their skills as advocates on an ongoing basis. At a minimum, evaluations should be completed on an annual basis and connected to measureable goals. The more specific and measureable the goals, the more likely that counselors can determine whether they are successful in accomplishing them. Exhibit 8.3 lists some criteria for evaluating successful advocacy skill at the microlevel, mesolevel, and macrolevel.

Exhibit 8.3 • **Evaluating Successful Advocacy at the Microlevel, Mesolevel, and Macrolevel**

Microlevel	Mesolevel	Macrolevel
Collaborate with supervisors to determine if the percentage of time spent on whether client problems are internally or externally based is adequate.	Assess whether interpersonal communication skills are effective in addressing social justice issues affecting clients.	Assess how technology can be used to address social justice issues.
Collaborate with clients to evaluate the extent to which client problems are biologically, psychologically, and/or sociologically based.	Evaluate whether alliances with others are effective in addressing multicultural and social justice issues.	Evaluate whether community collaboration efforts are effective in addressing social justice issues.
Work with clients to identify their strengths.	Use data to demonstrate a need for change.	Determine whether one's interpersonal communication skills are effective in addressing social justice issues to members of the media.
Use surveys to identify self-advocacy skills clients need to develop.	Create and disseminate surveys to identify potential resistance that may come with advocacy work.	Determine how collaboration with community and political leaders will garner support for systemic change.
In collaboration with clients, develop and carry out an advocacy plan that is specific, measureable, attainable, realistic, and timely.		Use data to develop programs and policies that will address issues of oppression.

Conclusion

Being a competent advocate does not occur haphazardly. Developing into an advocacy competent helping professional is a process that requires honest self-reflection and intentionality. The process to achieving advocacy competence requires a well thought out plan that is developmentally sequenced. Moreover, it is a process that is guided by a sequence of learning objectives that reflect the needs of the client and the sociopolitical context of the times.

The process to becoming a competent advocate can be achieved by using the ACSA Survey as a starting point to determining one's strengths and weaknesses as an advocate. The results of the survey can be used to develop accurate and meaningful needs assessments, objectives, design techniques, and evaluation tools that determine advocacy competence at the microlevel, mesolevel, and macrolevel. The four-step process described in this chapter provides guidance to help counselors develop advocacy competence.

References

Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education and Supervision, 50*, 82–87.

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. (2002). *ACA advocacy competencies.* Retrieved from http://www.counseling.org/docs/competencies/advocacy_competencies.pdf?sfvrsn=3

Ratts, M. J., D'Andrea, M., & Arredondo, P. (2004). Social justice counseling: "Fifth force" in field. *Counseling Today, 47*, 28–30.

Ratts, M. J., DeKruyf, L., & Chen-Hayes, S. F. (2007). The ACA Advocacy Competencies: A social justice advocacy framework for professional school counselors. *Professional School Counseling, 11*, 90–97.

Ratts, M. J., & Ford, A. (2010). Advocacy Competencies Self-Assessment Survey: A tool for measuring advocacy competence. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (pp. 21–26). Alexandria, VA: American Counseling Association.

Ratts, M. J., Toporek, R. L., & Lewis, J. A. (Eds.). (2010). *ACA advocacy competencies: A social justice framework for counselors*. Alexandria, VA: American Counseling Association.

Toporek, R. L., Lewis, J. A., & Ratts, M. J. (2010). The ACA advocacy competencies: An overview. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (pp. 11–20). Alexandria, VA: American Counseling Association.

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

Appendix 8.1 • **Advocacy Competencies Self-Assessment (ACSA) Survey©**

Directions: To assess your own competence and effectiveness as a social change agent, respond to the following statements as honestly and accurately as possible. See page 115 for scoring.

Statements	Almost Always	Sometimes	Almost Never
1. It is difficult for me to identify client's strengths and resources.			
2. I am comfortable with negotiating for relevant services on behalf of client/students.			
3. I alert community or school groups with concerns that I become aware of through my work with clients/students.			
4. I use data to demonstrate urgency for systemic change.			
5. I prepare written and multimedia materials that demonstrate how environmental barriers contribute to client/student development.			
6. I distinguish when problems need to be resolved through social advocacy.			
7. It is difficult for me to identify whether social, political and economic conditions affect client/student development.			
8. I am skilled at helping clients/students gain access to needed resources.			
9. I develop alliances with groups working for social change.			
10. I am able to analyze the sources of political power and social systems that influence client/student development.			
11. I am able to communicate in ways that are ethical and appropriate when taking on issues of oppression in public.			
12. I seek out and join with potential allies to confront oppression.			
13. I find it difficult to recognize when client/student concerns reflect responses to systemic oppression.			
14. I am able to identify barriers that impede the well-being of individuals and vulnerable groups.			
15. I identify strengths and resources that community members bring to the process of systems change.			
16. I am comfortable developing an action plan to make systems changes.			
17. I disseminate information about oppression to media outlets.			
18. I support existing alliances and movements for social change.			
19. I help clients/students identify external barriers that affect their development.			
20. I am comfortable with developing a plan of action to confront barriers that impact clients/students.			
21. I assess my effectiveness when interacting with community and school groups.			
22. I am able to recognize and deal with resistance when involved with systems advocacy.			
23. I am able to identify and collaborate with other professionals who are involved with disseminating public information.			
24. I collaborate with allies in using data to promote social change.			

(Continued)

Appendix 8.1 • **Advocacy Competencies Self-Assessment (ACSA) Survey©**

Statements *(Continued)*	**Almost Always**	**Sometimes**	**Almost Never**
25. I assist clients/students with developing self-advocacy skills.			
26. I am able to identify allies who can help confront barriers that impact client/student development.			
27. I am comfortable collaborating with groups of varying size and backgrounds to make systems change.			
28. I assess the effectiveness of my advocacy efforts on systems and its constituents.			
29. I assess the influence of my efforts to awaken the general public about oppressive barriers that impact clients/students.			
30. I lobby legislators and policymakers to create social change.			

Directions for scoring: **Score numbers 1, 7, and 13 first**, and then record the score next to the corresponding number below:

Almost Never = 4 points Sometimes = 2 points Almost Always = 0 points

Then score the remaining items by recording the score next to the appropriate number.

Almost Always = 4 points Sometimes = 2 points Almost Never = 0 points

Total the number of points earned for each domain. Then, add the total score earned for the 6 domains below to determine your multicultural competence rating.

Domain 1: Client/Student Empowerment
1. _____
7. _____
13. _____
19. _____
25. _____

Total: _____

Domain 2: Community Collaboration
3. _____
9. _____
15. _____
21. _____
27. _____

Total: _____

Domain 3: Public Information
5. _____
11. _____
17. _____
23. _____
29. _____

Total: _____

Domain 4: Client/Student Advocacy
2. _____
8. _____
14. _____
20. _____
26. _____

Total: _____

Domain 5: Systems Advocacy
4. _____
10. _____
16. _____
22. _____
28. _____

Total: _____

Domain 6: Social/Political Advocacy
6. _____
12. _____
18. _____
24. _____
30. _____

Total: _____

Scoring: indicates

100–120 points You're on the way to becoming a strong and effective social change agent.

70–99 points You've got some of the pieces in place. However, you need to do some work to develop your competence in specific advocacy areas in order to be an effective social change agent.

69 points or less If you earn low scores in certain advocacy domains (e.g., client/student empowerment, systems advocacy), obtaining training in these areas can greatly improve your effectiveness as a social justice counseling advocate. If being an advocate at the client/student level is a low area, you can expand your repertoire by familiarizing yourself with feminist counseling principles and multicultural counseling competencies. If, however, low scores are in a majority of domains you may want to reconsider your commitment to being a social justice advocate.

Note. From M. J. Ratts & A. Ford, "Advocacy Competencies Self-Assessment Survey: A Tool for Measuring Advocacy Competence," 2010, in M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA Advocacy Competencies: A Social Justice Framework for Counselors* (pp. 249–251). Copyright 2010 by American Counseling Association.

Chapter 9

Addressing Resistance and Gaining Buy-In for Multiculturalism and Social Justice

Many agree that multiculturalism and social justice are important and necessary approaches in counseling and psychology. Yet fully integrating multiculturalism and social justice into all facets of the counseling profession remains a challenge (Chang, Crethar, & Ratts, 2010). Despite calls advocating the need for change, both multicultural and social justice perspectives continue to be on the margins rather than at the center of counselor training, research, theories, and practices. Part of the difficulty with fully integrating multiculturalism and social justice into counseling and psychology is that it shakes up the social order of things. Multicultural and social justice counseling questions the core principles of counseling and psychology. For example, being apolitical is the prevailing belief inherent within predominant counseling theories. However, multicultural and social justice counseling defines counseling as a sociopolitical process.

Multicultural and social justice counseling perspectives are divisive topics in the field. Both proponents and naysayers of the multicultural and social justice perspective are equally passionate in their convictions. Staunch advocates of tradition do not see a need for change (Canfield, 2008; Hunsaker, 2008). They argue that multiculturalism and social justice have no place in counseling and psychology because they are political and border on social work practice.

Within any profession or discipline, it is not uncommon for new paradigms, theories, and ways of practices to be met with mixed reactions. Ratts and Wood (2011) observed that "challenging a profession to break old habits and adopt new ideas and ways of practicing is difficult" (p. 208). Some people are quick to try out new ideas; others are more hesitant and need additional time and data before adopting new ideas and different ways of doing things; and many are so entrenched in tradition that they are unable to even hear about new ideas.

Change is generally difficult to embrace, particularly when a new idea or way of doing things such as multiculturalism and social justice is controversial. The struggle for many multicultural and social justice advocates is gaining buy-in when there is resistance to change. Ardent supporters of multiculturalism and social justice often say their calls for change are unheeded. Rogers (2003) added:

> Getting a new idea adopted, even when it has obvious advantages, is difficult. Many innovations require a lengthy period of many years from the time when they become available to the time when they are widely adopted. Therefore, a common problem for many individuals and organizations is how to speed up the rate of diffusion of an innovation. (p. 1)

Though not new ideas, multiculturalism and social justice have yet to gain traction in counseling and psychology in part because of the lack of attention on how to promote them throughout the field. Most of the counseling literature tends to focus on what multicultural and social justice counseling is and its application. The counseling literature does not address how to introduce multiculturalism and social justice to others, how to promote them within an organization, and how to effectively address resistance when attempting to integrate them into all facets of the counseling profession. This explains the gap between multicultural and social justice rhetoric and practice. Thus, gaining buy-in is the challenge for many multicultural and social justice counselor educators, practitioners, and researchers.

This chapter explores resistance to multiculturalism and social justice. We also introduce readers to diffusion of innovation as a framework for gaining buy-in for multicultural and social justice initiatives. Understanding potential pitfalls and how to gain buy-in for multiculturalism and social justice can go a long way in preventing burnout.

Resistance to Multiculturalism and Social Justice

People have a wide range of emotions and opinions when it comes to integrating multiculturalism and social justice into the counseling profession. Some favor it, some do not, and some are undecided. In the classroom, Griffin and Ouellett (2007) identified four types of reactions from individuals during discussions of social justice issues: dissonance, anger, immobilization, and conversion. We highlight these reactions because we believe they are also germane to counseling and organizations.

Dissonance

It is not uncommon for people to experience internal conflict when hearing about multiculturalism and social justice for the first time. Their perfect world has been shaken. What was once considered true is now being questioned. Their worldview is not as stable as it once was. Griffin and Ouellett (2007, pp. 107–109) argued that dissonance is experienced by both dominant and target group members in various ways. We include those listed that are applicable to counseling, with bracketed text denoting the substitution of terms:

- Claim that the status quo is part of a "natural order",
- Invalidation of targeted group members' experience,
- Protection of [dominant] group members by targeted group members,
- [Dominant] group members' need to have own pain and hurt recognized ,
- [Dominant] group members focus on an identity in which they are members of the targeted group,
- Invalidation of the [change agent],
- Anecdote raised to the status of generalized fact, and
- Hostile silence.

Anger

Some people may experience anger when being introduced to issues of multiculturalism and social justice (Griffin & Ouellett, 2007). Dominant group members' anger may stem from realizing that they had been lied to their entire life about the merits of hard work as they realize how they benefit from their social group status. Target group members are angry at the injustice they, and other oppressed groups, experience on a daily basis. Both may become angry when others are resistant to multiculturalism and social justice.

Immobilization

Some may feel powerless because social justice issues overwhelm them. To lower their anxiety level, such individuals often do nothing. This helpless and powerless feeling often leads people to avoid discussions about multicultural and social justice issues. Other reactions include fear of being called a bigot, guilt experienced by dominant group members because of their unearned privilege, belief that oppressors include only those who are extremists, and inability to see one's own privileged status (Griffin & Ouellett, 2007).

Conversion

Some may become converts of multiculturalism and social justice without adequate reflection. Such individuals may be so zealous about their beliefs that others cannot talk to them. Some may become the "PC police" in conversations and interactions. Target group members sometimes act as the experts and use the opportunity to threaten individuals from dominant groups when discussions of multiculturalism and social justice occur (Griffin & Ouellett, 2007).

Individual resistance to multiculturalism and social justice can lead to organizational resistance. In a review of Kast and Rosenzweig (1974), Ratts and Wood (2011) identified four conditions that contribute to organizational resistance to change: threats to balance of power, risks of sunken costs, miscommunication of the need for change, and tradition. These conditions can slow multicultural and social justice efforts because they can make change agents hesitant to pursue change.

Diffusion of Innovation

Most counseling professionals have some understanding of multiculturalism and social justice. Yet, a common struggle among counseling professionals is how to gain buy-in for the multicultural and social justice perspectives. This struggle arises in part because counselors are not familiar with the manner in which innovations spread within an organization. Counselors lack familiarity with the various roles people play in organizations. They are not acquainted with the process through which individuals come to adopt new ideas. They do not know how to introduce a divisive topic such as multiculturalism and social justice to others without raising barriers. They are not familiar with the ways in which new ideas are communicated among members of an organization. Moreover, they tend to be unfamiliar with how long it takes for people and organizations to make decisions and adopt new ideas.

Diffusion of innovation theory can help people address many of the challenges they experience when they attempt to gain buy-in and spread an innovation such as multiculturalism and social justice within an organization. Diffusion of innovation is a theory that describes how, why, and at what rate innovations become adopted and spread through an organization (Rogers, 2003). Rogers, one of the foremost researchers on diffusion of innovation theory, helped popularize this concept (Murray, 2008). His book *Diffusion of Innovation*, which synthesized more than 508 studies on diffusion theory from various disciplines, led to the refinement of diffusion theory and a detailed description of how individuals and organizations come to adopt innovations.

Rogers (2003) believed that all organizations, no matter what size, tend to go through a predictable process in their adoption of innovation. Rogers made distinctions between the concepts *diffusion* and *adoption* in his diffusion of innovation theory. *Adoption* refers to the stages that individuals go through when they first hear about an innovation to eventually adopting it.

Diffusion is a process in which groups or organizations come to buy into a new idea or concept. Both are interrelated and are key to understanding diffusion of innovation theory.

Elements of Diffusion of Innovation

According to Rogers (2003), there are four key elements to understanding diffusion of innovation theory:

- *Innovation* is an idea or practice that is new or new to the person or individual hearing about it (even if it has existed for a long time).
- *Communication channels* refers to how new ideas are communicated from one person to another. Rogers (2003) believed that communication occurs either through mass media channels or interpersonally. Innovations can be shared through such mass media outlets as the Internet, radio, Listservs, television, and print. *Interpersonal communication* refers to communication between individuals and involves face-to-face contact. How an innovation is communicated is important; most people make a decision on whether to adopt an innovation on the basis of communication from other individuals like themselves rather than relying on research to make a decision (Rogers, 2003).
- *Time* refers to the time it takes from when an innovation is heard to when it becomes adopted or rejected by an individual or organization.
- *Social system* refers to the organization through which innovations spread, such as schools, colleges, mental health agencies, businesses, and communities. Factors that influence the spread of an innovation include (a) an organization's structure (knowing whether organizational decisions are made as a collective, where adoption of an innovation is made by a group, or by a select few individuals, which is referred to as the *authority-innovation decision process*), (b) established norms within an organization (the written and unwritten as well as overt and covert norms that are tolerable within an organization), (c) opinion leaders (people who are well respected by others in the organization and whose input is highly valued regardless of the title they hold) and change agents (individuals who introduce new ideas to an organization).

These four elements provide a framework that can help diffuse anxieties that come with integrating multicultural and social justice ideas into an organization. Moreover, these elements speak to the importance of developing patience, collaboration, and a well-thought-out strategy.

Stages of the Adoption Process

Rogers (2003) believed that innovations are diffused through a five-step decision-making process that occurs over a period of time among members of a social system.

1. Individuals are introduced to an innovation for the first time; they have no prior knowledge of the innovation and no real opinion about it. (Knowledge)
2. The innovation advocate uses interpersonal communication skills to persuade people to form an opinion about an innovation. (Persuasion)
3. Individuals will either make a decision to adopt the innovation or reject it based on weighing out the pros and cons of the practicality of the new idea or practice. (Decision)
4. Individuals integrate the innovation to varying degrees in their practice and organization and form an opinion of its usefulness. (Implementation)
5. Individuals will decide to either continue with the innovation or new practice or reject it. (Confirmation)

Adoption Rate

A common concern among multicultural and social justice advocates is how to gain buy-in quickly from individuals and organizations. When people advocate for multicultural and social justice changes, they want others to be just as passionate about it as they are and to adopt it quickly. Sometimes this passion can be counterproductive; one's passion for multicultural and social justice might affect the ability to develop a coherent strategy for gaining buy-in.

Rogers (2003) identified five factors that can speed up the rate of innovation adoption. These five factors influence whether people adopt or reject an idea. Multicultural and social justice advocates would do well to consider these five factors when communicating innovations to other individuals and organizations.

- *Relative advantage.* Discussing the benefits of an innovation can help garner support and buy-in from individuals and organizations. Questions such as "What's in it for me?" and "How will it benefit clients?" are not uncommon when an innovation is shared with others. Individuals and organizations are apt to buy into an innovation if they see how it benefits them and those they serve.
- *Compatibility.* Identifying how an innovation fits into an organization's existing structure can help alleviate concerns about new ideas and practices. Being able to integrate an innovation into an organization's existing structure is less scary than restructuring an entire organization.
- *Complexity or simplicity.* Individuals are less likely to buy into an innovation if it sounds too complicated. Therefore, knowing when and how much information to share is important.
- *Trialability.* People are less resistant to an innovation if they know that they can test it out before adopting it. Suggesting that individuals adopt an innovation on a trial basis (do a test drive, in effect) is likely to facilitate more buy-in than recommending that they make a permanent change.
- *Observability.* Being able to see how an innovation works helps make it more concrete. When people see the benefits of an innovation, they are likely to adopt it. Using data and research is an excellent way to demonstrate the pros and cons of an innovation.

Adopter Categories

Rogers (2003) identified five roles people tend to play in organizations, no matter how small or large the organization, that influence diffusion of an innovation.

- *Innovators* are individuals who are quick to adopt an innovation. They are open to taking risks and also tend to be the youngest in age among the adopter categories.
- *Early adopters* are individuals who have social capital within an organization. People value their input because they are respected among the group. Early adopters are the second fastest to adopt an innovation.
- *Early majority* individuals are more deliberate in their decision making, and so they may take longer to adopt an innovation. They seldom hold positions of opinion leadership within a group. Such individuals are less likely to take the lead in adopting an innovation. They also do not want to be perceived as resistant to an innovation.
- *Late majority* people are skeptical about the value of innovations and change. They are likely to adopt an innovation because of peer pressure after the average member of the group is in favor of it.

- *Laggards* are individuals who highly value tradition and therefore are the last to adopt an innovation. People in this category have no opinion leadership and tend to be older compared with other adopter categories.

The various adopter categories are all important roles within any organization. It may be easy to ignore the laggards within an organization. However, they too offer a rich perspective. Many laggards have a rich understanding of an organization's history that is valuable when attempting to make changes to an organization's structure. Building relationships with individuals across all adopter categories is important.

Understanding the needs of individuals from different adopter categories is important to the diffusion of an innovation. How change agents approach an early majority person will differ from how they work with late majority persons. Because innovators are likely to buy into an innovation, it may be good strategy to approach them first. Gaining the support of an innovator can help build movement toward the diffusion of an innovation. Gaining the respect of early adopters can help influence them to adopt an innovation, which in turn can lead others to buy into the new idea as well (because early adopters are well respected). Patience and face-to-face meetings may help early adopters buy into an innovation. Offering to identify the pros and cons of an innovation to early majority individuals can go a long way in gaining buy-in. In contrast, late majority individuals, who buy into a new idea out of pressure from peers, may be approached later once a critical mass has been established. Laggards bring a different perspective and thus require different attention. It would be important to acknowledge the perspective of laggards on the innovation and identify ways they can become a part of the solution. Excluding them may mean the delay of an innovation.

Conclusion

Merely possessing knowledge about multiculturalism and social justice is not sufficient in making transformative changes in counseling and psychology. We also believe it is insufficient if multicultural and social justice initiatives are being implemented by one individual within an organization or professional community. Greater impact can be felt when buy-in occurs from all members of an organization or profession.

Garnering support for multicultural and social justice from an entire profession is difficult, especially in a field that is steeped in tradition such as counseling and psychology. Change is slow and does not come easily when a new idea or practice challenges the existing structure of an organization. Thus, knowing the process by which innovations become adopted by individuals and organizations is critical to creating long-lasting multicultural and social justice changes. We believe that the diffusion of innovation theory developed by Rogers (2003) can help counselors address this challenge.

The next section of the book examines the different ways that counselors can work with clients on the individual and systems scale across various client populations. We invited experts in the field who are the best in their respective areas to write application chapters focused on counseling from a multicultural and social justice framework with a specific oppressed group. Each of the application chapters provides a historical overview of the group, identifies key multicultural concepts and systemic barriers to counseling, and offers a case study to help readers operationalize multicultural and social justice counseling tenets. Examples of individual counseling and advocacy counseling are offered for each client group discussed.

References

Canfield, B. S. (2008). Together, we make a difference. *Counseling Today, 50*, 5.

Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education and Supervision, 50*, 82–87.

Griffin, P., & Ouellett, M. L. (2007). Facilitating social justice education courses. In M. Adams, L. A. Bell, & P. Griffin (Eds.), *Teaching for diversity and social justice* (2nd ed., pp. 89–113). New York, NY: Routledge.

Hunsaker, R. (2008). Social justice: An inconvenient irony. *Counseling Today, 50*, pp. 21, 43.

Kast, F. Z., & Rosenzweig, J. E. (1974). *Organizational and management: A systems approach* (2nd ed.). New York, NY: McGraw-Hill.

Murray, C. E. (2008). Diffusion of innovation theory: A bridge for the research–practice gap. *Journal of Counseling & Development, 87*, 108–116.

Ratts, M. J., & Wood, C. (2011). The fierce urgency of now: Diffusion of innovation as a mechanism to integrate social justice in counselor education. *Counselor Education and Supervision, 50*, 207–223.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York, NY: Free Press.

Section III.

Addressing Individual and Systemic Oppression

Chapter 10

Counseling Clients From Asian and Pacific Island Heritages

Catherine Y. Chang, C. Peeper McDonald, and Caroline O'Hara

Asian American and Native Hawaiian and Other Pacific Islander (AANHPI) individuals are the fastest growing ethnic group in the United States (Humes, Jones, & Ramirez, 2011). Often represented as one homogeneous group, they represent more than 40 disparate and diverse cultural groups that vary in language, cultural and religious practices, immigration history, levels of acculturation, ethnic identity, and socioeconomic status (Chang & O'Hara, 2013). Professional counselors working with this cultural group should recognize the variability within the group. In this chapter, we provide an overview of the group, discuss the key multicultural concepts and characteristics of AANHPI individuals, explore the systemic barriers that they encounter, and provide recommendations at the microlevel and the macrolevel for working effectively with them. We conclude this chapter with an exploration of future directions for this diverse cultural group.

Overview of the AANHPI Group

Asian Americans are a diverse group of people whose origins are from the Far East (e.g., China, Korea, Japan), Southeast Asia (e.g., Cambodia, Philippine Islands), or the Indian subcontinent (e.g., India, Nepal, Pakistan). *Pacific Islanders* refers to individuals whose origins are in Hawaii, Guam, Samoa, or other Pacific Islands. Historically, Asians and Native Hawaiian and Other Pacific Islanders have been grouped together by government classifications (i.e., 2000 U.S. census) and by many organizations as an intentional strategy to build coalitions (Dabby, 2007). Although some have argued that grouping Asian Americans with Native Hawaiian and Other Pacific Islanders together does not accurately reflect the diversity and complexity or the challenges of this heterogeneous group (Ponce et al., 2009), for the purpose of this chapter we have decided that grouping Asian Americans and Native Hawaiian and Other Pacific Islanders together provides voice for the latter two groups, which are often neglected because of their limited numbers. Whenever available, we present information for both Asian Americans and for the Native Hawaiian and Other Pacific Islanders. We use the terms *Native Hawaiian* and *Other Pacific Islander* for consistency with the 1997 Office of Management and Budget directive that separated the Asian or Pacific Islander racial group into these two categories (U.S. Department of Commerce, 2012).

According to the 2010 census, approximately 17.3 million people (or 5.6% of the U.S. population) identified as Asian either alone or in combination with one or more races. This represents an increase of 45.6% when compared to the 2000 census. Of this total, 14.7 million (4.8% of the total population) identified as Asian alone, and 540,013 individuals (0.2% of the total population) identified as Native Hawaiian and Other Pacific Islander alone, reflecting an increase of more than one third. This dramatic increase in the AANHPI group is remarkable when compared to the 9.7% increase in the total U.S. population (Hoeffel, Rastogi, Kim, & Shahid, 2012).

The median income for those who indicated single-race Asian in 2010 was $67,022, whereas the median income for Native Hawaiian and Other Pacific Islander alone was $52,775. The poverty rate was 12% for those identifying as Asian only and 18.8% for Native Hawaiian and Other Pacific Islanders; the U.S. average was 12%. Fifty percent of single-race Asians and 15% of Native Hawaiians and Other Pacific Islanders aged 25 and older have a bachelor's degree or higher level of education compared with 28% for all Americans aged 25 and older. Twenty percent of single-race Asians and 4% of Native Hawaiian and Other Pacific Islanders alone reported having a graduate or professional degree compared with 10% for all Americans aged 25 and older (U.S. Department of Commerce, 2012; White House Initiative on Asian Americans and Pacific Islanders, n.d.).

There exists variability in language spoken among Asian American subgroups. More than 75% of Asians spoke a language other than English at home. More than 39 distinct Pacific Islander languages are spoken in the United States. Many subgroups of AANHPI have a higher percentage of people with limited English proficiency compared with other groups. About 38% of Asians do not speak English fluently, and 14% of Native Hawaiians and Pacific Islanders have limited English proficiency compared with 9% of the general U.S. population (Ponce et al., 2009; U.S. Department of Commerce, 2012; White House Initiative on Asian Americans and Pacific Islanders, n.d.). According to Africa and Carrasco (2011), approximately 66% of Asian American individuals speak their native language at home, and about 35% are linguistically isolated. After English and Spanish, Chinese is the most commonly spoken language in the United States. In fact, 2.8 million people age 5 and older spoke Chinese at home; at home Korean, Vietnamese, and Tagalog are spoken by more than 1 million each (U.S. Department of Commerce, 2012; White House Initiative on Asian Americans and Pacific Islanders, n.d.). Although many AANHPI speak their native language, most U.S. clinicians do not speak an Asian language; therefore, AANHPI clients may require a translator to receive effective treatment. Even if AANHPI clients speak English, vital information and constructs are often missed when they do not speak their native language; experiences that occur while using their native language may be encoded in memories specific to that language and difficult to communicate in English (Chang & O'Hara, 2013; Ivey, Ivey, & Zalaquett, 2010).

Clearly, within the AANHPI population there is a great deal of diversity; however, there also exists some commonalities among members of this group. To understand the growing AANHPI population, it is important to understand the history of the group. In the following section, we provide a brief history of the group and then discuss current experiences that affect the well-being of AANHPI individuals.

History of the Group

Most AANHPI individuals have a history of immigration and discrimination in the United States. AANHPI groups have experienced government-sanctioned discrimination including anti-miscegenation codes, housing restrictions, ethnic-specific business taxes, and anti-

naturalization and anti-immigration laws (Inman & Alvarez, 2010). One of the most blatant and horrifying examples was the incarceration of more than 120,000 Japanese Americans in internment camps in 1942 by the U.S. government (Chan, 1991; Inman & Alvarez, 2010).

AANHPI individuals constitute about one third of the total legal immigrants who enter the United States yearly (McCabe & Meissner, 2010), and approximately two thirds of AANHPI residents are foreign born. U.S. immigration laws such as the Chinese Exclusion Act of 1882, the Gentlemen's Agreement of 1908 with Japan, the Immigration Act of 1917, and the Tydings-McDuffie Act of 1934 have all restricted immigration from specific Asian countries. Additionally, like other ethnic minorities AANHPI individuals have been subjected to anti-miscegenation codes, which prevented intermarriage of individuals from different races. In practice, anti-miscegenation laws prevented the marriage between Whites and non-Whites (Browning, 1951). The *Loving v. Virginia* (1967) case was a landmark civil rights victory when the U.S. Supreme Court ruled against laws prohibiting interracial marriages.

In addition to anti-immigration and anti-miscegenation laws, AANHPI individuals experience racism at the institutional and individual levels. Institutional racism includes "English-only" language initiatives, income discrepancies (with Asians making significantly less than Whites with comparable education levels), and underrepresentation of Asians in administrative and managerial positions (U.S. Commission on Civil Rights, 1992). Examples of individual racism include verbal and physical assaults, racial slurs, and vandalism (Inman & Alvarez, 2010). According to the U.S. Department of Justice (2011), 47.3% of single-bias incidents of hate crimes in 2010 were racially motivated, and of these, 5.1% had an anti-Asian or Pacific Islander bias. Most disturbing about the hate crimes against AANHPI individuals is that many of these hate crimes are perpetuated against AANHPI children by other children (Altaffer, 2005).

AANHPI individuals face several challenges because of their immigration history and experiences with discrimination. In the next section, we discuss the impact of immigration, oppression, and discrimination on the mental health of AANHPI individuals.

Current Experiences

Asian American and Pacific Islander immigrants face emotional strain as they experience a new economic system and culture, economic decline, gender role and generation conflicts, and language difficulties. One major difference between the AANHPI immigrant population and nonimmigrant population is the emotional strain that immigrants often undergo because of the stress that accompanies acculturation (Chang & O'Hara, 2013). AANHPI immigrants may also experience feelings of loneliness from being separated from friends, family, and country of origin (Akhtar & Choi, 2004; Yu & Nguyen, 2012). The experience of refugees even further delineates this population because of the potential for feelings of guilt at leaving others behind.

Experiences of discrimination have an impact on the mental health of marginalized groups, including individuals from AANHPI heritages. Discriminatory experiences can expose individuals to chronic stressors and challenges, which can compromise their wellness, making them more vulnerable to depression, suicide, substance abuse, violence, anxiety, chronic stress, and acute stress (U.S. Department of Health and Human Services, 2001). Professional counselors are uniquely positioned to advocate for and with AANHPI individuals in a number of capacities to break down barriers to wellness.

AANHPI individuals experience a myriad of mental health issues that warrant attention, including suicide, substance abuse, gambling, and family violence. Asian American girls report the highest rates of depressive symptoms of any racial, ethnic, or gender groups. Asian American women (15 to 24 years old) die from suicide at a higher rate than other racial or

ethnic groups, and older Asian American women have the highest suicide rate for all women over 65. Suicide is the fifth leading cause of death among Asian Americans compared with ninth for White Americans. Foreign-born Asian Americans have higher rates of suicide when compared with American-born Asian Americans (Africa & Carrasco, 2011). Asian American college students report higher levels of depressive symptoms than White students, and Asian American adolescent boys experience great physical abuse (Africa & Carrasco, 2011).

AANHPI groups vary greatly in their substance use: Japanese Americans report the highest prevalence rate of alcohol use (62.1%) and individuals from the Philippines report the lowest prevalence rate (24.1%). Substance abuse disorders vary by generational status, with second- and third-generation Asian women at a higher risk of substance abuse compared with first-generation Asian women. Although AANHPI individuals are less likely than persons of other ethnic and cultural groups to need substance abuse treatment, they are also less likely to receive specialty treatment for substance abuse. As this population continues to grow, the need for specialty treatment that addresses the needs of the AANHPI population becomes more important (Substance Abuse and Mental Health Services Administration, 2013).

Intimate partner violence is a growing concern within the AANHPI population (Cho, 2012). Asian Americans were excluded from many reports on intimate partner violence, mainly because of the small number of reported cases. However, according to Dabby (2007), 41–60% of Asian women report experiencing intimate partner violence during their lifetimes. The challenge with these national studies is that most consider Asian Americans as a homogenous group with no recognition of the ethnic subgroups. Cho (2012) studied intimate partner violence within three Asian American subgroups (Chinese, Vietnamese, and Filipino) and found that prevalence rates varied greatly by ethnic group, with Vietnamese Americans reporting the least severe intimate partner violence and Chinese Americans reporting the lowest prevalence rate of severe intimate partner violence. U.S.-born Asian Americans were at a higher risk for intimate partner violence compared with their foreign-born counterparts. Clearly, there is a need for more studies that explore intimate partner violence in the AANHPI group with consideration for the subgroups within that population.

AANHPI individuals experience barriers to effective mental health treatment that result in low utilization of mental health services. When compared with all ethnic groups, AANHPI individuals are the least likely to seek out mental health treatment although their rates of psychological distress are comparable to those of the general public. AANHPI groups are less likely to seek out mental health services because of cultural issues (e.g., shame and stigma associated with seeking mental health services, lack of bicultural and bilingual providers, and the differing manner in which AANHPI individuals express psychological and psychiatric distress such as somatization of symptoms; Africa & Carrasco, 2011; Chang & O'Hara, 2013; U. S. Department of Health and Human Services, 2001). AANHPI clients delay seeking treatment because of stigma and cultural and linguistic barriers to mental health access; by the time they do seek out mental health services, they display more severe symptoms compared with clients from other groups (American Psychiatric Association, 2007). Because cultural background affects the mental health of AANHPI individuals and their utilization of mental health services, it is essential for professional counselors to be multiculturally competent.

Key Multicultural Concepts and Characteristics

Key Multicultural Concepts

A multiculturally competent counselor is one who values cultural diversity and recognizes the important role that culture plays in the mental health of clients and the counseling

process. Recognizing the importance of multiculturalism in counseling, Sue, Arredondo, and McDavis (1992) proposed a set of multicultural counseling competencies (MCC) and standards. The MCC include 31 professional competencies across three dimensions: beliefs and attitudes, knowledge, and skills. Professional counselors who are multiculturally competent have an awareness of their own cultural values and biases; they are knowledgeable of the worldview of their culturally different client; and they implement culturally appropriate interventions (Sue et al., 1992). Arredondo et al. (1996) operationalized these standards and expanded the scope of multicultural counseling competence to include diverse cultural groups (e.g., religion, sexual identity, ability status) and consideration for historical, political, sociocultural, and economic contexts in understanding self and clients.

As with other cultural groups, professional counselors working with AANHPI clients must be mindful of the important role that culture has on the well-being of their AANHPI clients as well as how their own cultural background affects their conceptualization of the clients, their working alliance, and their implementation of counseling interventions. To this end, it is essential that professional counselors reflect on their understanding of the AANHPI cultures and any biases they may have regarding those cultures. It is also important that professional counselors develop a working understanding about what it means to be a member of the AANHPI culture today. It is vital that professional counselors understand the difference between being culturally tolerant and being culturally responsive. Numerous studies with AANHPI clients reveal that counselor competence ratings improve when the counselor uses multicultural interventions as opposed to simply building the working alliance without culturally informed interventions (Wang & Kim, 2010; Zhang & Dixon, 2001).

Key Cultural Characteristics

Although there are distinctions among AANHPI subgroups, they share some core cultural values that are foundational to understanding this cultural group (Chang & O'Hara, 2013; Kim, Ng, & Ahn, 2009; Sue & Sue, 2013). We caution against stereotyping based on these cultural values and urge readers to recall that cultural values are influenced by acculturation levels, ethnic identity, and immigration status (Chang & O'Hara, 2013). The following cultural values appear salient across many Asian subgroups: conformity to norms, emotional self-control, family recognition through achievement, collectivism, hierarchical relationships, and humility (Chang & O'Hara, 2013; Kim, Ng, & Ahn, 2005; Miville & Constantine, 2007). These core cultural values can be grouped into two main categories: (a) group and family values and (b) communication and emotional expression (Chang, 2012).

Asian cultures value interpersonal harmony and therefore work toward conformity to the norm as well as practice emotional self-control so as not to offend others. Many AANHPI individuals practice silence and deference to avoid conflict and bringing shame on others (Chang & O'Hara, 2013). Academic achievement and formal education are greatly emphasized in AANHPI cultures. According to Inman and Alvarez (2010), academic achievement brings honor and prestige to the family. In collectivist societies, the needs of the group or the family have a greater priority than the individual's needs, wants, and desires. Interdependence versus independence is emphasized. For many AANHPI individuals, their identity is tied to their families; therefore, they may place their family needs ahead of their own needs (humility), and the whole family feels pride and grace collectively (Chang & O'Hara, 2013).

Given the importance of one's cultural values on the mental health of AANHPI clients, it is important to consider the relationship between one's cultural background and various mental health considerations. In a study by Atkinson, Kim, and Caldwell (1998), Asian American students preferred therapists who practice from the consultant role and from

the role as facilitator of indigenous support systems. When these clients shared a common worldview with their therapist clinicians, they reported a stronger working alliance, rated their therapist clinician as having more empathy, and reported more positive session outcomes than did clients whose therapists did not share their worldview (Kim et al., 2005, 2009; Wang & Kim, 2010). Additionally, Asian Americans clients who reported higher emotional self-control gave lower scores to their counseling process (Wang & Kim, 2010).

Systemic Barriers

AANHPI individuals face challenges as a result of several systemic barriers to treatment, including the mental health system and discriminatory immigration laws and policies. Many of the systemic barriers that AANHPI individuals face were highlighted in the previous sections. In this section we outline some recommendations for challenging the systemic barriers that hinder the well-being of AANHPI individuals.

- AANHPI individuals are a diverse group, and researchers and agencies studying this group are encouraged to explore the subgroups within this larger population (Africa & Carrasco, 2011; Cho, 2012).
- The mental health service system needs to develop strategies for increasing access and quality of care for AANHPI clients. Some recommendations include understanding the pivotal role that cultural values have on the mental health and help-seeking behaviors of AANHPI individuals. Additionally, it is important to understand the impact of discrimination, immigration history, and language on the well-being of AANHPI individuals (Africa & Carrasco, 2011).
- Intimate partner violence is a concern for AANHPI women, but they often have limited access to law enforcement and social services because of language barriers and racism. Education about intimate partner violence within the AANHPI community should be distributed not only to the AANHPI community but also to law enforcement and social services; they need to be aware of the cultural implications of intimate partner violence within this community and work to develop culturally relevant interventions (Dabby, 2007; Warrier, 2011).
- Asian Americans have the highest proportion of foreign-born members of all racial groups and are subject to issues faced by a broken immigration system. The immigration system affects new AANHPI immigrants entering the United States; it also affects them after they arrive, and it affects many who are already here. We as a nation must look toward a comprehensive immigration reform (see Asian Pacific American Legal Center [APALC] & Asian American Justice Center [AAJC], 2011).

Personal Voices
Mi Sun: A Case Study

Mi Sun is a 20-year-old Korean American female in her third year of college. Her parents moved to the United States in their twenties after getting married, and Mi Sun is their only child. She was born in the United States and has lived there her entire life. Throughout the session she constantly touched the right side of her face where a large scar spanned the length of her cheek. Mi Sun reported that she was in counseling because 6 months ago she was brutally attacked as she was walking to her car after class. Although she was somewhat vague, there was the hint that her attacker might be someone she knew well. She mentioned that she thought she was "doing okay with it," but her parents had been

pressuring her to speak to their church minister about everything that happened especially since her grades were starting to slip. Mi Sun reported, "I didn't feel comfortable going to my parents' minister so when my best friend told me that she noticed a difference in my personality lately and suggested I go to counseling, I decided to try it."

She commented, "I guess I have been spending more time by myself, but it's because I always feel so drained and tired. Everyday tasks take a lot out of me so I don't go out of my way to have fun anymore, and sometimes I forget to eat." Somewhat tentatively, Mi Sun reported that her parents only know that she was attacked. "They do not know about the rape . . . [*long pause*] or the abortion that I had to have because of it." When asked, she graciously spelled out her name and then teared up; her name "means beauty and goodness, though it doesn't mean much now."

Key Issues to Consider

The institutional and societal discrimination of the AANHPI population has been well documented (Chang & O'Hara, 2013; Shih, 2010). It is important for professional counselors to recognize the oppressive forces active in the lives of the AANHPI population and to seek out ways in which to advocate with and on behalf of this marginalized community (Kiselica & Robinson, 2001). Advocacy in counseling can take many forms, and the American Counseling Association (ACA) endorses a number of Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2002). These include Client/Student Empowerment, Client/Student Advocacy, Community Collaboration, Systems Advocacy, Public Information, and Social/Political Advocacy. First, we offer key points to consider regarding Mi Sun and her concerns. Then we explore each of the six Advocacy Competency domains in detail as they relate to Mi Sun and other AANHPI clients.

In the case study, Mi Sun freely offered information to the professional counselor about her heritage during the first session. However, if Mi Sun had not offered this information, the counselor would need to ask Mi Sun to give more information about where she was born and grew up to give the counselor a cultural context for her. It is imperative for the counselor not to make assumptions about any AANHPI client's cultural and national roots and to encourage the client to tell his or her story.

It is important for the counselor to assess Mi Sun's symptoms of depression and potential for suicidality. Mi Sun may express depressive symptomatology and reactions to traumatic events in unique ways depending upon various cultural, individual, and familial contexts discussed earlier. In addition, factors related to intimate partner violence should be explored.

As previously mentioned, it is common for AANHPI communities to espouse values of self-control, family recognition through achievement, humility, filial piety, and collectivism (Chang & O'Hara, 2013; Kim et al., 2005; Miville & Constantine, 2007). These values may be expressed in numerous ways: It is possible that there are many motivations for Mi Sun to seek counseling, such as the change in her personality that her friend noticed and her falling grades, about which her parents seem concerned. Perhaps it is more natural to her if she focused on the physical and bodily complaints that have been occurring. Our point is that there are many possibilities. The culturally competent counselor is open to, considerate of, and intentional with these ideas without stereotyping.

The professional counselor should explore Mi Sun's expectation of the counseling relationship and how it may be affected by the perceived gender, culture, and power of the counselor. For example, a counselor who identifies as male or is viewed by the client as the clear authority may be expected to take on a leadership role in the counseling relationship

and generate solutions to Mi Sun's presenting concerns. If there is a nonverbalized disconnect between Mi Sun's expectations and those of the Western counselor, Mi Sun may become frustrated and terminate the counseling relationship prematurely. It is imperative, then, for both the client and the counselor to discuss expectations for counseling and the roles that the culture of both the counselor and the client might play in the counseling process.

Mi Sun made it clear in her initial interview that she went against the wishes of her parents by choosing to see a counselor over her minister. Mi Sun and her counselor may need to spend time exploring what feelings and conflicts arise from that decision. While seeking to explore Mi Sun's concerns, the counselor must also recognize that emotional self-restraint for the purpose of perpetuating relational harmony is not uncommon across many AANHPI cultures (Chang & O'Hara, 2013; Miville & Constantine, 2007; Wang & Kim, 2010). It may be difficult for Mi Sun to even begin to talk about her family, values, and the emotions that accompany the experience of rape and abortion. Mi Sun's counselor needs to be careful not to compare Mi Sun's display of emotions or lack thereof with that of Western displays of emotion just because Mi Sun was born and raised in the United States. Instead, the culturally competent counselor must ask Mi Sun to clarify her values and emotions without forcing her to transcend what is culturally appropriate for her.

Furthermore, Mi Sun may need to explore and reconcile incompatibilities that exist between the values she holds and the values held by her family. Studies have shown that the ability to navigate and negotiate incompatibilities between culture of origin and the client's second culture has led to positive mental health outcomes (M. J. Miller, Yang, Farrell, & Lin, 2011). The counselor who embarks on this journey with Mi Sun must be sensitive and ready to navigate the complex cultural waters of an AANHPI client.

Individual Counseling: Applications at the Microlevel

Client/Student Empowerment begins within the counseling relationship but has macrolevel implications that reach far beyond the four walls of counseling (Kiselica & Robinson, 2001; Lewis et al., 2002). The counselor could facilitate an exploration of Mi Sun's own strengths and resources around her that could aid in her wellness. Empowerment in counseling involves identifying and developing client strengths and encouraging self-advocacy skill-building. Furthermore, the counselor could explore with Mi Sun social, political, economic, and cultural factors that could be affecting and impeding her growth. Mi Sun is a young Korean American female who has struggled financially to go to school full-time. Any of these factors could affect her wellness and growth. Her counselor, then, would process these factors with Mi Sun as well as explore what self-advocacy looks like to her. For example, Mi Sun's faith might be very important to her, but she has been avoiding some religious activities at her place of worship out of a fear of exposing her trauma history. By exploring how to navigate both of these needs in ways that feel safe and appropriate to her, she and her counselor could develop a plan where she could access the faith-based support she wants without jeopardizing her wish to protect herself and her family from unwanted information spreading. The final step would be for her counselor to help her implement a self-advocacy plan.

It appeared that Mi Sun once believed that she possessed the characteristics associated with the literal meaning of her name, but that she no longer believed that her name was indicative of her identity. Perhaps she was struggling to reconcile aborting the pregnancy that resulted from her being raped with the common stereotype that the AANHPI population is the "model minority" (Gupta, Szymanski, & Leong, 2011). The counselor should

help Mi Sun process what cultural values she adheres to and how these might be affecting her view of herself. Gupta et al. (2011) found evidence that as endorsements of the "model minority" increased in the AANHPI sample, the more likely participants were to suffer psychological distress and avoid help-seeking avenues such as counseling. It would be relevant for Mi Sun's counselor to explore the potential impact of the model minority stereotype and other oppressive forces on Mi Sun's view of herself.

Client/Student Advocacy involves the counselor taking on multiple roles, such as negotiator, action planner, and ally (Lewis et al., 2002). This may include, for instance, advocating for Mi Sun's educational needs. In some cases, depending on the diagnosis, students can receive disability accommodations to assist with living arrangements, test taking, course registration, and classroom instruction. It is possible that Mi Sun's counselor could explore and process these options with her to see whether these services might prove useful. Another example could include identifying and securing additional financial resources that could support Mi Sun as she continued her education. By modeling for Mi Sun what advocacy could look like, Mi Sun's counselor could also empower her to carry on and invent new ways to advocate within her system.

Advocacy Counseling: Applications at the Macrolevel

When professional counselors learn about environmental factors that impede client development, they can alert and sometimes facilitate communication about these factors among key community leaders and groups, a process referred to as *community collaboration* (Lewis et al., 2002). In a recent phenomenological study, counselor educators held a community town hall meeting concerning topics of social justice and made the following suggestions for how to mitigate oppression: "1) Stop waiting for permission and just act, 2) Use counselor education classrooms for healing and collective action, 3) Engage others in difficult dialogues, 4) Work in and across coalitions, 5) Draw healing tactics from other nations" (Schaefle, Gates, Malott, Conwill, & Daniels, 2011, p. 197). After counselors meet with the community, the effectiveness and productivity of the interaction should be evaluated.

In the case of Mi Sun, her counselor could work with her to identify AANHPI community leaders and facilitate communication between university leaders and community leaders about the lack of university support for AANHPI students in general. This might lead to the creation or bolstering of AANHPI organizations, scholarships, mentoring, or outreach campaigns that would provide education, support, and counseling options for the distinct and diverse needs of AANHPI clients. If Mi Sun had resources and support that acknowledged the unique experience of AANHPI students at her university, she could potentially find understanding and direction concerning her feelings of being torn between what her parents want and what she wants in terms of getting help after her attack.

Systems Advocacy, similar to the community collaboration competency, focuses on the system in which the client lives, the issues inherent within that system, collaboration and planning with stakeholders and political leaders in order to promote change, and planning for resistance and appropriate responses to resistance from the system (Lewis et al., 2002). Mi Sun's counselor may need to negotiate additional services that could be helpful to the larger community, such as informing key administrators of the lack of bicultural and bilingual providers of mental and medical health services. Mi Sun might know some fellow students who have also been attacked on campus but who lack identified support groups; her counselor could help advocate for the university to provide support services for this underserved group. Note that as community collaboration efforts are made to build an

AANHPI student group at the university or a support group for survivors of campus violence, resistance may surface.

For example, the university administrators may believe that the development of a support group might imply university culpability for these types of attacks. Similarly, the university may fear that specific organizations or outreach programs that specifically target the needs of AANHPI students might imply that the entire campus is somehow not affirming that student population. It is common for those unaware of systems of privilege and oppression to believe that "every space is a safe and welcoming space." From the perspective of administrators, promoting specific initiatives for the needs of specific groups implies that the lived experiences of various sociocultural groups are unequal, and this is often difficult for those in a position of power to admit. Mi Sun and her counselor should prepare and plan for the possibility of such backlash. It is important to acknowledge that resistance and ambivalence are natural components in any change process (W. R. Miller & Rollnick, 2013). The next counselor competency that is discussed might prevent or buffer this kind of resistance.

The *Public Information* counselor competency supports counselors in ethically and appropriately preparing and disseminating multimedia materials that explain systemic barriers to the target population (Lewis et al., 2002). As with the other competencies, counselors are expected to collaborate with ally groups working to supply public information in order to build cohesiveness and increase effectiveness (Kiselica & Robinson, 2001; Lewis et al., 2002). Outreach endeavors that seek to educate AANHPI communities about mental health services are another form of macrolevel advocacy (Chang & O'Hara, 2013; Kiselica & Robinson, 2001). Advocacy efforts are needed to demystify the process and reduce the stigma of help seeking in the AANHPI community.

In Mi Sun's case, advocacy work may take the form of collaborating with Mi Sun to explain the benefits of counseling to her parents. Additional public information efforts could include collaborating with organizations committed to preventing and responding to violence in disseminating brochures with statistics corresponding to campus violence and the resulting outcomes. Other initiatives could include publicizing information about the prevalence and impact of intimate partner violence, suicide, and other types of violence as they relate to AANHPI communities. This kind of information must be distributed not only to members of the AANHPI community, but also to legal, medical, and social services professionals in the hopes of developing culturally responsive prevention and intervention. Wang and Kim (2010) also noted that mental health professionals need quality continuing education and engagement regarding multicultural competence and social justice. All of these efforts model for clients the responsibility of professional counselors to gather information and integrate it into advocacy efforts. Just like research in the counseling field, counselor advocacy activities should be informed by data-gathered evidence and learning.

The *Social/Political Advocacy* competency encourages counselors to influence public policy by collaborating with allies; supporting existing social advocacy groups; preparing data for use as evidence to help lobby for change in government policies; and perpetuating open dialogue with advocacy groups, communities, and clients to uphold the integrity of the initial advocacy goal (Lewis et al., 2002). Mi Sun appeared to have depressive symptomatology as a result of a traumatic event. The information identified earlier regarding the unique needs and factors that influence AANHPI wellness and development (refer to the Overview of the AANHPI Group, Key Multicultural Concepts and Characteristics, and Systemic Barriers sections) could also be included in legislative and political lobbying efforts as well as awareness campaigns.

As Mi Sun begins the counseling process, her counselor also begins a journey that will lead to a better understanding of the client family's dynamics and how culture uniquely affects her trauma recovery. The counselor's new insight into Mi Sun's life and culture, though not homogeneous with all AANHPI members, offers more opportunity for the counselor to advocate specifically for the needs of Mi Sun and those of the AANHPI community in social and political forums.

Future Directions

The future directions of counseling in the AANHPI community should take into consideration (a) the roles and characteristics of professional counselors and (b) specific AANHPI issues. The following discussion integrates these two categories in the hopes of providing an intentional and relevant path forward.

As previously stated, there continue to be rapid increases in the AANHPI population in the United States and in the proportion of people here who identify as AANHPI (almost 6% of the total population). This trend is not expected to change in the near future. In addition, AANHPI individuals now comprise the largest percentage (36%) of recent immigrants, proportionately overtaking Hispanic and Latino/a Americans, who comprise 31% of recent immigrants (Pew Research Center, 2012). Regardless of whether AANHPI clientele are born in the United States, professional counselors will find it critically important to learn more about the experiences and needs of this diverse group of people.

Relatedly, it is imperative for professional counselors to recognize that AANHPI individuals are a vastly diverse group of people whose heritages span over half of the globe. To that end, it may prove useful to consider specific ethnicities, heritages, or countries of origin (in addition to acculturation and immigration status) when working with AANHPI people both in and out of the office. For example, the needs of a first-generation older adult Indian American woman may be totally different from the needs of a third-generation young adult Filipino American woman. Therefore, future studies should focus upon more targeted assessment and research of the needs and experiences of specific ethnicities, heritages, and subgroups within the diverse AANHPI group.

Because professional counselors operate from a wellness approach, we intentionally seek out and integrate multiple facets of our clients' worlds. Thus, factors such as sexual identity, religion, ability status, and socioeconomic status must be considered and integrated. In particular, socioeconomic status is one of the highly variable and often hidden aspects of clients' lives. With AANHPI individuals especially, there is a great deal of variety with educational attainment and socioeconomic status. Specific segments of the AANHPI population have much higher rates of poverty and much lower levels of formal educational attainment than (a) other AANHPI subgroups and (b) national averages (U.S. Department of Commerce, 2012; White House Initiative on Asian Americans and Pacific Islanders, n.d.). It is important for professional counselors not simply to rely on averages, but rather to consider the intersection of identities and to discover the details of their clients' actual lived experiences with intentionality.

The systemic barriers previously discussed provide opportunities for professional counselors to engage in roles of advocates, allies, consultants, trainers, and systemic change agents. For example, because of language barriers, professional counselors must access translators or provide translated materials, or they must become multilingual in larger numbers. Economic barriers exist as well. In a recent survey, 69% of AANHPI individuals agree with the idea that hard work generates success and opportunity for advancement

(Pew Research Center, 2012). The ongoing economic crises since 2008 pose another systemic barrier to financial security and the potential for upward mobility. It follows that if AANHPI clients are struggling with barriers to success, professional counselors are in a unique position to explore what success means and how to navigate barriers to it. One can engage in advocacy in many ways, including involvement in intimate partner violence prevention and intervention, suicide prevention and recovery, collaborations with community healers, and outreach efforts to break down the stigma of seeking mental health services. Because of the strong connection between oppressive experiences and poor mental and medical health outcomes, social justice-oriented efforts can help provide the kind of access and equity that promote wellness and positive mental health for AANHPI communities.

Two additional trends revolve around family make-up and longevity. According to a 2012 survey of AANHPI individuals, 29% of respondents who were married between 2008 and 2010 married someone who did not identify as AANHPI (Pew Research Center, 2012). If these unions produce children, it appears that there will be an increasing number of children who may identify as biracial or multiracial over the coming years. Counseling implications include exploring identity development, discrimination, belonging, culture, and values, as well as raising awareness about the unique needs of biracial or multiracial children. Regarding trends in longevity, AANHPI women, as a group, have longer average life expectancies than any other group in the United States (U.S. Department of Health and Human Services, 2012). However, this long life is contrasted with numerous health risk factors and barriers to wellness. For example, these individuals often cite lack of health insurance, language barriers, and fear of deportation as barriers to seeking mental and medical services; such obstacles may severely threaten longevity. Professional counselors must consider how to meet the needs of these members of our society in meaningful ways.

In this chapter, we have introduced foundational concepts regarding key considerations, characteristics, and specific issues facing AANHPI individuals and the professional counselors working with them. We have elaborated upon specific advocacy processes, outcomes, and recommendations across the microlevel and macrolevel, and we have provided future directions for meaningful ways in which to approach working with and collaborating with AANHPI communities in light of current trends. The next section of this chapter, Resources, lists agencies committed to supporting members of the AANHPI population.

One final note: Advocacy efforts may entail costs and benefits for the professional counselor (Kiselica & Robinson, 2001). Potential costs include the possibility that advocacy may be emotionally draining; advocates may encounter resistance from communities, employers, or colleagues; or they may be labeled as troublemakers. Kiselica and Robinson (2001) offered suggestions for how counselor advocates can mitigate the potential risks of advocacy: (a) be flexible, (b) engage in self-awareness, (c) set reasonable goals, (d) learn from the system, and (e) work to establish understanding of the people within the system. In addition, identifying and linking with allies can help support professional counselors in their advocacy journeys. As is the case with most worthwhile endeavors, high rewards are often the outcome of high costs and sacrifice. Advocacy work is also rich in benefits such as personal and professional growth and a deep satisfaction that one played a part in social change that helps underserved clients. Professional counseling involves much more than microlevel interventions within the four walls of the counseling room. The development of the Advocacy Competencies as a mainstay of professional counselor duties illustrates the value and necessity of advocacy to the wellness and growth of our clients (Chang & O'Hara, 2013; Kiselica & Robinson, 2001; Lewis et al., 2002).

Resources

Asian Pacific Islander American Public Affairs Association
http://www.apapa.org
Asian Pacific Islander Organization
http://www.apio.org
Asian Women in Business
http://www.awib.org
Conference on Asian Pacific American Leadership
http://www.capal.org/
East–West Center
http://www.eastwestcenter.org
Initiative on Asian Americans and Pacific Islanders
http://www.whitehouse.gov/aapi
National Alliance on Mental Illness (NAMI) Multicultural Action Center–Asian American and Pacific Islander Resources
http://www.nami.org/Template.cfm?Section=Multicultural_Support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=144591
Papa Ola Lokahi
http://www.papaolalokahi.org
South Asian Network
http://southasiannetwork.org
South Asian Women's NETwork
http://www.sawnet.org
Southeast Asia Resource Action Center (SEARAC)
http://www.searac.org
State of Hawaii official website
https://portal.ehawaii.gov/
U.S. Department of Health and Human Services, Office of Minority Health—Asian American Pacific Islander Profile
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=29
U.S. Department of the Interior, Native Hawaiian and Pacific Islander Resources
http://www.doi.gov/pmb/eeo/Native-Hawaiian-and-Pacific-Islander-Resources.cfm
U.S. Pan Asian American Chamber of Commerce Education Foundation
http://www.uspaacc.com

References

Africa, J., & Carrasco, M. (2011). *Asian-American and Pacific Islander mental health: Report from a NAMI listening session*. Retrieved from http://www.nami.org/Template.cfm?Section=Multicultural_Support1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=115281

Akhtar, S., & Choi, L. (2004). When evening falls: The immigrant's encounter with middle and old age. *American Journal of Psychoanalysis*, *64*, 183–191. doi:10.1023/B:TAJP.0000027272.64645.f2

Altaffer, M. (2005, November 13). Asian youth persistently harassed by U.S. peers. *USA Today*. Retrieved from http://usatoday30.usatoday.com/news/nation/2005-11-13-asian-teens-bullied_x.htm

American Psychiatric Association. (2007). *Mental health in Asian American and Pacific Islanders: Healthy minds. Healthy lives.* Retrieved from http://www.psychiatry.org/asian-americans

Arredondo, P., Toporek, R., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42–78. doi:10.1002/j.2161-1912.1996.tb00288.x

Asian Pacific American Legal Center (APALC), & Asian American Justice Center (AAJC). (2011). *A community of contrasts: Asian Americans in the United States: 2011.* Retrieved from http://www.advancingjustice-aajc.org/news-media/publications/community-contrasts-asian-americans-united-states-2011

Atkinson, D. R., Kim, B. S. K., & Caldwell, R. (1998). Ratings of helper roles by multicultural psychologists and Asian American students: Initial support for the three-dimensional model of multicultural counseling. *Journal of Counseling Psychology*, *45*, 414–423. doi:10.1037/0022-0167.45.4.414

Browning, J. R. (1951). Anti-miscegenation laws in the United States. *Duke Bar Journal, 1,* 26–41.

Chan, S. (1991). *Asian Americans: An interpretive history.* Boston, MA: Twayne.

Chang, C. Y. (2012, September). *Responding to a changing world: The ethics and practice of addressing mental health issues in Asian Americans.* Paper presented at the Georgia Psychological Association meeting, Atlanta.

Chang, C. Y., & O'Hara, C. (2013). Initial clinical interviewing with Asian American clients. *Journal of Contemporary Psychotherapy, 43,* 33–42. doi:10.1007/s10879-012-9221-9

Chinese Exclusion Act of 1882, 47th Cong., Sess. 1, Chap. 126; 22 Stat. 58.

Cho, H. (2012). Intimate partner violence among Asian Americans: Risk factor differences across ethnic subgroups. *Journal of Family Violence, 27,* 215–224. doi:10.1007/s10896-012-9413-9

Dabby, F. C. (2007). *Gender violence in Asian & Pacific Islander communities*. Retrieved from http://www.apiidv.org/files/Gender.Violence.APIs-APIIDV-2007.pdf

Gentlemen's Agreement of 1908. In *Encyclopaedia Britannica*. Retrieved from http://www.britannica.com/EBchecked/topic/229394/Gentlemens-Agreement

Gupta, A., Szymanski, D. M., & Leong, F. T. L. (2011). The "model minority myth": Internalized racialism of positive stereotypes as correlates of psychological distress, and attitudes toward help-seeking. *Asian American Journal of Psychology, 2*, 101–114. doi:10.1037/a0024183

Hoeffel, E. M., Rastogi, S., Kim, M. O., & Shahid, H. (2012). *The Asian population: 2010.* U.S. Department of Commerce. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf

Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). *Overview of race and Hispanic origin: 2010.* U.S. Department of Commerce. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

Immigration Act of 1917, H.R. 10384, 64th Cong. (1917).

Inman, A., & Alvarez, A. (2010). Individuals and families of Asian descent. In D. G. Hays & B. T. Erford (Eds.), *Developing multicultural counseling competency: A systems approach* (pp. 246–276). Columbus, OH: Pearson Merrill Prentice Hall.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2010). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (7th ed.). Belmont, CA: Brooks/Cole.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client–counselor worldview match, and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology, 52*, 67–76. doi:10.1037/0022-0167.52.1.67

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2009). Client adherence to Asian cultural values, common factors in counseling, and session outcome with Asian American clients at a university counseling center. *Journal of Counseling & Development, 87*, 131–142.

Kiselica, M. S., & Robinson, M. (2001). Bringing advocacy counseling to life: The history, issues, and human dramas of social justice work in counseling. *Journal of Counseling & Development*, 79, 387–397.

Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2002). *ACA advocacy competencies*. Retrieved from http://www.counseling.org/docs/competencies/advocacy_competencies.pdf?sfvrsn=3

Loving v. Virginia, 388 U.S. 1 (1967).

McCabe, K., & Meissner, D. (2010). *Immigration and the United States: Recession affects flows, prospects for reform.* Migration Information Source. Retrieved from http://www.migrationpolicy.org/article/immigration-and-united-states-recession-affects-flows-prospects-reform/

Miller, M. J., Yang, M., Farrell, J. A., & Lin, L. (2011). Racial and cultural factors affecting the mental health of Asian Americans. *American Journal of Orthopsychiatry*, *81*, 489–497. doi:10.1111/j.1939-0025.2011.01118.x

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing* (3rd ed.). New York, NY: Guilford Press.

Miville, M. L., & Constantine, M. G. (2007). Cultural values, counseling stigma, and intentions to seek counseling among Asian American college women. *Counseling & Values*, *52*, 2–11. doi:10.1002/j.2161-007X.2007.tb00083.x

Pew Research Center. (2012). *The rise of Asian Americans*. Retrieved from http://www.pewsocialtrends.org/files/2012/06/SDT-The-Rise-of-Asian-Americans-Full-Report.pdf

Ponce, N., Tseng, W., Ong, P., Shek, Y. L., Ortiz, S., & Gatchell, M. (2009). *The state of Asian American, Native Hawaiian and Pacific Islander health in California repor*t. Retrieved from escholarship.org/uc/item/3s89c1cm

Schaefle, S., Gates, J., Malott, K., Conwill, W., & Daniels, J. (2011). Implementing a community intervention to promote social justice and advocacy: Analysis of a town hall meeting on race, justice, and peace. *Journal of Humanistic Counseling*, *50*, 192–203.

Shih, G. (2010, May 2). Attacks on Asians highlight new racial tensions. *The New York Times*. Retrieved from http://www.nytimes.com/2010/05/02/us/02sfcrime.html?pagewanted=all

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2013). *The NSDUH Report: Need for and receipt of substance abuse treatment among Asian Americans and Pacific Islanders.* Retrieved from http://www.samhsa.gov/data/2k13/NSDUH125/sr125-aapi-tx.pdf

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70,* 477–486. doi:10.1002/j.2161-1912.1992.tb00563.x

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

Tydings–McDuffie Act of 1934, Pub. L. 73–127, 48 Stat. 456 (enacted March 24, 1934).

U.S. Commission on Civil Rights. (1992). *Civil rights issues facing Asian Americans in the 1990s*. Washington, DC: Author.

U.S. Department of Commerce. (2012). *Facts for features: Asian/Pacific American heritage month: May 2012*. Retrieved from http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb12-ff09.html

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Author.

U.S. Department of Health and Human Services, Office of Minority Health. (2012). *Asian American/Pacific Islander profile*. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=63

U.S. Department of Justice. (2011). *Hate crime statistics, 2010*. Retrieved from http://www.fbi.gov/about-us/cjis/ucr/hate-crime/2010/narratives/hate-crime-2010-victims.pdf

Wang, S., & Kim, B. S. K. (2010). Therapist multicultural competence, Asian American participants' cultural values, and counseling process. *Journal of Counseling Psychology, 57*, 394–401. doi:10.1037/a0020359

Warrier, S. (2011). (*Un)heard voices: Domestic violence in the Asian American community*. Retrieved from http://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/UnheardVoices.pdf

White House Initiative on Asian Americans and Pacific Islanders. (n.d.). *Fact sheet: What you should know about Native Hawaiians and Pacific Islanders (NHPI's)*. Retrieved from http://www2.ed.gov/about/inits/list/asian-americans-initiative/what-you-should-know.pdf

Yu, M., & Nguyen, T. D (2012). Clinical challenges in working with Asian immigrant women and their families. *Asian Social Science*, *8*, 11–19. doi:10.5539/ass.v8n7p11

Zhang, N., & Dixon, D. N. (2001). Multiculturally responsive counseling: Effects on Asian students' ratings of counselors. *Journal of Multicultural Counseling and Development*, *29*, 253–262. doi:10.1002/j.2161-1912.2001.tb00468.x

Chapter 11

Counseling African Americans

S. Kent Butler and M. Ann Shillingford-Butler

Counseling African Americans has been a challenge for helping professionals for many years; the therapeutic relationship has been plagued with many obstacles and systemic barriers, based mainly on African Americans' historical past and counselors' inability to navigate the elephant in the room. The terms *African American* and *Black Americans* are used interchangeably in this chapter both to honor the manner in which many of the referenced authors identified their subject matter and to illustrate the symbolic reasons many African Americans choose or prefer to be acknowledged by a specific term. In this chapter we take a look at the historical and present day ramifications of life in the United States on a community of individuals who collectively have had many shared experiences. The information provided may help to educate a counselor striving to be socially aware and multiculturally competent. Multicultural concepts and characteristics are defined, the systemic barriers affecting counseling relationships are explored, and a case study is discussed in terms of microlevel and macrolevel interactions. The final sections of the chapter discuss implications for the future and list appropriate resources that may help counselors who work with African American clients.

History of African Americans

What is African American history? Is it a history built on slavery and racism in America, or is it rich with the culture and traditions of the motherland? Is it a movement, miraculously steeped in Black liberation and power, each in its own right a vital force necessary to empower a people who are direct descendants of individuals who lost the power to live their lives humanely and on their own terms? A myriad of life circumstances tell the actual story (Becker, 1999; Vox, n.d.; Williams, 2010).

The coastal exploration of and trade with Africa began in 1434 or so and continued for the next several centuries. Unacquainted with the riches attributed to the inland of Africa, European traders were content to trade and raid along the coastline, first seeking spices, gold, and ivory and later upping the ante to individuals whom they saw fit to brutalize and commandeer as slaves (Battle & Wells, 2006; Williams, 2010).

With the advent of the transatlantic slave trade in the 16th century, individuals from central and western Africa accounted for most of those who were sold as slaves and trans-

ported to what was then termed "the new world." Often characterized as the *maafa*, a Swahili term signifying a "great disaster," many Africans were taken by European slave traders to North and South America unaware of the atrocities that awaited them (Becker, 1999; Williams, 2010).

The first to arrive in 1619 aboard a Dutch man-of-war in Virginia were 20 Africans whose enslavement changed the face of slavery in America from the "tawny" Indian to the "blackamoor." (Native Americans' vulnerability to European maladies and propensity to escape made the lucrative nature of the African slave trade that much more appealing.) This event marks the transition to an African-based institution of slavery (Becker, 1999).

Antebellum, Latin for "before the war," is the term used to refer to the time leading up to the U.S. Civil War. Throughout the antebellum period, the American South was an agricultural society, sustained by the backbreaking labor of African American slaves. During this period, 383,000 people (out of a population of 8 million) owned approximately 4 million slaves (U.S. Census Bureau, 2013; Wylie, 2003). Apalled by an environment in which human ownership was considered the norm, African Americans either became activists or fled north. Between 1700 and 1865, rebellions and individual acts of dissent helped an abolitionist movement to form, led by individuals committed to freeing Blacks from slavery and fighting for equality under the law. The abolitionist movement had many factions; however, the issue of slavery eventually led the newly formed states to civil war (1861–1865). The war ended with the defeat of the southern slave-owning states (Confederacy), followed by a very challenging reconstruction process and forging of a single government that would represent all the states (Williams, 2010).

The dozen or so years following the civil war (1865–1878) brought on new challenges for Blacks. The Emancipation Proclamation, which was written to protect the rights of freed slaves, was not implemented; the southern legislatures went so far as to create the Black Codes, which continued to keep Blacks at the mercy of Whites. Blacks were afforded the right to vote, schools and juries were integrated, and Blacks were allowed to marry interracially, but the Black Codes, another display of White supremacy, still made life difficult for the newly unencumbered (Williams, 2010).

Anti-Black legislation (also known as Jim Crow laws) were passed between 1890 and 1965. Laws rooted in racism restricted Black enrollment in public schools and use of restaurants, theaters, hotels, and communal watering holes; public transportation was also segregated during this time period. These laws ensured that African Americans were no more than second-class citizens (Preston-Grimes, 2010).

The New Negro Renaissance, often referred to as the Harlem Renaissance, was a period of originality and creativity within the intellectual Black community. This creativity was prompted by the social circumstances of the United States. Gates (1997) described it as an expression of dignity and humanity under the duress of racial bigotry and poverty. Blacks confidently expressed themselves through poetry, fiction, essay, drama, music, dance, painting, and sculpture; they were inspired to achieve and to claim their rightful place in American cultural life.

Actions of civil resistance from 1941 to 1968 led to such great triumphs as the 1954 *Brown v. The Board of Education* decision, the 1964 Civil Rights Act, and the Voting Rights Act of 1965, each in its own right contributing to equal citizenship for African Americans. Civil rights laws have opened the doors for Blacks and now offer equal access to public accommodations, employment, education, and housing (Battle & Wells, 2006; Preston-Grimes, 2010). Although much progress has been made, more is needed to erase the stain of racism and secure equal rights for Blacks.

African American artists and scholars joined forces in 1965 to form the Black Arts movement, the cultural extension to the Black Power movement. The Black Arts movement illustrated the profound impact that African American literature and art had on culture in the United States (Bridges, 2011; Brinson, 2008; Hanley, 2011; Littlefield, 2008).

Leadership in the Black community has changed since the 1970s. The unsung hero of yesterday has been replaced by a more Eurocentric figure. African Americans are no longer producing altruistic and charismatic leaders who attract a national audience. In fact, most movements may be seen as reactionary as opposed to proactive, and many people (e.g., Princeton University professor Cornel West; political comentator Tavis Smiley) take individualistic rather than collective routes. This is seen even more clearly since the election of President Barack Obama, whose presence in the White House is often viewed as evidence that the country has entered a postracial period in its history. Many African Americans have come to believe that hard work and equal opportunity are likely to show results; the election of President Obama is regarded as the ultimate proof (Hanks, 2009).

Current Experiences

What is the African American experience today? African Americans today have survived a very deliberate past filled with complexities and challenges, to a rich and hopeful journey to the 21st century (Barber, 2011; Golod, 2008). The years since the election of President Obama have cast a spotlight on the already racially tangled web that African Americans experience within the borders of the United States.

The same issues of prejudice and bias that plagued African Americans during the Jim Crow era remain, though in a more subtle form. African Americans are still disproportionately profiled and jailed, and their schools are underfunded. These and other areas of discrimination place Black individuals at a disadvantage personally and financially (McCray, 2008). At the forefront, however, are educational deficiencies that continue to impede the academic achievement of African American youth.

President Obama's election brings to light the struggles experienced by Black men on a daily basis. His very public experiences with verbal assaults and microaggressions provide evidence that much yet needs to be done to improve race relations (Sue & Sue, 2013). His election has not ended racial profiling, high rates of incarceration, the use of drugs and violence, poverty, or educational deficiencies in Black communities (Alexander, 2010); his election makes clear that meaningful systemic modifications are necessary in order for real change to occur. All Americans should be sufficiently troubled by racial inequality in the United States that they are motivated to have in-depth and heartfelt conversations about race that provide a positive framework for universal transformations that ultimately benefit every citizen (Golod, 2008). This chapter focuses on strength-based counseling techniques as possible methods to support African Americans who are struggling to find their way (E. J. Smith, 2006).

Key Multicultural Concepts

Counselors working with African American clients should be aware of nuances within the community. It would be a mistake to assume that all African Americans share a single worldview (Quiros, 2012; Ross, 2012). The dispositions of African Americans vary immensely in regards to values, lifestyles, spirituality, and financial stability, to name a few cultural dynamics (Ford & Airhihenbuwa, 2010). Counselors should respect this fact and use strength-based theoretical methods that are proven evidence-based practices in coun-

seling. The interventions used should also be culturally sound and infused with the multicultural counseling competencies and the American Counseling Association Advocacy Competencies (Ratts & Hutchins, 2009; Sue, Arredondo, & McDavis, 1992). Other factors that counselors need to consider are the racial identity development of African American clients, the family dynamics and family systems in which clients were raised, and the role that religion and spirituality play in their lives.

Racial Identity Development

Counselors should be aware that the concept of racial identity varies within the African American culture. Cross (1971) identified five stages of Black racial identity development:

1. *Preencounter.* Values and beliefs are fashioned after the dominant culture, and in turn African Americans at this developmental stage strongly believe that White is right and Black is wrong.
2. *Encounter.* Individuals might have experienced or witnessed a racial injustice to a friend, which opened them up to the reality that the dominant culture may in fact not be so right.
3. *Immersion/emersion.* Individuals have a new awareness of the African American culture, and so they become more informed and knowledgeable about their culture in an effort to feel better connected; they might make deliberate attempts to avoid Whites.
4. *Internalization.* African Americans are comfortable with being Black and are open to building relationships with those from the dominant culture who are respectful of their racial identity.
5. *Internalization–commitment.* African Americans develop a sense of commitment to their culture and strive to foster and sustain positive change.

Historically, African Americans have been looked down upon, which has affected their identity in mainstream society; therefore, it behooves counselors to determine how complex or simplistic their clients' views of racial identity are and make attempts to integrate this into therapy in an effort to create successful therapeutic connections.

Family Dynamics

How do African American family members relate to one another? Discovering the family dynamics may help counselors better understand African American clients and provide alternative ways to elicit family support. For instance, caring and supportive emotional relationships among extended family members help to enhance marital satisfaction among African American couples (Taylor, Brown, Chatters, & Lincoln, 2011). So a counselor should keep in mind the importance of this support system when working with couples (married, cohabitating, or even those just romantically involved). It is also imperative to understand the significance of single parenthood among African American families. According to the Annie E. Casey Foundation (2011), at least 67% of African American children reside in single-parent households; the percentage jumps to 74% in Arkansas, Illinois, and Ohio. Although single-parent households are at a disadvantage (e.g., financially), African American single mothers have often portrayed resilience in the face of joblessness, stress, and societal stereotypes. These determined women have found strength through religion and family support, helping them to improve their self-esteem, personal efficacy, and general quality of life (Mendenhall, Bowman, & Zhang, 2013).

Religion and Spirituality

African Americans have been known to find meaning in difficult times through their religious and spiritual practices. When their reliance on God is upheld, they have the subjective experience of a God who cares about their struggles (Schieman, Bierman, & Ellison, 2010). The African American churches have been instrumental in helping individuals rise above the pain and scars of social inequalities caused by a history of oppression, degradation, and racism to a greater sense of consciousness. Increased consciousness in turn has assisted in bolstering racial identity among African Americans, particularly those who are more actively involved in social reform and systemic change (Mattis & Jagers, 2001).

Counselors who work with African Americans would be well-advised to educate themselves about and to understand the ramifications surrounding the lived African American experience. Counselors must be culturally competent and comfortable exploring issues pertaining to ethnicity, race, religion, spirituality, and other aspects of culture and their impact on African American identity development (Adams & Welsch, 2009; Ellis-Williams, 2007; Ross, 2012; Sue, Bingham, Porche-Burke, & Vasquez, 1999). It is also imperative for helping professionals to integrate evidence-based theories and techniques that support, embrace, and validate the role of family, extended family, and friends in the lives of their clients.

Spirituality is a crucial element of the Black experience (Curry, 2010; McCray, Grant, & Beachum, 2010). The role of the Black church in shaping the morals and values of African American clients should not be overlooked. The elders of the church (i.e., pastors, deacons, mothers of the church) have been instrumental in helping the children of parishioners come to value the importance of a well-rounded edification. Equally important is education, which is often seen as the way out for many African Americans living under the harsh conditions of poverty. Education has become an afterthought replaced by delusions of grandeur related to superstardom. Helping reality to sink in that not every individual will find success through sports or within the entertainment industry can be a grueling uphill process and has become a long-standing issue within the community. Therefore, it is vital that counselors work with African American youth, family members, church officials, and other community stakeholders to find common ground that embraces the virtues of education and the significance that exceeding academic expectations has on one's life (Horsford, 2010), especially in light of the gaps typically found between the scholarly achievements of Black school-aged students and their counterparts (Barber, 2011; Blackwell, 2010; Harper & Davis, 2012). Lastly, African American youth need positive role models and mentors (Bandura, 2000; Barber, 2011; Brown, 2009; Patton, 2009), altruistic individuals who at their core are committed to the process of transforming and uplifting the Black community.

Systemic Barriers

African Americans in counseling may have various inhibitions and obstacles to overcome when pursuing a path to wellness. Sadly, the fear and distrust displayed toward the counseling process is deeply rooted in America's racial past (Madison-Colmore & Moore, 2002; J. M. Smith, 2002). These barriers may pertain more specifically to Black men, as opposed to women, because of their distinctive experiences with discrimination, racism, and oppression within the United States, but in reality everyone in Black communities may have been adversely affected. All of this may result in some African Americans not being able to engage and participate as full-fledged members of society (Madison-Colmore & Moore, 2002; Zion & Blanchett, 2011), which in turn may lead to relational issues that may need to be explored within an unbiased therapeutic relationship.

Therapists who work with African American clients should consider the systemic barriers that often prevent African Americans from seeking mental health services. It is crucial that practitioners understand the influence of culture and traditions, the effect of the language of origin on communication patterns within the community, misperceptions in the Black community regarding mental health and mental illness, the long-term effects of systemic discrimination, and the relationship between racism and fear of stigma and African American client wellness or lack thereof.

Personal Voices
The Story of Devanté

The following case study is based on the lyrics of the popular poem/rap, "Little Black Boy" (Appendix 11.1); we use this poem because it captures the reality of clients we have seen. The poem describes the life of a young man who struggled with the consequences of his poor decisions, all due to his living environment; his life spiraled out of control, and the only options seemed to be death or jail. One wonders whether the messages that he learned daily had stifled his growth and any chances at obtaining self-respect (Alexander, 2010; Blackwell, 2010; Brown, 2009; Harper & Davis, 2012; Houchins & Shippens, 2012; Piquero, 2008; Templeton, 2011); clearly his environment had the upper hand, and he saw no real way out of his predicament. He was resigned to live his life like many other Black men he had encountered throughout his lifetime.

Devanté was a 19-year-old African American male who struggled academically throughout school. He spent a significant amount of his time concerned about keeping up with the guys in this neighborhood and making sure that he looked good and was well liked by women and girls. Unfortunately for Devanté, his role models were those portrayed by the media as rich, popular, and thuglike. He did not see the value of getting an education; some of his television role models had barely gotten one themselves and yet they drove luxurious cars, were surrounded by beautiful women, and made more money than he could ever imagine. Although some of his teachers reached out to him, others just saw him as another Black boy, incapable of succeeding academically. Devanté dropped out of school before graduating and spent his time hanging out on the streets with other young Black men. Unable to find a decent job because he had dropped out of school, he eventually realized that in order to keep up his façade he had to seek other sources of financial support. Devanté and a friend decided to rob a convenience store. Unfortunately for him, the store clerk was armed. Devanté never made it out of the store.

Individual Counseling: Applications at the Microlevel

Culturally competent counselors of African American clients cannot disregard the current and historical oppressions experienced throughout their clients' lifetime (Adams & Welsch, 2009). These dynamics are worth exploring because they are likely to present themselves in some form; clients are likely to carry the burden of these experiences. The use of culturally appropriate theories and interventions to create a supportive therapeutic environment for African American clients is vital (American Counseling Association, 2014; Council for Accreditation of Counseling and Related Educational Programs, 2009). E. J. Smith's (2006) strength-based counseling model (SBCM) provides an excellent framework for helping professionals who work with diverse clientele. Nontraditional methods, such as strength-based counseling, can be integrated

into traditional talk therapies. In most cases SBCM successfully lays the foundation for helping clients make meaning of their life experiences (Miller & Rollnick, 2002; E. J. Smith, 2006). Rather than working from a deficit model, strength-based approaches focus on self-empowerment, a primary factor in facilitative growth and development in the African American community (Franklin & Boyd-Franklin, 2000).

The 10-stage SBCM parallels solution-focused methods in that counselors work cooperatively with clients to work with their assets.

1. Create a therapeutic alliance.
2. Identify strengths.
3. Assess presenting problems
4. Encourage and instill hope.
5. Frame solutions.
6. Build strength and confidence.
7. Empower clients.
8. Create change.
9. Build resilience.
10. Evaluate the progress and appropriately terminate the counseling relationship.

A counselor who works with a client who has Devanté's characteristics may choose to use the SBCM to help him become a more positively contributing citizen. At the therapeutic alliance stage, the counselor will want to learn more about the client: What are his strengths? What does he like to do? What does he want to do with his life? The strength-based counselor focuses on identifying the client's strengths to help him rise above his struggles. The identified strengths are then the focus of further exploration with the client. Through these discussions, the counselor also assesses the presenting problem and allows the client to verbalize what he views as problematic. What aspects of his life does he perceive to be restricting him? He might have the insight to see that lack of education has hindered his ability to get a decent paying job. The counselor should try to encourage the client and instill hope; this will help the client rekindle a positive spirit by focusing on what has worked in his life. (For example, if he is good at artwork and has identified this as a strength, he can be encouraged to see that he can use this skill to his advantage.)

Using a solution-focused approach, the counselor can now begin the process of framing a solution. The client can be paired with a mentor, an artist, who can assist him with developing his skill. The counselor also helps him recognize that he is competent enough to pursue a career in art. Realizing his autonomy, he is empowered to explore resources of support available to him. He can attempt to identify friends who have been able to rise above systemic challenges; they may be able to support his efforts to change. He can identify family members who have extended support to him in the past and who may still be willing to help him emotionally and socially.

Now that a path has been identified for him, the counselor can discuss behavioral changes that are required. What friends are going to be a social hindrance to him? What if there is a downturn in the art development? What coping skills can he use to help build resilience? What coping skills can he use when he is frustrated or angry? Finally, the counselor helps the client evaluate his progress. What changes has he seen within himself? What strategies have worked for him? The stages involved in the SBCM provide a framework for counselors to understand how best to move a client through behavioral change in order to develop a more meaningful existence.

Two other models may be considered when working with African American clients:

- the H.I.S. model (Madison-Colmore & Moore, 2002), in which counselors engage their clients by exploring the influences of history, identity, and spirituality within a societal milieu; and
- the counseling ministry model (Ennis, Ennis, Durodoye, Ennis-Cole, & Bolden, 2004), which has roots in the client's spirituality and affords inspiration through the use of prayer and support groups, individual and group counseling, and crisis mediation.

Advocacy Counseling: Applications at the Macrolevel

Counselors, especially White helping professionals, may have to find ways to become advocates for their clients outside of the traditional counseling environment (Ford & Airhihenbuwa, 2010; Golod, 2008; Kakli, 2011; McKay, 2010; Shin et al., 2010; Zion & Blanchett, 2011). The anxiety and mistrust of the counseling process exhibited by African American clients usually stems from a distrust of White persons caused by personal experience and America's history of institutionalized racism. Involving mentors, community organizations, and churches may go a long way in closing the divide. African Americans are more apt to enter counseling if they feel that revealing themselves is not costly.

According to Bandura (1986), a mentoring relationship may enhance self-efficacy because it provides educationally purposeful experiences that are appealing and ultimately challenge a person's worldview, understanding, and response to multiple sociocultural contexts. The mentoring relationship may also provide occasions to build self-awareness through cognitive challenges, investment in learning, and psychosocial examinations, key concepts revealed in Bandura's theory of self-efficacy. Mentors are crucial; they are the teachers and guides who offer opportunities for self-discovery within foundations assembled to provide a sense of belonging and security (Strange, 2003). In the hypothetical example above, the counselor recognized that a mentor with similar interests as the client would be most beneficial to his success. Imagine the sense of belonging that the client would feel being connected to someone "like" him who was willing to work with him.

The vicarious experience received through social models and mentors produces and strengthens self-beliefs of efficacy in individuals. Seeing people similar to oneself succeed through persistent effort increases the belief that one also retains the skills to master comparable undertakings (Bandura, 2000). To this end, social networking opportunities become influential in promoting opportunities to assist individuals in self-beliefs of efficacy.

Learning positive self-talk and behaviors that mobilize continued success is also essential with mentees. Engaging in positive self-talk helps to reframe the discussion and provides an opportunity for success. Individuals who can communicate their thoughts and feelings may possess the ability to master certain actions and summon a greater effort and sustainability than individuals who harbor reservations and dwell on personal deficits when difficulties surface (Bandura, 2000).

Patton (2009) used a phenomenological method to explore mentoring relationships. Grounded in the participants' perceptions, Patton claimed that mentoring relationships that provided empathy, understanding, and trust offered participants psychosocial support, leadership and career guidance, and a sense of confidence. Black participants reported genuine success stories of goal realization and professional achievement. Patton argued that productive mentoring relationships are needed to positively address the invisibility that many Black individuals face.

Future Directions

Strength-based perspectives may provide counselors with the ability to accept the self-definitions relevant to African Americans within their cultural and social milieus. Most therapists aspire to meet clients where they are; that said, it would befit a culturally competent therapist to use culturally relative and responsive theories and techniques that effectively support therapeutic relationships with African American clients. Therapeutically gratifying, it also provides a platform for ethical practice mandated under the standards of the Council for Accreditation of Counseling and Related Educational Programs and the *ACA Code of Ethics* (American Counseling Association, 2014).

It is incumbent upon counseling professionals to become more proactive when it comes to the mental wellness of clients. It has become increasingly important for counseling professionals to become socially active and culturally attuned to what clients are dealing with, especially clients from disenfranchised communities. It is no longer acceptable to counsel for conformity to the status quo, not when the lives of clients are at stake. Counselors must be trained in counselor education programs that are multiculturally sound and that advocate for the well-being of all clients. Curriculums need to be designed to enhance the supervised learning experiences of counseling students that transcend the classroom and create a culture and thirst for continued growth and development after graduation. This represents a cultural shift in the norm that requires a change of worldview of the entire profession. The profession as a whole will have to learn to embrace diversity and differences (especially important in light of the changing demographics in the United States). A movement in this direction will help to eliminate some of the stigma that African Americans associate with counseling.

Resources

The organizations listed below support counselor interactions with African American clients.

Community Services

African American Community Services Agency
http://www.sjaacsa.org
African American Family Services
http://www.aafs.net/
Africare, Inc.
http://www.africare.org/
A Better Chance, Inc.
http://www.abetterchance.org/
Association for Multicultural Counseling and Development
http://www.multiculturalcounseling.org/
Counselors for Social Justice
https://www.facebook.com/pages/Counselors-for-Social-Justice/125758701501
LGBT Health
http://guides.library.ucsf.edu/content.php?pid=211162&sid=2009927

Elderly Services

Catholic Community Services: African American Elders Program
http://www.ccsww.org/site/PageServer?pagename=seniors_africanamericanelders

USC Edward R. Roybal Institute on Aging
http://roybal.usc.edu/about/community_partnerships/aae/advocates.html

Mentoring

100 Black Men of America, Inc.
http://www.100blackmen.org/mentoring.aspx
African American Male Mentoring Initiative
http://www.needld.org/programs-services/aammi
League of Black Women
http://events.leagueofblackwomen.org/mentoring/
National CARES Mentoring Movement
http://www.caresmentoring.org

References

Adams, J. Q., & Welsch, J. R. (2009). Multiculturalism: The manifest destiny of the U.S.A.—An interview with Ronald Takaki. *Multicultural Perspectives, 11*, 227–231.

Alexander, R., Jr. (2010). The impact of poverty on African American children in the child welfare and juvenile justice systems. *Forum on Public Policy Online, 2010*(4).

American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.

Annie E. Casey Foundation. (2011). *Data center: Kids count*. Retrieved from http://datacenter.kidscount.org/

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Engelwood Cliffs, NJ: Prentice Hall.

Bandura, A. (2000). Cultivate self-efficacy for personal and organizational effectiveness. In E. A. Locke (Ed.), *Handbook of principles of organization behavior* (pp. 120–136). Oxford, UK: Blackwell.

Barber, E. (2011). "These are our babies": University student tutors, urban learners, public school and university staff crafting community through service learning. *Journal of Urban Learning, Teaching, and Research, 7*, 72–84.

Battle, T. C., & Wells, D. M. (2006). *Legacy: Treasures of Black history*. Washington, DC: National Geographic.

Becker, E. (Compiler). (1999). *Chronology of the history of slavery: 1619–1789. What is African–American history?* Retrieved from http://innercity.org/holt/slavechron.html.

Blackwell, D. M. (2010). Sidelines and separate spaces: Making education anti-racist for students of color. *Race, Ethnicity and Education, 13*, 473–494.

Bridges, T. (2011). Towards a pedagogy of hip hop in urban teacher education. *Journal of Negro Education, 80*, 325–338.

Brinson, S. A. (2008). NGOMA: Celebrate the dream with African–American literature. *Multicultural Perspectives, 10*, 100–104.

Brown, A. L. (2009). "O brotha where art thou?" Examining the ideological discourses of African American male teachers working with African American male students. *Race, Ethnicity and Education, 12*, 473–493.

Brown v. Board of Educ., 347 U.S. 483 (1954).

Civil Rights Act of 1964. Pub. L. No. 88–352, 78 Stat. 241 (July 2, 1964).

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 standards.* Retrieved from http://www.cacrep.org/wp-content/uploads/2013/12/2009-Standards.pdf

Cross, W. E. (1971). The Negro-to-Black conversion experience. *Black World*, 20(9), 13–27.

Curry, J. R. (2010). Addressing the spiritual needs of African American students: Implications for school counselors. *Journal of Negro Education, 79*, 405–415.

Ellis-Williams, A. (2007). Discovering the possibilities: A study of African American youth resistance and activism. *Educational Foundations, 21*, 107–124.

Ennis, W., Jr., Ennis, W., III, Durodoye, B., Ennis-Cole, D., & Bolden, V. (2004). Counseling African American clients: Professional counselors and religious institutions. *Journal of Humanistic Counseling, Education and Development, 43*, 197– 211.

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 100*, S30–S35. doi: 10.2105/AJPH.2009.171058

Franklin, A. J., & Boyd-Franklin, N. (2000). Invisibility syndrome: A clinical model of the effects of racism on African American males. *American Journal of Orthopsychiatry, 70*, 33–41.

Gates, H. L. (1997). (Ed.). *The Norton anthology of African American literature*. New York, NY: W.W. Norton.

Golod, F. (2008). Civil rights and social justice: A path to engagement and transformation. *Horace, 24*(3).

Gypsy. (1997). *Little Black boy.* Retrieved from http://www.gmsys.net/teachers/english/poetry/blackboy/blackboy.htm

Hanks, L. J. (2009). The Obama presidency and the question of social justice: A critical analysis of the meaningful milestone. *Forum on Public Policy Online, 2009*(1).

Hanley, M. S. (2011). You better recognize!: The arts as social justice for African American students. *Equity & Excellence in Education, 44*, 420–444.

Harper, S. R., & Davis, C. H. F., III. (2012). They (don't) care about education: A counternarrative on Black male students' responses to inequitable schooling. *Educational Foundations, 26*, 103–120.

Horsford, S. D. (2010). Black superintendents on educating Black students in separate and unequal contexts. *Urban Review: Issues and Ideas in Public Education, 42*, 58–79.

Houchins, D. E., & Shippen, M. E. (2012). Welcome to a special issue about the school-to-prison pipeline: The pathway to modern institutionalization. *Teacher Education and Special Education, 35*, 265–270.

Kakli, Z. (2011). Doing the work: A portrait of an African American mother as an education activist. *Urban Review: Issues and Ideas in Public Education, 43*, 175–195.

Littlefield, M. B. (2008). The media as a system of racialization: Exploring images of African American women and the new racism. *American Behavioral Scientist, 51*, 675–685. doi: 10.1177/0002764207307747

Madison-Colmore, O., & Moore, J. L., III. (2002). Using the H.I.S. model in counseling African–American men. *The Journal of Men's Studies, 10*, 197–208. doi:10.3149/jms.1002.197

Mattis, J. S., & Jagers, R. J. (2001). A relational framework for the study of religiosity and spirituality in the lives of African Americans. *Journal of Community Psychology, 29*, 519–539.

McCray, C. R. (2008). Constructing a positive intersection of race and class for the 21st Century. *Journal of School Leadership, 18*, 249–267.

McCray, C. R., Grant, C. M., & Beachum, F. D. (2010). Pedagogy of self-development: The role the Black church can have on African American students. *Journal of Negro Education, 79*, 233–248.

McKay, C. L. (2010). Community education and critical race praxis: The power of voice. *Educational Foundations, 24*, 25–38.

Mendenhall, R., Bowman, P., & Zhang, L. (2013). Single Black mothers' role strain and adaptation across the life course. *Journal of African American Studies, 17*, 74– 98.

Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.

Patton, L. D. (2009). My sister's keeper: A qualitative examination of mentoring experiences among African American women in graduate and professional schools. *Journal of Student Affairs Research and Practice, 45*, 510–537.

Piquero, A. R. (2008). Disproportionate minority contact. *Future of Children, 18*, 59–79.
Preston-Grimes, P. (2010). Fulfilling the promise: African American educators teach for democracy in Jim Crow's South. *Teacher Education Quarterly, 37*, 35–52.
Quiros, L. (2012). Raising the voice: Teaching through a multicultural lens. *Journal of Teaching in Social Work, 32*, 518–531.
Ratts, M. J., & Hutchins, A. M. (2009). ACA advocacy competencies: Social justice advocacy at the client/student level. *Journal of Counseling & Development, 87*, 269–275.
Ross, R. E. (2012). Overcoming misinterpretation and irrationality: Doing ethics at the intersection of social justice, liberation, and civil/human rights. *Religious Education, 107*, 241–245.
Schieman, S., Bierman, A., & Ellison, C. G. (2010). Religious involvement, beliefs about God, and the sense of mattering among older adults. *Journal for the Scientific Study of Religion, 49*, 517–535.
Shin, R. Q., Rogers, J., Stanciu, A., Silas, M., Brown-Smythe, C., & Austin, B. (2010). Advancing social justice in urban schools through the implementation of transformative groups for youth of color. *Journal for Specialists in Group Work, 35*, 230–235.
Smith, E. J. (2006). The strength based counseling model. *Counseling Psychologist, 34*, 13–79.
Smith, J. M. (2002). Fear as a barrier?: African American men's avoidance of counseling services. *Journal of African American Men, 6*, 47.
Strange, C. (2003). Dynamics of campus environments. In S. R. Komives & D. B. Woodard, Jr. (Eds.), *Student services: A handbook for the profession* (4th ed., pp. 297–315). San Francisco, CA: Jossey Bass.
Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64–89.
Sue, D. W., Bingham, R. P., Porche-Burke, L., & Vasquez, M. (1999). The diversification of psychology. A multicultural revolution. *American Psychologist, 54*, 1061–1069.
Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: John Wiley & Sons.
Taylor, R., Brown, E., Chatters, L., & Lincoln, L. (2011). Extended family support and relationship satisfaction among married, cohabiting, and romantically involved African American and Black Caribbeans. *Journal of African American Studies, 16*, 373–389.
Templeton, N. R. (2011). Understanding social justice: Improving the academic achievement of African American students. *International Journal of Educational Leadership Preparation, 6*(2).
U.S. Census Bureau. (2013). *Census of housing and population 1860 census*. Retrieved from https://www.census.gov/prod/www/decennial.html
Voting Rights Act of 1965, 42 U.S.C. §§ 1973–1973bb-1.
Vox, L. (n.d.). *What is African–American history? A history of how historians have defined the field*. Retrieved from http://afroamhistory.about.com/od/blackhistorymonth/a/AfAmHist.htm
Williams, G. W. (2010). *History of the Negro race in America from 1619 to 1880: Vol. 1. Negroes as slaves, as soldiers, and as citizens*. Retrieved from http://www.gutenberg.org/ebooks/15735
Wylie, K. (2003). *African American slavery in the Antebellum period* [e-book]. Retrieved from http://www.grin.com/en/e-book/60432/african-american-slavery-in-the-antebellum-period
Zion, S. D., & Blanchett, W. (2011). [Re]conceptualizing inclusion: Can critical race theory and interest convergence be utilized to achieve inclusion and equity for African American students? *Teachers College Record, 113*, 2186–2205.

Appendix 11.1 • **Little Black Boy**

There was a little black boy, a black boy was he
The boy went to school and he came out dunce
He never learn how to write, he never learn about math
He never learn how to write, he never study 'bout that
All the study was his sneakers, his sneakers and the clothes
So he learn how to dress and he learn how to pose
Now he can't get no work, he can't get no job
So he decide to steal and he decide to rob
But little black boy couldn't last long at all
The police put a bullet through his dunce head-skull

Little black boy, go to school and learn
Little black boy, show some concern
Little black boy, education is the key
To get you off the street and off poverty

There was a little black boy, a rude boy was he
All the boy ambition was to conduct a maxi
With ear-ring in he nose, a gold teeth in he mouth
He feel very proud when they call him a tout
So proud was the boy that the boy never learn
He could ah work hard and buy a maxi of his own
So he hustle for a dollar he hustle for a smoke
He hustle so that he could buy a little coke
Now he's hook on the coke and off the maxi
And is one more little black vagrant in the country

When you're black you just black. You can't help being black
But because you are black you don't stay back

Be black, be black
But be conscious!
Be black be black
But be conscious!

Look in the front, see who's the doctor?
Look in the back, see who's the lawyer?
Look in the bank, see who's the banker?
Look at the business, see who's the owner?
Look at the staff, see who's the worker?
Look at the drugs, see who's the clan man?
Look who eating out ah them garbage can?
Look in the jail see who you see too
Ah bet ah little black boy just like you!

Little black boy, go to school and learn
Little black boy, show some concern
Little black boy, education is the key
To get you off the street and off poverty
Little black boy, think 'bout your race
Little black boy, when would you find your place?
Little black boy, go to school and learn!

Little black boy, take a look at yourself
Little black boy, take a look at yourself
Little black boy, that's what you'd do
Little black boy, take a good look at you
Little black boy, look at other people, too
Little black boy, is that the way you should be?
Little black boy, don't put drugs in your vein
Little black boy, it will drive you insane
Little black boy, it will huddle your brain
Little black boy, don't you be no fool
Little black boy, keep yourself in school

When you're black you just black. You can't help being black
But because you are black you don't stay back

Be black, be black
But be conscious!
Be black be black
But be conscious!

—Lyrics by Gypsy

Chapter 12

Counseling Native Americans and Social Justice

Timothy C. Thomason

Many myths and stereotypes about Native Americans are common among non-Native Americans—for example, Native Americans are extinct; they all live on reservations; they are all quiet and submissive; and they are all rich from tribal gaming. Indian people make up a relatively small percentage of the population in the United States; they contribute actively to American society. Native Americans are unique among ethnic groups in the United States because they are the only indigenous people in North America.

The fact that the U.S. government attempted to exterminate all Indian people (Strickland, 1986) has created a significant barrier between service providers and Indian people who need assistance. It is necessary for counselors to understand the history of White–Indian relations if they are to overcome historical distrust and provide effective and culturally appropriate services. This chapter provides an overview of the history of the group, suggestions for how counselors can adapt their practice to the needs of Native Americans, and ideas for how counselors can fight racism and contribute to the struggle for social justice.

History of Native Americans

In 1492 the Italian explorer Columbus encountered the now-extinct Arawak people and called them *los indios*, and the terms *Indians* or *American Indians* continues to be used to refer to the indigenous peoples of the Western Hemisphere (Trimble & Thurman, 2002). Many contemporary Indian people prefer the term *Indian* to *Native American*, but both terms are in common use today, and these terms are used interchangeably in this chapter. When Columbus landed in North America, there were an estimated 8 to 12 million indigenous people on the continent; by 1900, only about 250,000 remained (Grandbois, 2005).

The experience of Native Americans was different from that of all other ethnic groups in the country. The indigenous peoples of North America had lived on their lands for thousands of years when Europeans colonized the continent, bringing wars and diseases that reduced the Native population by 90% (D. W. Sue & Sue, 2013). The colonists exterminated millions of Native Americans, seized their land, and treated them as an obstacle to their westward expansion.

The racist policies and practices of the U.S. government contributed to the destruction of the lives of most of the indigenous peoples who lived in what became known as North

America. For example, hundreds of Indian men, women, and children were killed in the massacre of Wounded Knee in 1890. During the European occupation of the continent, millions of Indian people were killed or died of diseases brought by the Whites. Most tribes lost their traditional lands and were forced to relocate. During the 1930s more than 125,000 Indian people from various tribes were forced to leave their homes and move to a reservation in Oklahoma (D. W. Sue & Sue, 2013).

Government agencies implemented a policy to forcibly assimilate Indian people into mainstream society. Many Native children were removed from their families and placed in boarding schools, where they were forbidden to wear their traditional clothes, speak their language, or see their families. This policy of attempting to "civilize" the Indians by moving them to boarding schools continued well into the 1950s (Trimble & Thurman, 2002). The forced removal of Indian children from their homes and their placement with non-Indian families continued until the passage of the Indian Child Welfare Act of 1978. These experiences disrupted family and tribal cohesion and prevented the transmission of traditional cultural values from parents to children (S. Sue & Lam, 2002).

The U.S. government made more than 300 treaties with Native Americans regarding housing, education, and health care, but it did not honor them (B. Richardson, 1993). The long history of broken treaties demonstrated to Indian people that the U.S. government could not be trusted, and the seizure or misuse of tribal land and battles over fishing and hunting rights continue to the present day. Although most Whites probably feel no guilt about how Indian people were treated in past centuries, they should understand that Indian people who are suspicious of Whites have good reason to be so. Non-Indian counselors may be seen as representatives of governmental agencies or institutions, so counselors should not expect that Indian people assume that they are trustworthy.

Current Experiences

About 60% of Native Americans live in metropolitan areas, 22% live on reservations or other trust lands, and 18% live in nontribal rural areas (Office of Minority Health, 2012). So more Native Americans live in urban areas than in rural or reservation areas; many moved to urban areas for work. About 28% of Indian people speak their Native language rather than English at home. In 2010, 77% of Indian adults had at least a high school diploma, 13% had at least a bachelor's degree, and 4.5% had an advanced graduate degree (Office of Minority Health, 2012).

A common misconception is that most Native Americans are rich because they receive profits from gaming at casinos on Indian lands. An example of a tribe that has done quite well is the Shakopee Mdewaknton tribe of Minnesota; each of the 480 adult members receives a million dollars per year from casino profits, making it the richest tribe in American history. This tribe is an exception, however, and recently the tribal casino business has gone flat. At any rate, most tribes have no casinos (Williams, 2012), which means that most Native Americans receive no income from tribal casino profits.

Unemployment among Indian people is a significant problem, especially in reservation and rural areas; in 2011 the overall unemployment rate of Native Americans was 14.6% (Bureau of Labor Statistics, 2011) compared with the national unemployment rate of 8.9% (Bureau of Labor Statistics, 2013). Many young Indian people move from rural areas to urban areas where more jobs are available, but this often results in broken ties with tribal culture back home. Poverty is an issue for a significant minority of Native Americans; 28% of them live at the poverty level, compared with 10.6% of non-Hispanic Whites in 2010.

The median family income for American Indians is $35,000, compared with $68,000 for non-Hispanic Whites and $50,500 for the nation as a whole (U.S. Census, 2012).

American Indians are American citizens and can access education, health, welfare, and other social service programs available to all citizens. They pay taxes, are subject to U.S. laws, and serve in the armed forces. In World War II, 25,000 American Indians served the United States, and 41,500 served in Vietnam. Currently there are about 153,000 American Indians in the U.S. armed forces, and about 3,000 American Indians have served in the Persian Gulf, Iraq, and Afghanistan wars (U. S. Census, 2012).

Politics

When Indian veterans returned from World War II, many were upset that they were not allowed to vote. Suffrage rights were eventually granted, but Indians could not vote in New Mexico and Arizona as recently as 1948 or in Utah until 1956 (Chavers, 2012). Native Americans belong to many different political groups and parties. Because of the relatively small size of the Native American population in the United States, in the past most politicians have paid little attention to the concerns of their Indian constituents. Historically, Native Americans have some of the lowest voter turnout rates of any ethnic group in the country. Many Indians are not interested in national issues, and obstacles to voting include gerrymandering and inconvenient polling locations for Indians living in remote areas. In only three states are Indians more than 10% of the total population, and in some states the majority of the Indian people are not registered to vote (Chavers, 2012). Overall, only 40% of eligible American Indians were registered to vote in 2008 (Blades, 2012).

Although the Native American influence in American politics is weak, in 2012 there were 85 Native American elected officials, the most ever (Pelosi, 2012). Because voting is a private matter, statistics on the actual voting record of Native Americans are not available, but many observers believe that Indians mostly vote Democratic (Brown, 2008). Chavers (2012) estimated that up to a million Indians voted in the 2008 presidential elections and that most of them voted for Barack Obama. Although most Native Americans are conservative and many have rural values, most vote Democratic (Ahtone, 2008). However, there are significant numbers of Republican voters among Indian people in some areas, such as Oklahoma, and the best known Indian senator, Ben Nighthorse Campbell from Colorado, switched his party affiliation from Democrat to Republican. There are groups such as Conservative American Indian Republicans and the American Indian Tea Party. According to Ullmann (2008), neither Democrats nor Republicans have a great record on Native American affairs. Giago (2008), an Oglala Lakota and editor of *Indian Country Today*, suggested that Indian people should get together and form a Native American Party, because neither of the dominant parties appeals to all Native Americans. As in many other areas, Native Americans are diverse and cannot be stereotyped as adhering to one particular political agenda or affiliation.

Religion

Historically, Native American religions have exhibited a great deal of diversity and have often been characterized by animism or panentheism. In animism nature spirits are worshipped, and in panentheism the divine is thought to interpenetrate all of nature (MacGregor, 1989). It is estimated that only about 9,000 people still practice Native American religions (J. T. Richardson, 2004). The Native American Church, which uses peyote in religious ceremonies but incorporates many Christian beliefs, has chapters in all of the Western states and has been estimated to have about 250,000 members (Fikes, 2012).

Most of the colonists from Europe who invaded North America were Christian, and the missionaries imposed Christianity on the survivors of the invasion. Many Native Americans incorporated Christian beliefs into their Native religions, resulting in what has been called a bewildering range of idiosyncratic Native Christianities (McNally, 2011). The type of Christianity practiced in many Indian communities has been characterized as fundamentalist in theology, conservative in practice, and often revivalistic or evangelical (Neusner, 2009). Peelman (2006) argued that Christ himself is a Native American, based on Pope John Paul II's declaration that "Jesus Christ in the members of his Body is himself Indian" (p. 13).

On the basis of the Pew Forum on Religion & Public Life (2008) survey on religion, an estimated 70% of Native Americans in the United States identify themselves as Christian, 9% belong to other religions, and 20% are unaffiliated, agnostic, or atheist. It is clear that the majority of people who identify themselves as Native American also identify themselves as Christian. Some may think it strange that so many Indian people identify with the colonists' religion rather than with their own traditional religions. The phenomenon of identification with the oppressor has been well established (Freire & Ramos, 2000). Indian people may have adopted Christianity as a survival mechanism, and some Indian people probably retain it out of tradition.

Social Issues

As a group, Native Americans are generally described as conservative regarding social issues such as abortion, gun control, and same-sex marriage. Because the majority of Native Americans identify themselves as Christian, their opinions on abortion may parallel those of White Christians. However, there are exceptions; in some tribal cultures, such as the Lakota, each woman is expected to make her own decisions about family planning, such as contraception and abortion (Ehrich, 2006).

Native Americans were almost exterminated by the colonizers' use of guns. Often the Indians were forced to give up their own weapons, rendering them defenseless, so it would be understandable if they were reluctant to forfeit the right to bear arms. It is a right they have had only since 1979, when the federal government restriction on the sale of firearms to Indians was abolished (Tahmassebi, 1991). On the other hand, the easy availability of guns probably contributes to the rates of violence and suicide on tribal lands.

Regarding sexual orientation, there is no reason to think there are any more or fewer gay and lesbian people among Native Americans than there are in the general population (estimated to be about 1.4%; Chandra, Mosher, & Copen, 2011). An additional 2% of American adults identify themselves as bisexual or transsexual (Gallup, 2012), for a total of 3.4% of U.S. adults who self-identify as lesbian, gay, bisexual, or transgender. It has been speculated that many genders and flexible sexualities were sanctioned among some American Indian communities prior to the European colonization; such diversity was generally condemned after the European arrival. Many Indian people converted to Christianity and adopted the idea that same-sex relations were sinful. Disapproval of and discrimination against gays are common in many Native communities (Gilley, 2006, 2010).

The racial objectification of Native Americans continues today. An example is the use of Native peoples as mascots by sports teams. Stereotypical depictions of Indian people with red skin wearing a full headdress are seen in the mascots of the Cleveland Indians, the Washington Redskins, and the Atlanta Braves. The names of Indian tribes are also used to sell products:

> There are "Cherokee" Jeeps and "Cheyenne" trucks, "Thunderbird" and "Pontiac" automobiles, "Mohawk" carpets, "Pequot" sheets, "Oneida" tableware, "Big Chief" writing tablets, "Red Man" chewing tobacco . . . "Eskimo" Pies, Piper "Cherokee" and "Navaho" airplanes, "Winnebago" motor homes, and of course the ironically named "Apache" and "Comanche" helicopters used by the U.S. military. There is no equivalent example for other peoples whose names are so objectified that they can be used as designations to sell products. (Trimble & Thurman, 2002, p. 137)

Some social justice advocates have called for the elimination of Native-themed mascots, nicknames, and logos (Steinfeldt et al., 2012). The misappropriation of American Indian culture continues, and it is important for counselors to understand this issue and consider supporting efforts to eliminate race-based names for mascots and consumer products.

Mental Health

It is difficult to generalize about how Native Americans think about the value of counseling or psychotherapy. Those who live on tribal lands and lead fairly traditional lives are more likely to be suspicious of counseling and consult tribal healers rather than counselors or psychologists for help with personal distress and disorders. Native people are more likely to seek assistance from hospitals and health clinics than counseling centers (Beals et al., 2007). Many Native people use both traditional healers and modern health care systems, and some may seek counseling at the Indian Health Service or tribal behavioral health centers. However, only 20% of Native Americans have easy access to Indian Health Service clinics, because most live in urban areas (Yurkovich & Lattergrass, 2008).

Precise prevalence rates of mental disorders are often difficult to obtain because of limited research methodologies, and Native Americans are routinely omitted from many studies, probably because of the small size of the population in many areas. However, some data are available in the literature. Although the great majority of Native Americans do not experience serious mental disorders at a rate any greater than the general population, about one fifth of the population does suffer from serious mental disorders or self-destructive behavior. Suicide is the second-leading cause of death among Native Americans aged 10 to 34, and other frequently mentioned problems include depression, anxiety, and alcohol use disorders (Nathan Kline Institute, 2012).

Many writers on Native American mental health have emphasized the differences in values between Indian people and European Americans (e.g., Trimble, 1976). For example, Indian people are said to value holism, nature, spirituality, and family and group relationships more highly than European Americans. These alleged differences are hard to verify because no data-based studies have actually compared the two groups on this dimension. However, traditionally Native Americans most likely did place more emphasis on community well-being and group success than Whites as a group, who are often described as highly valuing individualism. This suggests that Native Americans who hold traditional values may be more responsive to family, group, and network interventions than individual counseling and psychotherapy.

Some writers have speculated that contemporary Native Americans may suffer from trauma today as a result of the trauma inflicted on past generations of Indian people:

> The cumulative trauma has been fueled by centuries of incurable diseases, massacres, forced relocation, unemployment, economic despair, poverty, forced removal of children to boarding schools, abuse, racism, loss of traditional lands, unscrupulous land mongering, betrayal, broken treaties—the list goes on. (Trimble & Thurman, 2002, p. 64)

The theory is that this history has created a great reservoir of unresolved grief in Indian people, contributing to individual and social problems such as depression, suicide, alcoholism, and other problems (Brave Heart & DeBruyn, 1998; Duran, 2006; Gone, 2009; LaDue, 1994). It is certainly possible that some Indian people feel a deep sense of discouragement, demoralization, and even depression when they think about the history of their people since colonization. However, whether this amounts to a specific mental disorder called *historical and intergenerational trauma* is unclear. This use of the term *trauma* is not well defined and is not consistent with the criteria for the term in standard diagnostic systems. There is also no clear proposal for how such trauma could be transmitted across generations, unless parents traumatize their children by emphasizing the negative aspects of Indian history. Would such a diagnosis apply to people from other oppressed groups who suffered abuse in past generations, such as African Americans? Much research is needed to establish whether historical trauma exists, whether it should be seen as a mental disorder, and (if so) how it could be treated. Speculation that such trauma "may be unresolvable" (Trimble & Thurman, 2002, p. 65) may be too pessimistic, considering that effective treatments exist for other types of trauma.

From a practical perspective, rather than proposing a vaguely defined new mental disorder and trying to develop specific treatments for it, it may be more beneficial to view this kind of psychological distress as a normal and understandable consequence of historical abuse and oppression. Such an approach would not deny or minimize the horrific history of Indian people since colonization, but it would focus on the prospects for positive change in the future. Treatment for generational trauma could be the same kind of counseling provided to other Native people who suffer from trauma and depression from other causes. There is no reason to think that cognitive behavioral therapy, for example, would not be just as effective to treat "generational trauma" as other forms of trauma (LaFromboise, 2012; Morsette et al., 2009).

Key Multicultural Concepts and Characteristics

Identifying Native Americans

It is important that counselors understand that Indian identity is a controversial concept among Native Americans. Who is Native American, and how many Native Americans are there? The difficulty involved in counting Native Americans illustrates the complexity of defining racial and ethnic identity. It should be understood that various interest groups might emphasize one population figure over another depending on what they are trying to accomplish. The U.S. government might prefer to minimize the number of Native Americans, because it has legal and financial obligations to Indian people. The government requires Indian people to be registered tribal members to receive benefits set aside for them. On the other hand, Indian people themselves are likely to prefer a large population figure in order to increase their influence.

The definition of who is Indian depends on who is doing the defining (Utter, 2002). Tribes have the right to determine the membership criteria for their members, and ancestry may not be enough to qualify for membership in a tribe. Tribes may also vary in their membership requirements; some tribes have more stringent criteria than others. Many tribes use *blood quantum*, or percentage of genetic heritage, as the criterion. For example, a person with one parent who belongs to a tribe and another parent who does not would have a blood quantum of one-half. Some tribes require a blood quantum as small as one-thirty-second for membership, whereas others require as much as one-half. Some tribes have

considered blood quantum less important than other factors such as speaking the tribal language and following cultural practices (Utter, 2002).

As a general rule, the U.S. government recognizes people as American Indian if they have blood quantum from and membership in a federally recognized tribe. However, there is no single federal or tribal standard that establishes a person's identity as American Indian, and different government agencies use different criteria (Bureau of Indian Affairs, 2013). Some historians believe that the use of blood quantum was imposed on tribes by the U.S. government as a way of decreasing the number of Indian people who would be eligible for money and land assigned to the tribes. In the 19th and 20th centuries, many politicians hoped that Native Americans would assimilate with Whites and intermarry, thus diluting their political power. This has in fact happened to some extent. For whatever reason, today more than half of Native Americans marry non-Natives, and if this trend continues many tribes may lose benefits unless they loosen their membership requirements (Treuer, 2013). If this trend of intermarriage continues (and there is no reason to think it will not), eventually there will be very few Indian people who have only Indian genetic heritage. However, genetics is only one part of defining who is Indian; certainly there are some biracial Indian people who are more involved in Indian culture than some "full blood" Indian people. The complexity of counting the number of Native Americans in the United States illustrates the difficulty of defining cultural identity in the postmodern world.

Depending on the criteria used for counting, there are somewhere between 2.25 and 6.2 million Native Americans. According to the U.S. Bureau of the Census, as of 2007 there were about 4.5 million American Indians and Alaska Natives (about 1.5% of the total U.S. population). Using looser criteria, the 2010 census counted 6.2 million people who identified themselves as Native American or Alaska Native alone or in combination with one or more other races (Office of Minority Health, 2012). The 6.2 million figure no doubt includes many people (perhaps as many as 2 million) who have only a tenuous connection to Native American culture and consider themselves biracial or multiracial.

About 2 million people are enrolled members of one of the federally recognized tribes. Probably about another half million people are members of state-recognized tribes or other tribes or have significant Indian heritage or identification. Not all American Indian tribes care about U.S. government recognition. Many have never sought such recognition and deny the right of the government to define or certify Indian identity. The census figures are thus somewhat misleading, because the Census Bureau simply asks people to identify their race; no documentation is required, and apparently many people say they are Indian even though they have few or no ties to any tribe. Possibly as many as 2 million Americans claim to be Native American even thought they are not enrolled members of any tribe and would not be able to document any such relationship. So an accurate estimate of the number of people who have strong Native Americans identity is probably about 2.25 million, or about 0.75% of the total U.S. population.

Key Characteristics

Contemporary Indian people are quite diverse, and generalizations about them are sometimes misleading. It is important that counselors understand that there is no average or typical Indian person. The large number of tribal groups illustrates the diversity of Indian people. Currently there are 566 federally recognized tribes, more than 100 state recognized tribes, and other tribes that have not requested recognition from any governmental entities; as mentioned in the Current Experiences section, 60% of them live in metropolitan areas (Office of Minority Health, 2012).

Counselors should undertake some study of Indian cultures. Counselors who work in regions of the country where many Indian people live should learn as much as they can about the local tribes. However, 60% of Indian people live in urban rather than rural areas, so counselors who live and work in cities may well have some Indian clients.

One goal of this chapter is to emphasize the diversity of Indian peoples. They vary on many dimensions, including tribe, cultural beliefs and traditions, language, and degree of acculturation. Each Indian person is an individual who can only be understood in the context of his or her family, background, tribe, living situation, values, personality, and many other factors. White Americans understand that identifying someone as White says very little about that person's beliefs, values, or personality, and the same is true for Native Americans.

As an example of how Native Americans vary, consider linguistic differences. Before the arrival of European culture, about 250 languages were spoken in the present territory of the United States. With the decrease in the Native population due to White colonization (from about 20 million to about 2 million), most of the Native languages have ceased to exist. However, eight indigenous languages are still spoken by more than 9,000 people. Of these, only the Dine (Navajo) language has more than 25,000 speakers in the United States, with an estimated 148,530 speakers (Rehling, 2012).

There can be dramatic differences even between two Indian people from the same tribe. Consider the following examples. Mary is a Dine (Navajo) woman who was born in a rural part of the Dine tribal lands and grew up speaking the Dine language. Both of her parents were Dine. Her family lived in a *hogan* (a round wood and earth dwelling) and had neither running water nor electricity. Mary's mother was a rug weaver; she sheared sheep for wool, dyed it using plants she gathered, and did the weaving based on traditional patterns. Her father was a rancher who had sheep, horses, and a few cows. Mary learned to herd sheep as a child, and she participated in tribal ceremonies and social gatherings with her family. When she got sick her parents took her to a medicine man. Mary enjoyed living a traditional style of life and did not much enjoy visiting cities.

Now consider Erma; she is also Dine, but she was born in Flagstaff (population 66,000) and she grew up speaking English; her parents rarely spoke Dine in the home. Her family lived in an apartment, and she attended a school where most of the children were White. As a child she enjoyed going to the mall and riding a bicycle; she watched television and had a cell phone. Erma's mother worked as a receptionist at a dental office, and her father did skilled construction work. Her family considers themselves Catholic, and they enjoy attending church. They sometimes visit friends back "on the rez," but they rarely participate in tribal ceremonies and have never consulted a medicine man. They feel comfortable living in a city and appreciate having more job opportunities there.

The dramatic differences between these two Dine women illustrate the difficulty of generalizing about what Dine people are like. Should a counselor work with them differently? It goes without saying that counselors should treat every client as a unique individual who has his or her own culture. One difference in cross-cultural counseling is that, in order to be effective, the non-Indian counselor must get a sense of the Indian client's acculturation style (Harper, 2011). More information on acculturation style and how to assess it can be found in Garrett and Pichette (2000) and Choney, Berryhill-Paapke, and Robbins (1995).

Systemic Barriers

One of the greatest systemic barriers to Native Americans seeking assistance with mental health issues is their concern that providers will not understand their cultural differences

(Yurkovich & Lattergrass, 2008). This suggests that counseling centers should provide cultural awareness training for staff, monitor counselors' success rate with Native clients so that mentoring can be provided if necessary, and ask Native clients for feedback on how to improve counseling services. In some locales there are counseling centers that specialize in working with Native clients, but mainstream clinics and counseling centers should still strive to provide culturally appropriate services. Resources are available to help trainers design curriculum materials for counselor training (e.g., Thomason, 2011a, 2011b, 2011c, 2013).

Financial barriers can also prevent Native Americans from obtaining needed counseling services. Only about half of them have employer-provided health insurance coverage (compared with 72% of Whites); Medicaid is the primary insurer for 25% of Indian people, and 28% lack any kind of health insurance coverage (U.S. Census, 2012). Counseling centers should be prepared to offer poor clients counseling services for free or on a sliding scale.

Agencies and other organizations that provide counseling services may unintentionally put up barriers to Native American clients. For example, requiring an appointment far in advance or requiring extensive paperwork prior to the first session can discourage Native clients who have an immediate concern. Counseling services must be easily accessible to Native clients. This means they should be easy to find, convenient, affordable, and culturally sensitive. Counseling services for Native people should be advertised widely and use images and language that make potential clients feel understood and welcomed. Agency décor should be welcoming, and receptionists and office staff should be trained in cultural sensitivity.

Having Native American counselors on staff is important to build credibility with Native clients and serve them better. Services can be adapted to meet the needs of Native clients who live in rural areas. For example, clients should be allowed to drop in without an appointment; outreach services should be provided; extended family members should be encouraged to accompany clients; and translators should be available if necessary for Native clients. Low-income working parents may have great difficulty taking time off from work for counseling without losing pay or jeopardizing their jobs. Counseling centers should provide childcare for clients' children if possible.

The attitudes of counselors can also be a barrier to serving Native clients. It is important that counselors be approachable, show that they appreciate Indian culture, and demonstrate that they are trustworthy. Counselors who think that all clients are pretty much alike, or that conventional counseling models are effective with all clients, are not likely to be effective with Native American clients.

Personal Voices

The Story of Kai

Kai (a pseudonym) was a 21-year-old, single, Dine (Navajo) woman who was living in Flagstaff in Northern Arizona while attending a training program in dentistry at the state university. She had grown up in a rural area near Kayenta, 150 miles from Flagstaff. Kai spoke both Dine and English and considered herself "bicultural." She traveled back home as often as possible to visit her family and participate in social and cultural events. She said that she had a few good friends on campus but that she wanted to have time for more socializing and recreation.

Kai's presenting problem was distress and frustration due to three issues: some difficulties "fitting in" with her peers on campus; difficulty with her role as the leader of a campus

group; and distress over failing some tests in her courses. Kai said she had Dine friends but had difficulty making friends with non-Indians. She was concerned that some people may have avoided her or rejected her because of racism. She said that she considered herself shy but that she wanted to socialize with a wide variety of people. At the intake interview the counselor noticed that Kai was nervous, although she calmed down as the session went on.

Kai had volunteered to be the leader of a student group on promoting cultural understanding on campus, but she said that the members of the group, most of whom were non-Indian, ignored her contributions and her efforts to direct the activities of the group. They actually spoke over her, interrupted her, and dominated the group meetings. Kai was frustrated and found it impossible to lead the group. Kai was also concerned about some academic difficulties; she felt extreme test anxiety and had failed tests in two of her courses. She was very unhappy about this and said she was determined to do whatever was necessary to overcome her test anxiety.

Individual Counseling: Applications at the Microlevel

Kai's counselor at the university counseling center was White but had received coursework and training in multicultural counseling and had attended a 3-day workshop on counseling Native Americans. He had also read several articles and book chapters on the topic and had had several Indian clients in the past, so he felt comfortable seeing Kai.

The counselor adapted his standard approach to counseling somewhat when seeing Native clients. He met Kai in the waiting room when she first came in and let her bypass most of the intake paperwork, except for the consent form. He made a special effort to be warm and welcoming and even offered her coffee or tea. The counselor modeled his nonverbal behaviors and voice tone and volume on that of the client because he found this helpful in building rapport. He spent more time than usual getting to know Kai and shared more than usual about himself, including his family background, his hometown, and his current family situation. This self-disclosure elicited similar information from the client without the need for too many personal questions. The counselor worked hard to establish a safe atmosphere in which Kai would feel willing to talk about her concerns. He brought up the topic of the ethnic difference between himself and Kai and said, "We have some time to get to know each other, and I know it takes time to trust someone you have just met. I hope you will feel comfortable with me, but please let me know if I'm moving too fast or being too direct. I want you to be comfortable. I hope you will let me know how you would like for me to work with you."

The counselor provided Kai with an orientation to counseling and described how counseling can help people sort out their ideas and feelings. The counselor encouraged Kai to contact her friends and relatives whenever she felt the need for support, and he said they would be welcome to attend counseling with her if they wished. Regarding his theoretical model, the counselor took an eclectic approach with Kai. He conducted the first part of the intake session using standard methods of building rapport, such as listening intently, doing his best to convey sincerity and a nonjudgmental attitude, and using silence and minimal prompts to encourage Kai to talk. He paraphrased her comments to ensure that he understood her concerns and used summary statements and clarifications as needed. He avoided any direct inquiries about Kai's personal life. The counselor used his comments to guide Kai toward stating her concerns, specific examples of problematic situations, and her goal for counseling.

In the second half of the intake interview the counselor worked with Kai to put her concerns in a social context, to normalize them, and to begin working on potential solutions.

He helped Kai identify her strengths and resources, and he investigated Kai's prior solution attempts regarding her presenting problem about having difficulty making friends. He also described how focusing on recurrent, automatic negative thoughts can increase distress. The counselor commented that Kai's distress about fitting in with her peers on the mostly non-Indian campus was a common issue for Indian people who moved to town to attend the university and that talking through her issues might help her feel better. Kai was receptive to these ideas and appeared to be highly motivated to work toward resolving her concerns.

Toward the end of the first session the counselor summarized Kai's concerns and suggested that counseling could be helpful. Kai agreed to come to a few weekly counseling sessions. Kai and her counselor agreed that her goals for counseling would be to decrease her negative thoughts about herself and her ability to make friends; increase her socializing; improve her assertiveness skills; improve her grades in her courses by getting treatment for test anxiety; and develop coping strategies to help her decrease her acculturative stress. Toward the end of the intake interview the counselor asked Kai if she would be willing to monitor her thinking for a few days and make a written note of her recurring negative thoughts, and she agreed. After the intake interview the counselor noted Kai's diagnosis as acculturation difficulty and academic problem, neither of which is considered a mental disorder. He also wrote a cultural formulation to supplement the diagnostic assessment, as recommended by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013).

During the next few sessions the counselor worked with Kai to show her how to question the validity of her negative thoughts, dispute them, and decrease their salience. Over time, Kai reported that she was finding it easier to notice when she was thinking negatively and was often able to analyze her thoughts and change them to make them more realistic. Using ideas from solution-focused counseling, the counselor also investigated things Kai had done in the past to help her feel better and make new friends. Kai practiced starting conversations with strangers by doing role-plays with the counselor, and she decided to join some student groups, such as the hiking club, as a way to meet new people. The counselor taught Kai assertiveness skills by doing role-plays, and she applied her new skills to take back the leadership role in her campus organization. The counselor also led Kai through a standard process for coping with test anxiety by learning physical and mental relaxation methods. Kai practiced the methods at home, and gradually her test anxiety decreased and her grades on her tests improved.

Given the historically contentious relationship between Native Americans and European Americans, it is understandable that many Indian people may be reluctant to engage in counseling with non-Indian counselors. A common suggestion in the literature is that non-Indian counselors should anticipate this reluctance and ensure that they demonstrate trustworthiness. They can do this by being warm, respectful, authentic, concerned, and good listeners (Lokken & Twohey, 2004). These characteristics are assumed to be present in all good counselors, but perhaps they do need to be emphasized in the context of cross-cultural counseling.

Counselors should establish a trusting relationship with their Indian clients, help them explore their concerns, and discuss the influence of social factors if they are relevant. Counselors should talk about cultural differences between them and the client and ask clients to let them know about cultural beliefs that may affect counseling. Counselors should adapt their interviewing style to the client and use self-disclosure to elicit client information. As part of the intake interview the counselor should informally assess the client's acculturation

tion; decide whether counseling is likely to help the client; and refer the client to other social services if needed. Counselors should determine whether issues of advocacy, client empowerment, and social justice are relevant and, if so, how to address them.

Counselors should ensure that their services are not structured such that they exclude or discourage Native American clients. For example, excessive intake paperwork can discourage Native clients, as can the lack of Native service providers. In areas with a significant Indian population, it can be effective to offer days when clients can drop in without an appointment. Native art on the walls can help clients feel welcomed, as can refreshments.

It is important for counselors to consider the client's family situation, their strengths and resources, their personality and temperament, and their perception of how counseling may be able to help them. Some clients prefer a nondirective style of counseling (where the client generates topics and issues and discusses them with the counselor), whereas others prefer a more directive problem-solving approach (where the counselor helps the client actively search for potential solutions to practical problems). Rather than assume that they know what their clients need, counselors should allow Native clients to direct the nature and style of the counseling interaction.

The client's acculturation style will have a great influence on what is done in counseling (Trimble, 2010). Native American clients who are very traditional may benefit more from an orientation to what counselors can do for them, and in some cases, depending on the client's concern, referral to a traditional healer in the client's tribe may be appropriate. More acculturated clients may be responsive to standard counseling approaches such as behavioral, cognitive, and solution-oriented models (Thomason, 2011c).

Less traditional (more acculturated) Native Americans who live in urban areas do sometimes seek counseling from community mental health centers, university counseling centers, or independent counselors. Native people who seek counseling voluntarily have a good chance of receiving assistance, though only if their counselor is culturally sensitive and uses methods the client responds to well. Counselors should always ask their clients to evaluate whether the counseling is helpful and offer the counselor feedback on ways to improve. There is little reason to think that mandated treatment for Native clients is any more successful than it is with non-Indian clients, but counseling can certainly be successful with voluntary clients.

Traditional Native American cultures sometimes stigmatize mental illness, and ideas about disorder resulting from misbehavior or the breaking of a taboo are common. Some disorders and disabilities are thought to be contagious in some tribes, so the person with the disorder may be stigmatized and avoided. Although the majority of Native Americans today probably do not hold such ideas, it is still very important to emphasize the confidential nature of the counseling relationship, so that Indian clients will feel comfortable revealing their personal concerns.

Counselors who work in urban areas can expect that some of their Indian clients may be unavailable for treatment for days or weeks at a time because they may need to return to their tribal homelands to visit family or attend ceremonies. Counselors should also be aware that Indian clients who live in rural and reservation areas may be unable to call to change or cancel appointments because of the lack of telephone service (Nathan Klein Institute, 2012). The lack of public transportation in rural areas and the great distances involved can also prevent potential clients from seeking counseling services. Language barriers are most likely to be encountered when counseling older Native Americans who live in rural areas (Nathan Klein Institute, 2012); interpretative services may be required.

Native Americans have been described as favoring communal approaches to intervention rather than the one-on-one approach of many psychotherapeutic models (Calabrese,

2008). Counselors are routinely trained in group and family counseling, so they can use these modalities with Indian clients if desired.

Advocacy Counseling: Applications at the Macrolevel

The counselor suspected that Kai's concerns were related to both individual factors and social factors. Her shyness could be an integral part of her personality, but it was exacerbated when she was in an unfamiliar or challenging environment such as a campus where the majority of the students were non-Indian. Acculturative stress is common in culturally diverse clients who find themselves away from home and their naturally occurring support systems. Similarly, any student can have test anxiety, but Kai's anxiety was made worse by excessive demands she placed on herself to perform well in the non-Indian world of a modern university. She felt she absolutely had to get As in all her courses, and this perfectionism set a high bar for her achievement and made her susceptible to discouragement.

The counselor's discussions with Kai revealed that she had several strengths and resources. Kai was a hard worker and was highly motivated to succeed in her academic program. She was intelligent and active in both tribal and campus organizations. She traveled back home to visit her family as often as possible, and she was very close to her mother and her sisters, who were available to provide emotional support whenever needed. Kai also held some traditional Dine beliefs and had access to tribal elders and healers.

Regarding Kai's concerns about her grades, the counselor suggested that Kai might consider talking to her teachers to discuss her concerns and ask for their advice on how to do well in their courses. Kai felt nervous about doing this, so the counselor suggested that they role-play Kai talking with her teachers. The counselor also offered to contact Kai's teachers to advocate for her regarding her academic concerns. As a way to address the general problem, the counselor proposed to his supervisor that the counseling center sponsor a workshop for faculty on working effectively with Native American students. This would be a way to sensitize faculty to cultural issues that affect Native students' learning and encourage them to take into account potential acculturative stress occurring in culturally diverse students. Based on the counselor's suggestion, a series of workshops were conducted to help faculty learn how to work more effectively with Native American students.

Kai's counselor suggested that she visit the Native American Cultural Center on campus and consider joining a support group for Native students. The counselor also visited the center and volunteered to facilitate groups for Native students to explain what counseling is and how it can help them. When, during their third counseling session, Kai mentioned that her sister would be visiting her, the counselor suggested that they come in together so they could brainstorm ideas for improving Kai's feeling of social support. Kai was pleased with her counselor's willingness to think outside the box to help her.

Counseling for Social Justice

The term *social justice* has been defined as "societal-level commitment to equity for all groups of people" (McAuliffe, Danner, Grothaus, & Doyle, 2008, p. 47). It includes the idea that there should be equitable access to resources, opportunities, and services; this is a typical goal of democratic societies and religious traditions. As applied to counselors, the commitment to social justice implies that counselors will work toward eliminating biases based on race, ethnicity, and other factors and work to promote equity in the attitudes of individuals and the policies of institutions.

A social justice approach in counseling uses advocacy and activism as a way to address inequitable social, political, and economic conditions that impede the success of individuals (Lewis, Ratts, Paladino, & Toporek, 2011; Ratts, Lewis, & Toporek, 2010). Advocating for clients should be seen as a natural extension of counseling's traditional emphasis on working with clients as individuals. Reaching out to make social systems and institutions more culturally sensitive and responsive can help many clients rather than just one. The American Counseling Association has endorsed advocacy competencies for counselors, and the advocacy role is increasingly seen as an essential one (Ratts, DeKruyf, & Chen-Hayes, 2007; Ratts et al., 2010). Social justice for Native Americans has been called "historically an illusory concept" (Eason & Robbins, 2012, p. 18), but some authors have provided suggestions for how counselors can promote social justice for Native Americans (Herring, 1999a; Turner & Pope, 2009a, 2009b).

McAuliffe's (2008) guidelines for flexibility in working with culture certainly apply to counselors' work with Native Americans: Recognize fluidity in culture; make measured, tentative generalizations; and flexibly adapt traditional counseling theories to the client's culture. Cultural concepts are constantly changing social constructions; there is no such thing as "Native American culture," but there are many Native American people in diverse settings who adapt and change over time based on their own beliefs, wishes, and understandings. Cultural norms are not absolutes, and counselors should not allow tentative generalizations (such as "Native Americans speak quietly and avoid eye contact") to become stereotypes. There are, no doubt, individual Native Americans who contradict all stereotypical ideas about Native Americans in general. Likewise, there can be no theory of counseling specifically about Native Americans, because not all Native Americans are the same. Vontress (2003) noted that such an approach would be "groupism," if not outright racism. There is currently no generally accepted culturally specific or universal counseling approach that can be applied to work with Indian people. Counselors must accept this perhaps uncomfortable reality and be willing to encounter each client on his or her own terms and adapt their counseling approach as needed to be culturally appropriate.

The much-studied dimension of individualism–collectivism is relevant to work with Native Americans, because they are often referred to as collectivist. In such societies, the needs of the group often take precedence over the needs of the individual. Collectivist cultures tend to emphasize social networks and social rules for behavior rather than individualism (McAuliffe, 2008). They are hierarchal and value adherence to authorities such as elders and are characterized by "high context" communication, in which the implicit social message is more important than the literal meaning of the words. For example, Native Americans may ask someone "Where are you from?" as a way to determine that person's relationship to traditional Native culture.

Culturally competent counselors have an awareness of their own cultural values and biases, they have knowledge of clients' worldviews, and they use culturally appropriate intervention strategies and skills. Counselors who work with Native Americans should consider their clients' language proficiencies, the appropriateness of the use of various psychological assessment instruments, and the potential need to adapt their communication style to that of their clients. Counselors should assess Indian clients' type of acculturation and adapt their interventions to clients' needs. Counselors should understand that in some cases, it may be necessary to refer Native American clients with traditional values to indigenous tribal helpers. Counselors who want to be culturally competent will seek out opportunities to learn about local indigenous groups by attending tribal social activities

that are open to the public, taking courses and attending workshops, and reading books and viewing films about counseling Native Americans (Thomason, 2013).

Culturally competent counselors look for opportunities to engage in advocacy to address the needs of Native Americans. They are open to learning about Native beliefs, traditions, and ways of living. They recognize the effects of oppression on Native clients and are committed to doing what they can to ameliorate such oppression. They seek opportunities to begin dialogue with both Natives and non-Natives on how both individuals and institutions can become more culturally responsive to Native Americans. Culturally competent counselors are able to use a wide variety of verbal and nonverbal responses and interventions, depending on the specific needs of the client. They are not tied to counseling theories or techniques that may be culture-bound; they are willing to adapt their approach to each client in order to help the client reach his or her goal for counseling.

Several authors have recommended ways that counselors can implement advocacy and social action with their clients, and many of these methods can be adapted to work with Native American clients (Hage et al., 2007; Ivey & Collins, 2003; Kiselica & Robinson, 2001). Counselors can leave their offices and work in the client's home, school, or social environments; they can meet with policymakers to discuss needed changes; they can question whether certain psychological tests are appropriate for use with Native clients before using them; and they can write articles and talk to the media about issues relevant to Native Americans. Counselors should be careful in their use of diagnostic manuals with Native clients so they do not overpathologize or overdiagnose their clients. Counselors can challenge their own agencies and institutions to do outreach to Native clients, provide written and other materials in formats appealing to Native people, and make access to counseling services easier. Counselors can mediate between clients and institutions; complain to funding agencies about inadequate or ineffective services; and lobby policymakers to improve counseling services for Native people. Counselors can also work to implement prevention programs adapted to the mental health problems and needs of Native Americans.

It is important for counselors to recognize that Native clients' problems sometimes are more properly seen as problems in other people, institutions, or society. For example, racism in other people may cause distress in the client, but the best response may be to confront and try to change such racism. Native clients may also be distressed by policies resulting from institutional racism, in which case the proper target of intervention is the institution. Counselors can help Native clients frame their distress in ways that empower them rather than discourage them from taking action. Taking positive action against oppressive institutional policies can empower both counselors and clients.

Future Directions

There is much discussion in the literature about how best to conduct effective counseling with Native American clients. There is a general understanding that standard models of counseling were designed for European Americans and may not be culturally appropriate for diverse populations. Some have suggested that counselors should add ideas or methods from traditional Indian healing to their counseling model. However, there is little evidence that such a hybrid approach is effective. Gone (2010) pointed out that integrating psychotherapy and traditional healing is extremely complex, and it is unreasonable to think that psychologists and counselors could become traditional healers. Non-Indian counselors should not attempt to use tribal healing methods unless they have been trained

and approved by recognized healers from the client's tribe (Thomason, 2011c). Incorporating traditional healing practices into counseling is too complex for casual use, especially by providers who see Native clients only occasionally.

Regarding the use of specific counseling models and methods with Native American clients, unfortunately it is impossible to make any valid generalizations. This is understandable, given the great diversity of Indian people; just as no one approach works with all non-Indians, no one approach is likely to help all Indian clients. Although the literature on counseling Native Americans abounds with specific ideas and suggestions based on clinical experience and anecdote, very little research has been done to compare the effectiveness of different counseling models with members of this population (Gone, 2010; Portman & Dewey, 2003; Trimble & Thurman, 2002). Evidence-based psychological interventions for Native Americans have yet to be identified (Gone, 2010; Whaley & Davis, 2007). Given the difficulty of conducting randomized, controlled, outcome research with large matched groups of Native people, counselors and clinicians have to continue to rely on the recommendations of counselors and others who have experience with this population. Although this literature contains many speculative ideas, currently it is the best source of advice on how to conduct counseling with Native clients. Counselors should try to keep their knowledge current regarding new research results in this area.

Non-Native counselors may view providing effective counseling services to Native American clients as quite challenging. However, counselors have a responsibility to do what they can to maximize their effectiveness, and this mandate certainly applies to their work with Native Americans. Fortunately, the task is quite manageable. It is not difficult for counselors to educate themselves about Native American cultures and thus increase their sensitivity to Native clients. Many good resources are available to increase counselors' awareness of issues of general concern to Native Americans. There are also many good books, book chapters, and articles that provide specific suggestions for how to provide culturally sensitive and appropriate counseling for Native American clients (e.g., Gone, 2004, 2007; Herring, 1999b; Trimble, 2010; Trimble & Thurman, 2002). However, most of the recommendations in the literature about how to counsel Native American clients are based on opinion and anecdote rather than any kind of systematic research. There is very little outcome research on the effectiveness of counseling when applied to Native American people with mental disorders (Turner & Pope, 2009a). Much more research is needed to establish the best practices for the assessment, diagnosis, and counseling of Indian clients.

The majority of Native American clients that most counselors are likely to encounter will be acculturated enough that they will probably benefit from various standard models of counseling. "Some Native individuals can and indeed have benefited from conventional psychotherapy" (Gone, 2010, p. 214). Other Native clients will benefit from more culturally modified forms of counseling. In other cases, particularly with more traditional Indian clients, referral to an indigenous healer may be the best alternative. Given the small number of Native American counselors and psychologists, by default most Native clients will continue to be served by non-Indian providers.

Counselors are beginning to heed the call to attend to social factors that affect their clients' lives and problems. Counselors who see Native clients should recognize that their clients' problems often result from a complex interplay of individual traits (such as genetics, personality, and learning history) and social factors (such as racism, discrimination, and poverty). Counselors who attend to the social factors by advocating for clients' rights and fighting for social justice increase their ability to help both their clients and society as a whole.

Resources

Books

Herring, R. D. (1999). *Counseling with Native American Indians and Alaska Natives.* Thousand Oaks, CA: Sage Publications.

Moodley, R., & West, W. (Eds.). (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage Publications.

Paniagua, F. A. (2005). *Assessing and treating culturally diverse clients* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Swinomish Tribal Mental Health Project. (1991). *A gathering of wisdoms.* LaConner, WA: Swinomish Tribal Community.

Witko, T. M. (Ed.). (2006). *Mental health care for urban Indians: Clinical insights from Native practitioners.* Washington, DC: American Psychological Association.

Podcast

Baltimore, M. L. (interview). (2006, January 26). *Counseling with Native American/Alaska Natives* [Audio podcast]. Retrieved from http://www.counseloraudiosource.net/feeds/CAS003.mp3

Videos

American Psychological Association (Producer). (2005). *Working with Native Americans* (Item #4310722). Available from http://www.apa.org/pubs/videos/4310722.aspx

Jenerson-Madden, D. (1996). *Counseling the Native American client*. Retrieved from http://www.worldcat.org/wcpa/top3mset/38983627

LaFromboise, T. (1996). *Counseling and therapy with Native American Indians* (Product ID 453). Retrieved from https://www.academicvideostore.com/video/counseling-therapy-native-american-indians

Martinez, A., & Martinez, N. (2000). *Innovative approaches to counseling Native American Indian People* (Part IV of the series Culturally Competent Counseling and Psychotherapy; Product ID 504). Retrieved from https://www.academicvideostore.com/video/culturally-competent-counseling-and-therapy-part-iv-innovative-approaches-counseling-native

Websites

First People
http://www.firstpeople.us/

NativeWeb
http://www.nativeweb.org/

Society of Indian Psychologists
http://www.aiansip.org/

References

Ahtone, T. (2008, November 4). *Paying attention to the Native American vote*. Retrieved from http://www.pbs.org/frontlineworld/election2008/2008/11/paying-attention-to-the-n.html

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

Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2007). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations. *American Journal of Psychiatry, 162*, 1723–1732.

Blades, M. (2012, July 2). *American Indians organize largest get out the vote campaign in history.* Retrieved from http://www.dailykos.com/story/2012/07/02/1102913/-American-Indians-organize-largest-get-out-the-vote-campaign-in-history-You-can-help-make-it-happen

Brave Heart, M. Y. H., & DeBruyn, L. (1998). The American Indian holocaust: Healing unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*, 56–78.

Brown, C. B. (2008, May 29). *Dems woo Native American vote*. Retrieved from http://www.politico.com/news/stories/0508/10676.html

Bureau of Indian Affairs. (2013). *Frequently asked questions*. Retrieved from http://www.bia.gov/FAQs/index.htm

Bureau of Labor Statistics, U.S. Department of Labor. (2011). *Racial and ethnic characteristics of the U.S. labor force, 2011*. Retrieved from http://www.bls.gov/opub/ted/2012/ted_20120905.htm

Bureau of Labor Statistics, U. S. Department of Labor (2013). *Databases, calculators & tables by subject.* Retrieved from http://data.bls.gov/timeseries/LNU04000000?years_option=all_years&periods_option=specific_periods&periods=Annual+Data

Calabrese, J. D. (2008). Clinical paradigm clashes. *Ethos, 36*, 334–353.

Chandra, A., Mosher, W. D., & Copen, C. (2011). *Sexual behavior, sexual attraction, and sexual identity in the United States* (National Health Statistics Reports). Washington, DC: National Center for Health Statistics.

Chavers, D. (2012, October 29). A history of Indian voting rights and why it's important to vote. *Indian Country Today*. Retrieved from http://indiancountrytodaymedianetwork.com/2012/10/29/history-indian-voting-rights-and-why-its-important-vote-140373

Choney, S. K., Berryhill-Paapke, E., & Robbins, R. R. (1995). The acculturation of American Indians. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 73–92). Thousand Oaks, CA: Sage Publications.

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

Eason, E. A., & Robbins, R. (2012). Walking in beauty: An American Indian perspective on social justice. *Counseling and Values, 57*, 18–23.

Ehrich, T. (2006, August 13). Where does God stand on abortion? *USA Today*. Retrieved from http://usatoday30.usatoday.com/news/opinion/editorials/2006-08-13-forum-abortion_x.htm

Fikes, J. (2012). *A brief history of the Native American Church*. Retrieved from http://csp.org/communities/docs/fikes-nac_history.html

Freire, P., & Ramos, M. B. (2000). *Pedagogy of the oppressed*. New York, NY: Bloomsbury Academic.

Gallup (2012). *Special report: 3.4% of U.S. adults identify as LGBT*. Retrieved from http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx

Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling & Development, 78*, 3–13.

Giago, T. (2008, October 12). *Forming a Native American party*. Retrieved from http://www.huffingtonpost.com/tim-giago/forming-a-native-american_b_133976.html

Gilley, B. J. (2006). *Becoming two-spirit: Gay identity and social acceptance in Indian country*. Lincoln: University of Nebraska Press.
Gilley, B. J. (2010). Native sexual inequalities: American Indian cultural conservative homophobia and the problem of tradition. *Sexualities, 13*, 47–68.
Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice, 35*, 10–18.
Gone, J. P. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity and Ethnic Minority Psychology, 13*, 356–363.
Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Counseling and Clinical Psychology, 77*, 751–762.
Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist, 38*, 166–235.
Grandbois, D. (2005). Stigma of mental illness among American Indian and Alaska Native nations: Historical and contemporary perspectives. *Issues in Mental Health Nursing, 26*, 1001–1024.
Hage, S. M., Romano, J. L., Conyne, R. K., Kenny, M., Matthews, C., Schwartz, J. P., & Waldo, M. (2007). Best practice guidelines on prevention practice, research, training, and social advocacy for psychologists. *Counseling Psychologist*, *35*, 493–566.
Harper, F. G. (2011). With all my relations: Counseling American Indians and Alaska Natives within a familial context. *Family Journal*, *19*, 434–442.
Herring, R. D. (1999a). *Advocacy for Native American Indian and Alaska Native clients and counselors* [Abstract]. Education Resources Information Center, ED435908.
Herring, R. D. (1999b). *Counseling with Native American Indians and Alaska Natives.* Thousand Oaks, CA: Sage Publications.
Indian Child Welfare Act of 1978, 25 U.S.C. ¶¶1901–1963 (1994).
Ivey, A. E., & Collins, N. M. (2003). Social justice: A long-term challenge for counseling psychology. *The Counseling Psychologist, 31*, 290–298.
Kiselica, M. S., & Robinson, M. (2001). Bringing advocacy counseling to life. *Journal of Counseling & Development, 79*, 387–401.
LaDue, R. (1994). Coyote returns: Twenty sweats does not an Indian expert make. *Women and Therapy, 5*, 93–111.
LaFromboise, T. (2012). *Faculty profile: Quote*. Retrieved from http://ed.stanford.edu/faculty/lafrom
Lewis, J. A., Ratts, M. J., Paladino, D. A., & Toporek, R. L. (2010). Social justice counseling and advocacy: Developing new leadership roles and competencies. *Journal for Social Action in Counseling and Psychology, 3*, 5–16.
Lokken, J., M., & Twohey, D. (2004). American Indian perspectives of Euro-American counseling behaviors. *Journal of Multicultural Counseling and Development*, *32*, 320–331.
MacGregor, G. (1989). *Dictionary of religion and philosophy*. New York, NY: Paragon House.
McAuliffe, G. (2008). What is culturally alert counseling? In G. McAuliffe (Ed.), *Culturally alert counseling* (pp. 2–44). Los Angeles, CA: Sage Publications.
McAuliffe, G., Danner, M., Grothaus, T., & Doyle, L. (2008). Social inequality and social justice. In G. McAuliffe (Ed.), *Culturally alert counseling* (pp. 45–83). Los Angeles, CA: Sage Publications.
McNally, M. D. (2011). The practices of Native American Christianities. In C. A. Brekus & W. C. Gilpin (Eds.), *American Christianities* (pp. 59–75). Chapel Hill: University of North Carolina Press.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive behavioral intervention for trauma in schools (CBITS): School-based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry, 40*, 169–178.

Nathan Klein Institute, Center of Excellence in Culturally Competent Mental Health. (2012). *Native Americans*. Retrieved from http://ssrdqst.rfmh.org/cecc/index.php?q=node/22

Neusner, J. (Ed.). (2009). *World religions in America* (4th ed.). Louisville, KY: Westminster John Knox Press.

Office of Minority Health. (2012). *American Indian/Alaska Native profile*. Retrieved from http://www.cdc.gov/minorityhealth/populations/REMP/aian.html

Peelman, A. (2006). *Christ is a Native American*. Eugene, OR: Wipf & Stock.

Pelosi, N. (2012). Native American voting rights. *First Peoples Worldwide*. Retrieved from http://firstpeoples.org/wp/native-american-voting-rights

Pew Forum on Religion & Public Life. (2008). *U.S. religious landscape survey*. Retrieved from http://religions.pewforum.org

Portman, T. A. A., & Dewey, D. (2003). Revisiting the spirit: A call for research related to rural Native Americans. *Journal of Rural Community Psychology, E6*, 1–7.

Ratts, M. J., DeKruyf, L., & Chen-Hayes, S. F. (2007). The ACA advocacy competencies: A social justice advocacy framework for professional school counselors. *Professional School Counseling, 11*, 90–97.

Ratts, M. J., Lewis, J. A., & Toporek, R. L. (2010). Advocacy and social justice: A helping paradigm for the 21st century. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *American Counseling Association advocacy competencies* (pp. 3–10). Alexandria, VA: American Counseling Association.

Rehling, J. (2012). Native American languages. *Center for Research on Concepts and Cognition*. Retrieved from http://www.cogsci.indiana.edu/farg/rehling/nativeAm/ling.html

Richardson, B. (1993, July 7). More power to the tribes. *New York Times*, A15.

Richardson, J. T. (2004). *Regulating religion*. New York, NY: Springer.

Steinfeldt, J. A., Foltz, B. D., Lafollette, J. R., White, M. R., Wong, Y. J., & Steinfeldt, M. C. (2012). Perspectives of social justice activists: Advocating against native-themed mascots, nicknames, and logos. *Counseling Psychologist, 40*, 326–362.

Strickland, R. J. (1986). Genocide-at-law: An historic and contemporary view of the Native American experience. *University of Kansas Law Review, 34*, 713–755.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse* (6th ed.). New York, NY: John Wiley & Sons.

Sue, S., & Lam, A. (2002). Cultural and demographic diversity. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 401–421). New York, NY: Oxford University Press.

Tahmassebi, S. B. (1991). Gun control and racism. *George Mason University Civil Rights Law Journal, 67*(2).

Thomason, T. C. (2011a). Assessment and diagnosis of Native American clients: Results of a survey. *Journal of Rural Mental Health, 35*, 24–34.

Thomason, T. C. (2011b). Best practices in counseling Native Americans. *Journal of Indigenous Research, 1*, 4.

Thomason, T. C. (2011c). Recommendations for counseling Native Americans: Results of a survey. *Journal of Indigenous Research, 1*, 1–10.

Thomason, T. C. (2013). Resources for counseling Native Americans. *Journal of Indigenous Research, 3*, 1–15.

Treuer, D. (2013). *Rez life*. New York, NY: Grove Press.

Trimble, J. E. (1976). Value differences among American Indians: Concerns for the concerned counselor. In P. Pedersen, W. J. Lonner, & J. G. Draguns (Eds.), *Counseling across cultures* (pp. 203–226). Thousand Oaks, CA: Sage Publications.

Trimble, J. E. (2010). The virtues of cultural resonance, competence, and relational collaboration with Native American Indian communities: A synthesis of the counseling and psychotherapy literature. *The Counseling Psychologist, 38*, 243–256.

Trimble, J. E., & Thurman, P. J. (2002). Ethnocultural considerations and strategies for providing counseling services to Native American Indians. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (5th ed., pp. 53–91). Thousand Oaks, CA: Sage Publications.

Turner, S. L., & Pope, M. (2009a). Counseling with North America's indigenous people. In C. M. Ellis & J. Carlson (Eds.), *Cross cultural awareness and social justice in counseling* (pp. 185–209). New York, NY: Routledge.

Turner, S. L., & Pope, M. (2009b). North America's native peoples: A social justice and trauma counseling approach. *Multicultural Counseling and Development, 37*, 194–205.

Ullmann, M. (2008). *Native Americans bring their voice to Democratic and Republican conventions*. Retrieved from http://www.culturalsurvival.org/publications/voices/maryann-ullmann/native-americans-bring-their-voices-democratic-and-republican-co

U.S. Census. (2012). *American Indian and Alaska Native heritage month*. Retrieved from http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb12-ff22.html

Utter, J. (2002). *American Indians: Answers to today's questions* (2nd ed.). Norman: University of Oklahoma Press.

Vontress, C. (2003, January 19). Matching counseling with culture [Electronic mailing list message]. Retrieved from diversegrad-l@listserv.american.edu

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*, 563–574.

Williams, T. (2012, August 9). $1 million each year for all, as long as tribe's luck holds. *New York Times*. Retrieved from http://www.nytimes.com/2012/08/09/us/more-casinos-and-internet-gambling-threaten-shakopee-tribe.html?_r=0

Yurkovich, E. E., & Lattergrass, I. (2008). Defining health and unheathiness: Perceptions held by Native American Indians with persistent mental illness. *Mental Health, Religion & Culture, 11*, 437–459.

Chapter 13

Counseling Latin@s From a Social Justice Perspecive

Edil Torres-Rivera and Manivong J. Ratts

The history of people of Latin ancestry in the United States is as complicated and multifaceted as the history of any group in all the Americas. However, before we can begin to talk about the complexity of people of Latin ancestry, we draw the reader's attention to our use of the term *Latin@.* Use of the symbol @ is not a typo or misprint; rather, we adhere to the guidelines of many Latin American writers who use the symbol @ to be gender inclusive and to express gender neutrality (Hernández-Wolfe, 2013). We recognize that this is unfamiliar to some readers; we note, however, that the term is being used with increasing frequency among activists as a way to push back against the overmasculinization of the Spanish language. Rarely is it necessary to use gender pronouns in either print or interpersonal communication.

The use of *Latin@* is also preferred over *Latina/os*. The term *Latino* is used in many ways in society. It is a masculine noun that can refer to men, or it can be used to refer to both males and females of Latin heritage. When the term *Latino* is used in reference to both genders, it invariably places females in a subordinate position. The use of *Latina/os* is slightly better; however, this term is imperfect as well. The term *Latina/os* comprises both males and females. Yet it renders individuals of Latin heritage who do not conform to the traditional gender binary of male or female as invisible.

The terms *Hispanic* is also used to refer to individuals of Latin@ ancestry and was first used by the U.S. government in the 1970 U.S. Census. Both *Hispanic* and *Latino* were used interchangeably for the first time during the 2000 census (Office of Management and Budget, 1997; see also U.S. Census Bureau, 2010, 2011). Some prefer not to use *Hispanic* or *Latino* because these terms were imposed on the Latin@ community. Because the purpose of this chapter is to reaffirm the interdependence, freedom, and identity of Latin@ from a social justice perspective, we use Latin@ throughout this chapter (Comas-Diaz, 2001; Hernández-Wolfe, 2013).

History of Latin@s in the United States

Latin@s are the largest underrepresented racial group in the United States (U.S. Census Bureau, 2010). According to the most recent census (2010), Latin@s account for about 16% of the U.S. population. In 2010, 41% of Latin@s lived in the West, 36% in the South, 14%

in the Northeast, and 9% in the Midwest. The Latin@ population is a large and diverse group that continues to grow at a rapid rate, mostly in the South and Midwest. California had the largest number of Latin@ residents in 2010; they comprised about 27% of the population. In the census, people of Latin ancestry have origins in the following countries: Mexico, Puerto Rico, Cuba, Central America (Costa Rica, Guatemala, Honduras, Nicaragua, Panama, El Salvador), South American (Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela), and Spain. Here we focus on the three largest Latin@ groups: Mexicans, Puerto Ricans, and Cubans. According to the U.S. Census Bureau (2010), approximately 50 million Americans identify as Latin@, of which 63% are Mexicans or Mexican descendants, 9% are Puerto Ricans, 4% are Cubans, and 24% belong to other Latin@ groups, which include Central and South American descendants.

The realities of life for Latin@s in the United States are difficult to understand without firsthand experience and a real grasp for the aftermath of colonization and the psychological distress that this experience has had on the Latin@ community. Saenz and Murga (2011) maintained that Latin@ culture cannot be fully understood without understanding how the belief in manifest destiny led to the conquest, colonization, and annexation of Latin@ land. During the 19th century, manifest destiny (the belief in divine intervention from God) was used to justify westward migration and the acquisition of land by White settlers (Takaki, 1993). White settlers believed that they were on a mission from God to conquer and civilize those along the way. The rhetoric of manifest destiny was used to justify the occupation of Native American land and the assimilation, forced relocation, rape, and genocide of Native Americans. The same crusader mentality carried over to Latin@s, who were viewed by White settlers politically, civilly, and economically as inferior.

According to Saenz and Murga (2011), the conquest and colonization of Latin@ culture and land in North America, Puerto Rico, and Mexico are intertwined and have similar undertones of racial and religious oppression. White settlers' belief in the inferiority of Latin@ people and the need to civilize them was used to justify the war with Mexico in 1840 and White expansion into Texas and California. Similarly, as early as the 1500s Spanish conquistadors invading Mexico and Puerto Rico believed that they had a calling from a higher God to civilize the people of Mexico (Saenz & Murga, 2011) and tried to convert indigenous people of Mexico to Catholicism.

Similar to Native Americans, Latin@s of Mexican heritage in the United States are viewed as immigrants despite their long history of being in North America well before White settlers (Saenz & Murga, 2011; Takaki, 1993). The Mexican-American War (1846–1848) led to the annexation of Mexican land; that territory is now known as California and New Mexico. The Spanish-American War in 1898 was a conflict between Spain and the United States regarding Cuba's independence; it ended with the United States gaining temporary control of Cuba and authority over Puerto Rico, Guam, and the Philippines (Saenz & Murga, 2011). In summary, most Latin@s have been affected in one or another by the European and U.S. colonization of their countries of origin. (The colonization process included the importation of African slaves to work in mines and sugar cane plantations—slaves who contributed to the racial mix of the Latin@ countries.)

Current Experiences

The influence of the Latin@ community in this country permeates society. Many city and county names are Spanish (e.g., Alameda County, San Diego). The Latin@ influence is also reflected throughout mass media and popular culture. It is difficult to go anywhere without seeing a Latin@ restaurant or turn on the television without seeing a Latin@

station. Professional baseball, once a game dominated by White Americans, has seen an influx of Latin@ players over the last 15 years. Spanish is the second most common language in the United States after English and is spoken by 76% of Latin@s and by more than 17 million people the United States (Ryan, 2013). In business, approximately $345 billion was generated by Latin@-owned businesses alone in the United States (U.S. Department of Commerce, 2010).

Despite being designated as the largest underrepresented ethnic group in the United States and having a longstanding history in this country, Latin@s continue to be marginalized in society. For example, urban schools across the country with high Latin@ enrollment are inferior in quality (Kozol, 2005). Challenges to quality health care and employment opportunities abound across the United States. Many Latin@s are also perceived as foreigners even though they arrived in the United States well before White settlers. For example, there is growing sentiment within the White dominant political structure in Arizona that the Latin@ community's growth both socially and politically is becoming too large. This belief has incited fear to address the issue of illegal immigration in Arizona through immigration reform. As a result, Arizona's legislator crafted the nation's strictest immigration bill that contained undertones of racial profiling. Arizona Governor Jan Brewer signed Senate Bill 1070 (Arizona Senate, 2010), which allows law enforcement to request one of the following documents to determine U.S. citizenship status:

- a valid Arizona driver license;
- a valid Arizona nonoperating identification license;
- a valid tribal enrollment card or other form of identification; or
- (if the entity requires proof of legal presence in the United States before issuance) any valid United States federal, state, or local issues identification. (p. 1)

Although parts of Arizona's immigration law were subsequently struck down by the U.S. Supreme Court in *Arizona v. United States* (2012) because they interfered with the federal government's authority to set and enforce immigration policy, law enforcement is able to check for a person's immigration status if there is reasonable suspicion that the person is in the United States illegally. This opens the door for racial profiling.

The sociopolitical challenges experienced by many within the Latin@ community are individually taxing. When combined, they create a toxic environment for an entire community of people. Moreover, these experiences contribute to the racial divide between the Latin@ community and the White dominant group in the United States. There is also evidence to support the claim that oppression and discrimination results in depression, posttraumatic stress disorders, and other mental health issues.

Key Characteristics and Multicultural Concepts

Characteristics of Latin@s

Demographically, Latin@s are a diverse group that include Cuban, Mexican, Puerto Rican, South or Central American, and other Spanish cultures (U.S. Census Bureau, 2010). Zentella (2008) added that Latin@s also include people of Brazilian descent. In addition, more than 19% of the United States population speaks another language besides English at home (U.S. Census Bureau, 2010). Latin@s can be found in every state of the United States; the largest concentration is in the Southwest in part because they were already there before White settlers arrived. Approximately 80% of all Latin@s live in California, Texas, New York, Florida, New Jersey, Arizona, New Mexico, Colorado, Massachusetts, and Illinois (U.S. Census Bureau, 2010).

Mexicans, Puerto Ricans, and Cubans constitute the majority in the Latin@ community. However, Latin@s from Central and South America are growing at a faster rate (U.S. Census Bureau, 2010). The ethnic diversity of Latin@s in the United States is a reflection of immigration patterns. Immigration within the Latin@ community is influenced by local, national, and global politics and economic developments. For instance, the Central American Free Trade Agreement between the United States and Central and South America has led to immigration of Latin@s to the United States (Wise, 2006).

Latin@s, on average, are younger than the general U.S. population. According to the 2010 U.S. Census, the average age of Latin@s is 28 years. In contrast, the average age of the total U.S. population is 37 years. Socioeconomically, 23% of all Latin@ households are below the poverty level. More than 87% of all Latin@s are employed in service, support, or labor. The proportion of Latinos to Latinas in the United States is relatively equal, the unemployment rate for men is 6.2% versus 7.7% for women—and 3.6% for non-Latin@ males (U.S. Census Bureau, 2010).

Differences can be found among the various Latin@ groups. Although many Latin@s speak Spanish, there are variations in terminology. For instance, individuals of Mexican descent refer to *socks* as *calcetines*, whereas Puerto Ricans refer to them as *medias*. More significant differences pertain to how Latin@ groups celebrate particular religious events. For example, *El día de los muertos* (Day of the Dead) is a significant celebration that is unique to Mexico and among people of Mexican descent. It is important to note differences among Latin@ groups to avoid stereotypes or generalizations.

Key Multicultural Concepts

When working with Latin@ client populations, it is important to make note of some key concepts and commonalities. Understanding these shared concepts can help counselors understand the group's worldview and lived experiences.

- *Language.* Slightly more than 74% of Latin@s speak Spanish at home (U.S. Census Bureau, 2010). About 34% of Latin@ immigrants are bilingual in both Spanish and English, and 77% of foreign-born Latin@s who arrived at age 10 or younger are bilingual (Hakimzadeh & Cohn, 2007).
- *Religion.* Many in the Latin@ community see religion as an important part of their identity and life. Approximately 68% of all Latin@s in the United States identify as Catholic, whereas 25% of all Latin@s identify as Protestant, mainly Pentecostals (The Pew Forum on Religion & Public Life, 2007). Many Latin@s tend to be present oriented because they believe their future is in God's hands.
- *Familismo*. Latin@s have a preference for and loyalty to immediate and extended family over the individual, including *compadres* and *comadres* (co-parents). Family needs of marriage, childbearing, and supporting siblings supersede individual needs for autonomy and independence.
- *Respeto* (deference to those of higher status in a traditional setting). Because Latin@ communities are highly patriarchal, women tend to defer to men and children to adults.
- *Personalismo*. Latin@s prefer a warm, friendly relationship as opposed to a more formal, distant, professional one.
- *Machismo*. Within Latin@ communities *machismo* (Latin@ masculinity) refers to males providing for, protecting, and caring for their families.
- *Marianismo.* Latin@ woman must be pure, long-suffering, nurturing, and pious (Lopéz-Baéz, 1999).

- *Simpatia*. The ability to be nice, friendly, and easygoing is valued.
- *Time.* Latin@s tend to be more relaxed and nonchalant in their notion of time. Being "in time" is more valued than being "on time." The latter phrase stresses the importance of punctuality whereas the former places less emphasis on being prompt and more emphasis on being fully engaged in the present. Latin@s place less emphasis on punctuality when compared with the White-dominant culture in the United States (Schaef, 1992; Torres-Rivera, Phan, Maddux, Wilbur, & Arredondo, 2006). White-dominant culture tends to be future oriented, whereas Latin@s value the past and the present (Torres-Rivera, 2004).

Having intimate familiarity with each of the listed concepts can help counselors better structure therapeutic approaches that align with the lived experiences of Latin@ clients. For example, counselors should speak Spanish when possible or consider the option of using interpreters if Spanish is a client's primary language. Using the same language as clients levels the power differential between counselor and client. Moreover, it allows clients to be themselves because they are able to speak in their native tongue. Ramos-Sanchez's (2007) research on bilingual counseling suggested that Mexican American clients had better perceptions of European American counselors when they spoke Spanish in counseling. Mexican American clients attributed a European American counselor's ability to speak Spanish as an attempt to be more respectful of their culture, which in turn made them feel "more comfortable, more at ease, and more willing to open up to the counselor, leading to greater emotional expression" (Ramos-Sanchez, 2007, p. 164). When appropriate, counselors should also consider ways to integrate the use of prayer and religious concepts in counseling. Collaboration with religious leaders should be given consideration. Counselors working with clients who place high value on family over individual needs should incorporate discussions about how individual decisions reflect on the immediate and extended family unit. If counselors are not careful, they may misjudge a Latin@ male's *machismo* and female's *marianismo* attributes as unhealthy. For some in the Latin@ community deadlines and appointments are perceived as ballpark estimates. For instance, a 1:00 p.m. appointment may mean the appointment is sometime around 1:00 p.m. Thus, a Latin@ client would not regard a 1:15 p.m. arrival as late.

Systemic Barriers

Latin@ clients cannot be understood without consideration of their social, political, and economic environments. The systemic barriers that Latin@ encounter in the United States are many; however, in this section we focus on language, colonization, immigration, and education. These barriers (among others) limit opportunities for Latina@ individuals to live self-fulfilling lives and become full members of society.

Language

Spanish is the primary language among Latin@s in the United States; many Latin@s are also bilingual in Spanish and English. Being bilingual gives people advantages in life. However, having an accent when speaking English can be a disadvantage. Deprez-Sims and Morris (2010) defined accents as

> [a] distinctive way of speaking associated with a particular group of people, typically based on differences in phonology or intonation across geographic regions or social groups. It is not that some individuals have an accent while others do not. Rather, residents of a region will define a "local" accent, which is distinct from residents of other

> regions, who have "foreign" accents. Because these linguistic patterns become associated with social and economic divisions between groups, accents play an important role in social categorization. (p. 418)

Accents can create divisions that separate people socially and economically into "haves" and "have nots" (Campbell-Kibler, 2007). Spanish accents and languages are racialized in that people with Spanish accents or with Spanish surnames are viewed as inferior and less educated than those with European accents (Torres-Rivera, West-Olatunji, Conwill, Garrett, & Phan, 2008). Individual bias regarding accents can also lead to systemic barriers. For instance, research by Deprez-Sims and Morris (2010) found that having an accent affected a person's ability to obtain a job; hiring committees were more likely to evaluate people with accents more negatively because they were perceived to be different from themselves. In this research difference was equated to being a deviation rather than as a variation in society. Similarly, anti-Latin@ sentiments in Arizona have created barriers for Latin@ teachers who speak English with a heavy accent:

> Ms. Aguayo is a veteran teacher in the Creighton Elementary School District in central Phoenix as well as an immigrant from northern Mexico who learned English as an adult and taught it as a second language. Confronted about her accent by her school principal several years ago, Ms. Aguayo took a college acting class, saw a speech pathologist and consulted with an accent reduction specialist, none of which transformed her speech. (Lacey, 2011, para. 3)

Rather than view people who can speak more than one language as an asset to a district, many teachers in Arizona were subjugated to systemic forms of racial oppression. A federal investigation found that many teachers with heavy accents in the state were being reprimanded for enunciating "the" as "da," "another" as "anuder," and "lives here" as "leeves here" (Lacey, 2011, para. 10).

Colonization

Using Virgilio Enriquez's (1992) work, Laenui (2000) outlined the stages of colonization: denial of the culture of the group to be colonized; attempts at cultural genocide; minimizing and disparaging the cultural values and way of life of the native culture; and acceptance by the dominant culture of only certain aspects of the native culture. The final stage reflects taking and controlling the cultural values and practices of the colonized people, which includes commercialization and exploitation of the colonized culture.

Many people view colonialism as a phenomenon of the past and not as something that still has lasting effects on Latin@ people. This belief is due in part to the inability of people to connect the past with the present. The effects of colonialism are hard to see because of the invisible infrastructure set up by White Americans that benefits their own racial group. One needs to look no further than the U.S. Congress to see how colonialism has benefited White Americans. Nationally, Latin@s represent 16.9% of the total population (U.S. Census Bureau, 2010); however, as of August 2013 there were only 38 Latin@s in the 113th Congress, which equates to 7% of the total body (Manning, 2013). Of these, 34 were in the House and four were elected to the Senate. This disproportionality allows White Americans to vote for their own self-interest.

The psychological and sociological impact of colonialism has been of interest in the mental health field for some time. Smith (2012) and Trimble (2009) argued that colonization still has a direct influence on the people who were colonized and is reflected in disciplines

such as psychology. White European Americans, because of the power they hold, continue to disseminate their views on mental illness across the nation (Torres-Rivera, 2013); their values and worldviews determine what is considered normal and healthy.

Immigration

Anti-immigration sentiments in the United States are often entrenched in racial animus toward the Latin@ community. Brader, Valentino, and Suhay (2008) found that opinions regarding immigration were more negative for Latin@ Americans than for European Americans. Fears of an overwhelming number of immigrants arriving in the United States illegally, coupled with negative media portrayals of undocumented workers of Latin@ background taking jobs, have led to increasing calls for immigration reform, which in turn has led to increased racial tension between Latin@ Americans and White Americans. A recent bill titled the Border Security, Economic Opportunity, and Immigration Modernization Act (2013), introduced by Senator Charles Schumer (D-NY), proposed immigration reform that would create a pathway for undocumented workers to become legal citizens and would increase security along America's borders. Opponents of this bill fear that granting citizenship to millions of undocumented immigrants, many of whom live in poverty, would result in a strain on social service agencies and welfare. Although the United States has come a long way in its inclusion of Latin@s, many Latin@s are still considered second-class citizens in this country.

Education

In 2010, the percentage of Latin@s ages 25 years and older who have a high school diploma was 62.9%. This is relatively low compared with White (87.6%), Black (84.2%), and Asian and Pacific Islanders (88.9%). The number of college graduates is even lower. Only 13.9% of Latin@s ages 25 or older have a college degree compared with 30.3% of Whites, 19.8% of Blacks, and 52.4% of Asian and Pacific Islanders (U.S. Census Bureau, 2012). This educational disparity comes at a financial cost for many Latin@s; it means lower wages and less career opportunities for those in the Latin@ community.

Schhneider, Martinez, and Owens (2006) contended that educational barriers faced by Latin@ students cannot be explained by one single experience but rather by an accumulation of disadvantages; the combination of poverty, immigrant status, low-quality schools, lack of resources, and racism all contribute to educational barriers for Latin@ youth.

Access to higher education for undocumented Latin@ immigrants is also a concern. Although there are no state or federal laws prohibiting an undocumented immigrant from attending a public or private college in the United States, some universities, such as those in Virginia, require applicants to submit proof of citizenship or legal residency (College Board, 2013). Some states classify undocumented immigrants as international students, which means they pay higher tuition rates than resident students (College Board, 2013). This extra cost is a financial burden for many Latin@ youth and families who live in poverty.

Another added barrier to a college degree for undocumented Latin@ immigrants is that they are not eligible for federal student financial aid (U.S. Department of Education, 2013). This barrier excludes undocumented Latin@ immigrants from such aid as federal loans, grants, scholarships, and work-study. Private scholarships and foundations tend to require applicants to be U.S. citizens (College Board, 2013). Some states, such as Washington, have passed legislation allowing for undocumented immigrants to receive state financial aid for college. A current bill (The DREAM Act: Development, Relief, and Education for Alien

Minors Act of 2010) seems promising in that it would provide federal aid to undocumented immigrants. However, this bill is currently held up in Congress because it lacks votes to support its passage.

The practice of leaving home and going away to college can also be a challenge for many Latin@s, especially those who are first generation. Going away to college is considered a rite of passage for many youth in the United States. It signifies the transition from late adolescence to young adulthood and is a sign of growing independence and autonomy. This cultural practice pushes against the Latin@ cultural grain of *familismo*. Leaving home for college requires Latin@s to temporarily put the individual before the family. We emphasize the temporary aspect of this experience because some Latin@ college students do return home to support the family upon receiving their college degrees.

Personal Voices

The Story of Lupa

Lupa was a Latina who worked as the minister of education in Monterey, Mexico. She had a master's degree from the Universidad Nacional Autonoma de Mexico in Teaching and Learning. A devout Catholic, she was a divorced mother with a 14-year-old son. When she arrived in the United States she found it difficult to secure employment because she lacked command of the English language. To make ends meet she worked as a maid, cleaning houses for professors at a midsized university. Unable to find a career that aligned with her passion and skill set, Lupa became depressed and began to question her abilities and self-worth. She always thought of herself as someone who had something to offer society. Because she was educated and interested in working with children, she was a preferred maid and babysitter for many professors at the university. Her depression deepened because although she enjoyed working with children, she did not find her work to be stimulating.

One day a university professor noticed that she seemed depressed and smelled of alcohol. He asked her if she would like to talk with a counselor; she replied that she did not know what counseling was and that she could not afford it. The professor explained what counseling entailed and told her that he knew of free counseling being offered to the community through a Latin@-based Catholic counseling agency; the therapists were fluent in Spanish and English. Lupa agreed to see the counselor because she felt she had no one else to confide in for support. During the initial session it was clear that Lupa showed symptoms of depression. She was often sad, had low energy, and felt hopeless. She used alcohol to cope with the stress and problems related to the move and discrimination that she experienced because of her status in the United States.

Individual Counseling: Applications at the Microlevel

Counselors using a traditional Western psychotherapeutic approach might misdiagnose Lupa's sadness, decreased energy, and feelings of hopelessness as depression. Such counselors may even label her as an alcoholic and refer her to a substance abuse counselor. Traditional Western psychology tends to use intrapsychic approaches without consideration for the social context. If the counselor is working with insurance companies, he or she is likely to diagnose Lupa as depressed; a diagnostic code is required for reimbursement for services. Being diagnosed with depression and labeled as an alcoholic implies that the deficit resides in the client; the client and not the environment is the problem. Thus, the responsibility for change is within Lupa and not her environment.

The principles of liberatory psychology could be used successfully when working with Lupa for several reasons. Liberatory psychology has roots in Latin America, which is important because it aligns with Lupa's cultural background and worldview. The praxis of liberatory psychology focuses on the psychology of the oppressed by addressing how oppressive sociopolitical structures influence human development (Martin-Baró, 1996). The assumption is that individuals are not independent of society. People shape and are shaped by the social context.

Montero (2009) identified key concepts that are inherent in liberation psychology that can be used in counseling with Lupa:

- *Conscientization. Conscientization* is the process of helping people achieve an awareness of their situation in the context of an oppressive society. The awakening of the critical consciousness of the person or group is the main goal of liberation psychology. According to this approach, critical conscientization is required for transformation and action to take place. Clients need to be aware of how social structures influence their lives if they are to externalize that which they have internalized. Achieving conscientization can be challenging because there is no one single method. Freire (1970/2000) identified a process whereby client and counselor use counseling as a venue for dialogue and reflect on the actions clients take, an ongoing sequence of steps referred to as *action-reflection-action*.
- *Participation.* A key component of liberatory psychology is that clients need to be active participants in therapy. Both the client and counselor are in a mutually collaborative relationship. Counselors are not experts but rather guides. Montero (2009) believed that participatory action research (a process in which groups who are oppressed take leadership in solving the social ills in their community) could be a helpful framework to client participation.
- *Problematization.* Problematization involves questioning the dominant status quo by creating a safe space for dialogue between client and counselor. The intent of problematization is to create what Freire (1970/2000) coined *conscientization*, bringing not only change but also transformation as people gain a more realistic understanding of a situation or an event.
- *Reflection.* The process of critically analyzing, rethinking, and questioning experiences within a broad context of issues is referred to as *reflection* (Montero, 2009). To truly understand a situation or event, one must be able to analyze it and go beyond the tendency to analyze, judge, and compare other people's situation from only one perspective or experience (also known as the *single story syndrome*). Through reflection clients gain a deeper understanding of how social forces influence their lives.

According to Montero (2009), no single approach or manual truly captures how to apply liberatory psychology principles with marginalized communities. To create such a manual would mean there is a universal approach to working with all Latin@s, which would amount to ignoring the unique within-group differences among Latin@s.

Participation

Clients are more likely to participate in therapy when they feel connected and familiar with the counseling process. The suggestion that Lupa see a counselor from a Latin@-based Catholic counseling agency can help alleviate concerns she may have about counsel-

ing. Aligning counseling with her religious beliefs also allows Lupa and the counselor to freely incorporate faith and prayer into counseling.

An added benefit is that counselors are bilingual in Spanish and English. Organista (2007) noted that bilingualism is as important and at times even more essential than being bicultural. For this reason it may be important for counselors who do not speak Spanish to learn basic conversational Spanish. Doing so can break down potential barriers between Latin@ clients and counselors. Lupa might feel more at ease with counseling when therapy sessions are in Spanish. She could share her experiences and discuss her feelings without being concerned that language was a barrier to communication, which in turn is likely to make her a more active participant in counseling.

Because of Latin@ culture's concept of time and Lupa's identification with traditional Latin@ culture, counselors may need to consider how therapy is structured. Setting a typical 50- to 60-minute appointment for therapy may not be ideal. This point is especially true if Lupa arrives 10–15 minutes after the scheduled session. What counselors might want to do is consider setting aside two appointment times for the initial session. This strategy allows for Lupa to arrive later without being considered late. It also gives the counselor time to get to know Lupa and allow her to not feel rushed in the first session.

Reflection

Asking reflective questions such as "How might these experiences connect with how you feel about yourself?" and "Have you considered that your feelings and behaviors are actually healthy responses to an unsupportive environment?" can be important in helping Lupa to critically analyze her situation in context. Reflective questions can help Lupa develop a deeper understanding of her experiences that goes beyond surface-level meaning.

Conscientization

Latin@ clients must tell their stories, accounts, and life events in order to feel heard. Listening to the specific events that shape client lives and validating those experiences will result in congruency between their beliefs, behaviors, and experiences. A counselor could achieve this goal by helping Lupa see her situation within the context of living in a world where immigration reform and White-dominant culture are prevalent. By seeing her situation in context, Lupa can externalize her experience by understanding how immigration affects mental health and well-being. The depression she experienced was actually a normal response to environmental challenges.

For many Latin@s the primary source of self-definition and self-esteem, as well as the structure and support for the individual, is the family (Falicov, 2009). Mental health professionals who are unable to recognize this important variable may inadvertently focus only on Lupa and her needs. A counselor would do well to initiate a dialogue about Lupa's immediate and extended family within the context of an oppressive society. Exploring the type of support Lupa has from family during her transition to the United States can provide rich insight into her support system.

Problematization

In a safe and therapeutic environment, Lupa is likely to share about her lived experiences and how being female, Latin@, and a single parent influence her experiences. Montero (2009) believed problematization to be a process that involves the following characteristics:

- *Listening.* Counselors use active listening skills so they can understand the world through the client's frame of reference.
- *Dialogue.* There is a mutual shared dialogue that occurs between the client and the counselor; counseling is not a process where clients share and counselors just listen.
- *Taking care of the ways to dialogue.* Counselors should use language and jargon that is understandable to clients. This means avoiding using academic language that puts distance between clients and counselors.
- *Communication.* Interaction between clients and counselors is a two-way process in which both feel free to exchange information, discuss, question, and disagree on ideas.
- *Humility and respect.* Counselors are no better than their clients. Mutual respect creates a more egalitarian relationship between client and counselor.

Advocacy Counseling: Applications at the Macrolevel

Lupa faced significant systemic challenges: She lived in a society that did not value her master's degree, and her career struggles affected her sense of self-worth. To address these systemic barriers, counselors must step out of their offices to advocate with and on behalf of Lupa. Collaborating with Lupa to identify a community college or university that will give her an adjunct teaching position in an education program might be a good first step. A traditional counseling strategy is for a counselor to work with Lupa to identify colleges that she might be able to contact. Sessions could be used to identify chairpersons to contact in area colleges. Looking at online programs could help expand her options; so too could using her connections with the professors she knows to have them help her connect with department chairs of respective programs.

If Lupa cannot meet with department chairs, her counselor could meet with them on her behalf and explain her situation without breaking confidentiality. Counselors can use their status in society to set up meetings that may be difficult for Lupa to establish. Meeting with department chairs can help the counselor gain valuable insight into the hiring process. In this role the counselor operates as a temporary liaison between Lupa and the department chair.

Counselors who work for a better world would recognize that Lupa's issue was a larger systemic concern that affected millions of refugees and immigrants who come to the United States and are unable to have their degrees acknowledged. Counselors can use their technology skills to e-mail and call respective local and federal legislators to lobby for change. They can access the calendars of legislators to identify where they may be meeting. They can contact local area agencies to bring issues to the public and work with local area agencies to address the problem of education discrimination.

Future Directions

As the changing racial demographics of the United States demonstrate, Latin@s are the fastest growing racial group in the country. As this group continues to grow, it is highly probable that mental health professionals will encounter Latin@ clients. Therefore, they should be prepared to work with Latin@ client populations; understanding the group's history and current experiences is a start.

Mental health professional must also continue to increase their awareness of their attitudes, values, and belief about the Latin@ community. When working with Latin@ clients, or any oppressed group, it is important to understand one's own personal biases, stereo-

types, and assumptions, which can impede one's ability to understand the worldview and lived experiences of the group (McGoldrick & Hardy, 2008; Montero & Sonn, 2009). Such biases, stereotypes, and assumptions may unintentionally lead mental health professional to misdiagnose clients.

More societal awareness about the challenges Latin@ clients experience is needed. Many Latin@s still struggle to understand how immigration reform and racism have impacted them. Such issues need to be better investigated, understood, and addressed from the perspective of Latin@s. Counselors can identify and collaborate with local Latin@ agencies and organizations to bring these issues to the public domain. Working in collaboration with other allies can lead to larger scale efforts that involve local and federal government officials.

Resources

Books

Akkeren, R. V., & Taracena, L. P. (2007). *La vision indigena de la conquista*. Guatemala: Serviprensa.

Black, T. (2009). *When a heart turns rock solid: The lives of three Puerto Rican brothers on and off the streets*. New York, NY: Pantheon Books.

Bourgois, P. (2002). *In search of respect: Selling crack in el barrio*. Cambridge, UK: Cambridge University Press.

Césaire, A., & Robin K. D. G. (2000). *Discourse on colonialism*. New York, NY: Monthly Review.

Farmer, P. (2003). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley: University of California Press.

Fernandez, O. M., & Paravisini-Gebert, L. (2001). *Healing cultures: Art and religion as curative practices in the Caribbean and its diaspora*. New York, NY: Palgrave.

Fox, D., Prilleltensky, I., & Austin, S. (2009). *Critical psychology: An introduction*. Los Angeles, CA: Sage Publications.

Martin-Baró, I., Aron, A., & Corne, S. (1996). *Writings for a liberation psychology*. Cambridge, MA: Harvard University Press.

Rogler, L. H. (2008). *Barrio professors: Tales of naturalistic research*. Walnut Creek, CA: Left Coast Press.

Sandoval, C. (2000). *Methodology of the oppressed*. Minneapolis: University of Minnesota Press.

Villarruel, F. (2009). *Handbook of U.S. Latino psychology: Developmental and community-based perspectives*. Los Angeles, CA: Sage Publications.

Websites

Office of Minority Health
http://minorityhealth.hhs.gov/Default.aspx

Pew Research Center, Hispanics (and other sections)
http://www.pewhispanic.org/

References

Arizona Senate. (2010). Cooperation and assistance in enforcement of immigration laws: Indemnification (S.B. 1070). Retrieved from http://www.azleg.gov/legtext/49leg/2r/bills/sb1070s.pdf

Arizona v. United States, 567 U.S. (2012).

Border Security, Economic Opportunity, and Immigration Modernization Act of 2013, S. 744, 113th Cong., 3d Sess. (2013).

Brader, T., Valentino, N. A., & Suhay, E. (2008). What triggers public opposition to immigration? Anxiety, group cues, and immigration threat. *American Journal of Political Science, 52*, 959–978.

Campbell-Kibler, K. (2007). Accent, (ING), and the social logic of listener perceptions. *American Speech, 82*, 32–64. doi: 10.1215/00031283-2007-002

College Board. (2013). *Advising undocumented students*. Retrieved from http://professionals.collegeboard.com/guidance/financial-aid/undocumented-students

Comas-Díaz, L. (2001). Hispanics, Latinos, or Americanos: The evolution of identity. *Cultural Diversity and Ethnic Minority Psychology*, *7*, 115–120.

Deprez-Sims, A.-S., & Morris, S. B. (2010). Accents in the workplace: Their effects during a job interview. *International Journal of Psychology, 45*, 417–426.

Development, Relief, and Education for Alien Minors (DREAM) Act of 2010, S. 3992, 111th Cong. (2010).

Enriquez, V. (1992). *From colonial to liberation psychology: The Philippine experience*. Diliman, Quezon City: University of the Philippines Press.

Falicov, C. J. (2009). Ambiguous loss: Risk and resilience in Latino immigrant families. In M. M. Suárez-Orozco & M. M. Páez (Eds.), *Latinos: Remaking America* (pp. 274–288). Berkeley: University of California Press.

Freire, P. (2000). *Pedagogy of the oppressed* (M. Bergman Ramos, Trans.). New York, NY: Continuum International Publishing Group. (Original work published 1970)

Hakimzadeh, S., & Cohn, D. (2007). *English usage among Hispanics in the United States. VI. Bilingual adults*. Retrieved from http://www.pewhispanic.org/2007/11/29/vi-bilingual-adults/

Hernández-Wolfe, P. (2013). *A borderlands view on Latinos, Latin Americans, and decolonization: Rethinking mental health*. Lanham, MD: Jason Aronson.

Kozol, J. (2005). *The shame of the nation: The restoration of apartheid schooling in America*. New York, NY: Random House.

Lacey, M. (2011, September 25). In Arizona, complaints that an accent can hinder a teacher's career. *New York Times*. Retrieved from http://www.nytimes.com/2011/09/25/us/in-arizona-complaints-that-an-accent-can-hinder-a-teachers-career.html?pagewanted=all

Laenui, P. (2000). Process of decolonization. In M. Battiste (Ed.), *Reclaiming indigenous voice and vision* (pp. 150–160). Vancouver, Canada: University of British Columbia Press.

Lopéz-Baez, S. (1999). Marianismo. In S. Mio, J. E. Trimble, P. Arredondo, H. E. Cheatham, & D. Sue (Eds.), *Key words in multicultural interventions: A dictionary* (p. 183). Westport, CT: Greenwood.

Manning, J. E. (2013). *Membership of the 113th Congress: A profile*. Washington DC: Congressional Research Service.

Martin-Baró, I. (1996). *Writings for a liberation psychology*. Cambridge, MA: Harvard University Press.

McGoldrick, M., & Hardy, K. V. (Ed.). (2008). *Re-visioning family therapy: Race, culture, and gender in clinical practice* (2nd ed.). New York, NY: Guilford Press.

Montero, M. (2009). Methods for liberation: Critical consciousness in action. In M. Montero & C. C. Sonn (Eds.), *Psychology of liberation: Theory and applications* (pp. 73–91). New York, NY: Springer.

Montero, M., & Sonn, C. C. (Eds.). (2009). *Psychology of liberation: Theory and applications*. New York, NY: Springer.

Office of Management and Budget. (1997). *Revisions to the standards for classification of federal data on race and ethnicity*. Retrieved from http://www.whitehouse.gov/omb/fedreg_1997standards

Organista, K. (2007). *Solving Latino psychosocial and health problems: Theory, practice, and populations*. Hoboken, NJ: John Wiley & Sons.

The Pew Forum on Religion & Public Life. (2007). *Changing faiths: Latinos and the transformation of American religion*. Retrieved from http://pewforum.org/Changing-Faiths-Latinos-and-the-Transformation-of-American-Religion.aspx

Ramos-Sanchez, L. (2007). Language switching and Mexican Americans' emotional expression. *Journal of Multicultural Counseling and Development, 35*, 154–168

Ryan, C. (2013). *Languages in the United States: 2011*. Retrieved from http://www.census.gov/prod/2013pubs/acs-22.pdf

Saenz, R., & Murga, A. L. (2011). *Latino issues: A reference handbook*. Santa Barbara, CA: Contemporary World Issues.

Schaef, A. W. (1992). *Women's reality: An emerging female system*. New York, NY: HarperOne.

Schneider, B., Martinez, S., & Owens, A. (2006). Barriers to educational opportunities for Hispanics in the United States. In M. Tienda & F. Mitchell (Eds.), *Hispanics and the future of America* (pp. 179–227). Washington, DC: National Academies Press.

Smith, L. (2012). *Decolonizing methodologies: Research and indigenous peoples*. London, UK: Palgrave Macmillan.

Takaki, R. (1993). *A different mirror: A history of multicultural America*. Boston, MA: Little, Brown.

Torres-Rivera, E. (2004). Group work with Latinos. In J. L. DeLucia-Waack, D. Gerrity, C. Kalodner, & M. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 213–223). Thousand Oaks, CA: Sage Publications.

Torres-Rivera, E. (2013). Is quality a culturally-based or universal construct? *Interamerican Journal of Psychology, 47*, 1–8.

Torres-Rivera, E., Phan, L. T., Maddux, C. D., Wilbur, M. P., & Arredondo, P. (2006). Honesty the necessary ingredient in multicultural counseling: A pilot study of the counseling relationship. *Interamerican Journal of Psychology, 40*, 37–45.

Torres-Rivera, E., West-Olatunji, C., Conwill, W., Garrett, M. T., & Phan, L. T. (2008). Language as a form of subtle oppression among linguistically different people in the United States of America. *Perspectivas Socials/Social Perspectives, 10*, 11–28.

Trimble, J. (2009). *Infusing the psychology curriculum with ethnocultural content: Truths, half-truths, anecdotes, and the role of critical thinking*. Paper presented at the 2009 Winter Round Table Conference, Teacher College, Colombia University, New York.

U.S. Census Bureau. (2010). *State and county QuickFacts*. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

U.S. Census Bureau. (2012). *Education*. Retrieved from http://www.census.gov/compendia/statab/cats/education.html

U.S. Census Bureau. (2011). *Overview of race and Hispanic origin: 2010*. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

U.S. Department of Commerce. (2010). *Census Bureau reports minority business ownership increasing at more than twice the national rate*. Retrieved from http://www.census.gov/newsroom/releases/archives/economic_census/cb10-107.html

U.S. Department of Education. (2013). *FAFSA general questions*. Retrieved from https://fafsa.ed.gov/help.htm

Wise, R. D. (2006). Migration and imperialism: The Mexican workforce in the context of NAFTA. *Latin American Perspectives, 33*, 33–45. doi: 10.1177/0094582X05286083

Zentella, A. C. (2008). *Latin@ languages and identities*. In M. M. Suárez-Orozco & M. M. Páez (Eds.), *Latinos: Remaking America* (pp. 321–338). Berkeley: University of California Press.

Chapter 14

Counseling Multiracial Individuals and Families

Kelley R. Kenney and Mark E. Kenney

The number of multiracial individuals and families is rapidly increasing and becoming a noticeable part of mainstream society in the United States. This chapter provides information about multiracial individuals and families that counselors need know in order to work effectively with this population. The chapter describes the systemic barriers and issues faced by the population as well as the skills and strategies useful for counseling and advocacy intervention with this population at both the microlevel and the macrolevel.

History of Multiracial Individuals and Families

Several events are crucial to the discussion of the history of multiracial individuals and families in the United States. According to Kenney and Kenney (2012), the first and most salient of these events was the landmark *Loving v. Virginia* (1967) Supreme Court decision striking down the laws against interracial marriage that remained on the books of 16 states. Although interracial couples and multiracial individuals had been part of the fabric of American history since the days of the early settlers, concerns over the maintenance of White racial purity and superiority gave way to systems of racial and sociopolitical hierarchies and laws that regulated racial identification and that prohibited interracial marriages (antimiscegenation laws). Thirty states enacted laws against interracial marriage, beginning with Virginia in 1661 (Douglass, 2003; Henriksen & Paladino, 2009b; Wehrly, Kenney, & Kenney, 1999).

The establishment of multiracial organizations around the country, beginning with Interracial Intercultural Pride (I-Pride) in 1978, offered opportunities for members of the population to come together not only for purposes of social interaction and sharing but also for political development and networking. This ushered in the start of the multiracial civil rights movement, and what emerged were several national advocacy organizations that were committed to placing the concerns and issues of the multiracial population at the forefront of America's public consciousness (Douglass, 2003). The evolution of this movement was historic in and of itself in that it gave way to discussions of race and what it means to be of more than one race. These discussions, along with the work and representation of national multiracial advocacy groups, particularly the Association of MultiEthnic Americans, resulted in the second major historical event, the U.S. Office of Management

and Budget's Directive No. 15, which provided individuals of multiple heritages the right to check more than one racial category on the 2000 census. The U.S. Census 2000 data indicated that 6.8 million Americans identified as being of two or more distinct racial heritages (Douglass, 2003).

Current Experiences

The 2008 election of Senator Barack Obama as the 44th president of the United States sparked a national dialogue on race that continued long after the election. The fact that President Obama was born in the United States to a Kenyan father and a White mother from Kansas gave particular attention to the increasing numbers of interracial couples and multiracial individuals in the United States and to the challenges they face as well as to their issues and concerns.

According to U.S. census data for 2010, as many as 1 in 10 (or 5.4 million) heterosexual married couples were interracial. This represents a 28% increase from the 2000 census. Although this increase has been observed all over the United States, it has been most noticeable in the western and southwestern parts of the country (U.S. Census Bureau, 2012). Among heterosexual unmarried couples, 18% or 1.2 million were interracial; among same-sex couples, 21% or 133,477 couples were interracial (U.S. Census Bureau, 2012).

Much of the discussion on the current experiences of interracial couples has examined the rise in occurrence and how they are related to changes in approval rates of interracial coupling and marriage. Historically, interracial dating and marriage, particularly those unions involving Blacks and Whites, have met with significant controversy, scrutiny, and ridicule, stemming back to historical myths and stereotypes borne out of racism and misinformation about persons of color (DaCosta, 2007; Wardle & Cruz-Janzen, 2004; Yancey, 2002). However, data from recent research conducted by the Pew Research Center and the Gallup Organization have revealed that dramatic shifts have occurred in societal attitudes toward interracial coupling, indicating an increase in the rates of approval and acceptance of these relationships (Carroll, 2007; Ludwig, 2004; Passel, Wang, & Taylor, 2010; Taylor, Funk, & Craighill, 2006). According to the results of the Pew Research Center's 2009 study, 83% of the general public approved of interracial dating, up from 48% in 1987. With regard to interracial marriage, 63% of respondents in the Pew Research Center's 2009 study indicated that they would accept a family member marrying a person of a different race, and 80% indicated that they would accept a person of a different race marrying into their family (Passel et al., 2010). Further analysis of the Pew Research Center's 2009 findings revealed that the acceptance and approval rates for interracial marriages varied for specific groups. The approval rates for interracial marriages to Whites were 81%, to Asians 75%, to Latinos 73%, and to Blacks 66%. Conversely, 72% of Blacks approved of interracial marriages to Whites, Latinos, or Asians, whereas 63% of Latinos and 61% of Whites approved of such marriages (Passel et al., 2010).

The relationship experiences of interracial couples are similar to and no more problematic than those of same-race couples (Poulsen, 2003; Root, 2001; Wehrly et al., 1999; Yancey, 2002). Concerns that arise in these relationships related to racial differences seem to be a function of experiences encountered in dealing with parents, siblings, extended family members, and the greater society. These experiences range from lack of support and acceptance or outright rejection by family members to stares; racist comments; and acts of discrimination, hostility, and violence in public and social encounters (DaCosta, 2007; Poulsen, 2003; Root, 2001; Wehrly et al., 1999). Couples navigating both racial and cultural

worldview differences related to variances in levels of assimilation and acculturation may also experience concerns around language, communication, religion, gender role expectations, parenting, traditions, and food (Bhugra & DeSilva, 2000; Bustamante, Nelson, Henriksen, & Monakes, 2011; Waldman & Rubalcava, 2005).

The literature on divorce suggests that the divorce rates for interracial couples are higher than those for same-race couples (Bramlett & Mosher, 2002). It is important to note, however, that other variables significant to each partner, such as level of education, age at the time of marriage, and gender, may play a larger part in predicting the success or failure of these marriages than race. With regard to gender, interracial marriages involving White women appear to be at greater risk for failure (Bratter & King, 2008). Success of these relationships often depends upon the partners' honesty with themselves and one another about their reasons for being together. It is also important that they each have a strong self-concept and be secure within themselves and with one another (Ware, 2002; Wehrly et al., 1999). A strong and secure relational foundation is critical as these couples navigate the influences of their individual backgrounds over the life span (Poulsen, 2003).

According to Kenney and Kenney (2010), couples may be challenged to deal with society's obsessions with race for their children, evidenced in the question "what about the children?" Hence, prior to birth or even conception couples may feel forced to think about how their children may be regarded and accepted and how they will address matters of their children's racial makeup (DaCosta, 2007; Jackson-Nakazawa, 2003; Root, 2001). The notion of raising multiracial children often presents parents with the need to be intentional in making decisions about how and when they discuss and address issues of race that come up (DaCosta, 2007; Jackson-Nakazawa, 2003; Laszloffy, 2005). Hence, it is essential that these parents understand the importance of being vigilant and proactive even with regard to the practical concerns of race that arise in relationships with extended family and others significant to their lives, including health care providers, teachers, and other professionals, as well as the community in which they live, work, and worship.

The family is usually the primary social environment for young children and provides the first opportunity for them to learn about who they are. It is also the source of early socialization around race, ethnicity, and culture. Multiracial children may need help from parents and other family members with understanding and negotiating the implications that their multiple heritages have in the social environments of school and community. For this reason, it is critical for parents to provide family environments that are open, honest, supportive, and encouraging of exploration and age-appropriate dialogue (Jackson-Nakazawa, 2003; Sheets, 2003; Wardle & Cruz-Janzen, 2004).

Racial and ethnic identity formation presents different issues and challenges for multiracial children and youth depending on where they are developmentally (Jackson-Nakazawa, 2003; Wardle, 2001; Wardle & Cruz-Janzen, 2004). Multiracial children of preschool and early elementary school ages may have experiences of dealing with quizzical stares and racial questions and comments made by peers and adults. They may also have encounters where they feel expected to identify with or engage in interactions with peers and others of particular groups to the exception of others, or conversely they may feel rejected by particular groups. Such experiences can cause stress, can add to their confusion about themselves and where they fit, and can negatively affect their self-esteem (Jackson-Nakazawa, 2003; Sheets, 2003; Wijeyesinghe, 2001). As they progress into the later elementary and middle school years, children develop the ability to make use of racial and ethnic classifications to describe themselves and others; develop an understanding of the permanence of race; and develop values and feelings related to their racial and ethnic group memberships (Fhagen-

Smith, 2003; Wardle & Cruz-Janzen, 2004). They also become more socially conscious and are able to make comparisons between themselves and those in their peer group. This is also the time when the perceptions of others (particularly peers) become significant to their sense of being and self-worth (Jackson-Nakazawa, 2003). During this period it is typical for multiple-heritage children to develop interests and preferences for one aspect of their racial and ethnic heritage and begin to experiment with activities and behaviors that they attribute to that group. This is considered a normal and healthy part of the developmental process, as these children attempt to better understand who they are and where they fit (Fhagen-Smith, 2003; Jackson-Nakazawa, 2003; Wardle & Cruz-Janzen, 2004).

Junior and senior high school students are at the developmental period of adolescence during which major cognitive and physical changes occur and are made more salient by concerns about external perceptions and the desire for social acceptance by peers (Broderick & Blewitt, 2010). Over time, peer-group involvement and interaction increase and take on greater significance than ever before (Steinberg, 2008). It is during this time period that dating occurs and friendships and relationships become more intimate (Broderick & Blewitt, 2010). For multiracial adolescents, issues that emerge during this period can involve concerns related to acceptance by peers as well as expectations to engage in and conform to specific peer-group social norms, activities, and behaviors. In addition, and as a result of new experiences around race and racism, some multiracial adolescents feel pressured to engage in interactions with one racial reference group over another, bringing about feelings of dissonance as well as guilt and disloyalty over having to choose one aspect of one's heritage over the other (Bracey, Bamaca, & Umana-Taylor, 2004; Jackson-Nakazawa, 2003; Sheets, 2003; Suyemoto & Dimas, 2003; Wright, 2000). All of these experiences can be painful and traumatic, adding to an already tumultuous period of development (Cheng & Lee, 2009; Jackson-Nakazawa, 2003; Wright, 2000). Multiracial children and adolescents need adults in their lives who can help them to articulate feelings that emerge during these various developmental periods in their lives. They also need to be given tools to understand and negotiate the meaning and significance that their multiple heritages take on as they interact in schools, communities, and other environments (Jackson-Nakazawa, 2003; Wardle & Cruz-Janzen, 2004).

Results of the 2010 U.S. census revealed that 9 million individuals (or 2.9% of the total U.S. population) identified as having two or more racial heritages, a 32% increase from the 2000 U.S. census. More than 4.2 million of these individuals were under the age of 18 (U.S. Census Bureau, 2012). Similar to the experiences of interracial couples, multiracial individuals find themselves challenged by perceptions about who they are, borne out of myths and stereotypes that are indicative of our society's obsessions about race (DaCosta, 2007; Wardle, 1999; Wardle & Cruz-Janzen, 2004). The preponderance of these myths and stereotypes suggests that persons of mixed race are unhappy, confused, and doomed to a miserable existence of living life on the margins (Sue & Sue, 2013; Wardle & Cruz-Janzen, 2004).

According to Jackson (2010), several themes emerge and are salient to the experiences of multiracial individuals as they navigate life and attempt to resolve and to integrate their multiple racial identities. *Shifting racial/ethnic expression* involves altering the expression of one's racial or ethnic identity depending upon the social or environmental context. This is often an attempt at making others comfortable (Jackson, 2010). *Racial resistance* is described as defying traditional social norms and conventions of race perpetuated in the United States as a response to inquiries about one's racial or ethnic identity. This response in and of itself may be indicative of resiliency and a more evolved and integrated sense of self and identity (Jackson, 2010). *Seeking community* refers to the desire of multiracial individuals to

find and to connect with others with whom they share similar worldview experiences and values. This includes other multiracial persons as well as others who can empathize with the experience of being different (Jackson, 2010).

Jackson (2010) identified two other themes: *racial/ethnic ambiguity,* which refers to the ambiguous racial and ethnic physical appearance that for many multiracial individuals results in comments and questions from others concerning their racial/ethnic identity, and *feeling like an outsider*, which equates being multiracial with not fitting in and being marginalized and unaccepted by any of one's reference groups (Jackson, 2010). Experiences around these two themes substantiate and coincide with earlier themes identified by Root (1994), including acceptance, uniqueness, physical appearance, sexuality, self-esteem, and identity. The manifestations and experiences associated with these themes are unique and vary depending on developmental stage and phase of life. The level of understanding and support provided by family and others who are influential and significant in the individual's life and the manner by which the individual navigates these themes have implications for positive and healthy identity development, identity integration, and psychological adjustment throughout the life span (Jackson, 2010; Jackson, Yoo, Guevarra, & Harrington, 2012; Root, 1994, 2002).

Key Multicultural Concepts and Characteristics

Key Concepts

A broad range of terms have been proposed and used in discussing and describing the multiracial population; examples include *biracial* and *mixed race* (Henriksen & Paladino, 2009c; Root & Kelley, 2003) and *multiracial, multicultural*, and *mixed heritage* (Aspinall, 2009; Jackson et al., 2012). The most commonly used and accepted terms of the past two decades are *interracial* and *multiracial*. The term *multiracial* is frequently used because it acknowledges the possibility of two or more racial backgrounds (Henriksen & Paladino, 2009c; Root & Kelley, 2003). The term *multiple heritage* has recently been used to acknowledge the multiple dimensions of identity, including race and culture, that influence the worldview experiences of this population (Henriksen & Paladino, 2009a). The term *mulatta(o)* was used as a label to describe multiracial individuals; like *half-breed*, *mongrel*, and *mutt*, it is derogatory, offensive, and inappropriate (Root, 1992, 1996; Sue & Sue, 2013). The term *multiple heritage* is used synonymously with *interracial* and *multiracial* throughout this chapter.

Finally, the term *multiracial identity integration* is frequently used when discussing the positive identity development of multiracial individuals. *Multiracial identity integration* refers to the extent to which the multiracial individuals view their multiple racial identities as compatible and complementary and feel comfortable identifying with all aspects of their racial heritages (Cheng & Lee, 2009).

Key Characteristics

The multiracial population includes interracial couples, multiracial families, and multiracial individuals. *Interracial couples* are partners, married or not, where each individual has a different socially constructed racial background (Root & Kelley, 2003). *Multiracial families* are families comprising interracial couples and their multiracial offspring, single parents with biological offspring who are multiracial, and single parents with multiracial offspring as a result of a surrogate pregnancy process or artificial insemination process (Kenney, 2000). *Multiracial individuals* are individuals who have two or more different socially constructed racial heritages or backgrounds (Root & Kelley, 2003).

Rates of intermarriage specifically to White, European Americans have tended to be highest among Asians, Latinos, and Native Americans (Bean & Stevens, 2003; Taylor et al., 2006). Although the intermarriage rates for African Americans have been low historically, more recent data reveal a marked increase in the number of African Americans outmarrying (Passel et al., 2010). Increased social proximity between groups, increased educational attainment, and decreased parental influence as a result of geographic distance from family of origin appear to be factors that account for these increases (Passel et al., 2010; Rosenfeld & Kim, 2005). The number of interracial marriages between two persons of color, while growing, remains small comparatively (Bean & Stevens, 2003; Taylor et al., 2006). Intermarriage rates for Asians and Hispanics have continued to increase; however, the growth of immigration patterns of these two groups has expanded the options and possibilities for in-group marriages (Passel et al., 2010).

Although recent gender patterns have revealed some shifts (Passel et al., 2010), African American women continue to be the least likely of all women to out-marry, and White and African American men have tended to out-marry at higher rates than men from other groups (Taylor et al., 2006). Recent out-marriage rates reveal a pattern of increase in the numbers of Asian women and African American males who intermarry (Passel et al., 2010).

Systemic Barriers

Although the legal barriers to interracial marriage no longer exist and approval and acceptance rates have increased, the subject of these unions continues to meet with societal scrutiny and criticism, and couples continue to report experiences with racism and discrimination. Interracial coupling challenges the sociopolitical hierarchies and racial stratification systems of our society. This is particularly the case with regard to the notion of Black–White unions, due to the history and legacy of slavery in the United States (Root, 2001; Yancey, 2002; Yancey & Yancey, 2002). However, the degree of scrutiny and criticism, as well as experiences of racism even in the case of Black–White unions, varies depending upon a wide range of variables including gender, age, geographic region, education level, ideology, and political affiliation (Jones, 2011).

The fact that persons of multiple racial heritages have been able to select more than one racial category to identify themselves on U.S. census and some other government forms (U.S. Office of Management and Budget, 1997) has not granted them or their families immunity from societal opposition and ridicule (Miranda, 2003). Additionally, numerous organizations, including schools, colleges and universities, and government agencies, either do not provide respondents the option to check more than one option when identifying their race or do not acknowledge or accurately record the multiple identities selected. This contributes to continued experiences of marginalization by multiracial individuals (Kellogg & Niskode, 2008; Townsend, Markus, & Bergsieker, 2009). Multiracial individuals encounter ongoing pressures to either identify with a single racial group (Johnston & Nadal, 2010; Shih & Sanchez, 2005) or to adopt a racial identity that is not consistent with their view of themselves (Salahuddin & O'Brien, 2011). Finally, similar to interracial couples, multiracial individuals encounter barriers associated with racism and discrimination, ranging from daily microaggressions to outright verbal or physical attacks (Jackson, 2009; Johnston & Nadal, 2010; Shih & Sanchez, 2005). Ample evidence suggests that the impact of these barriers on psychological well-being and adjustment over the life span is negative (Jackson et al., 2012).

Personal Voices
The Story of Bonita

Bonita was a 19-year-old sophomore at a midsize public university. Bonita had ambiguous racial features; she had an African and Dominican American mother and a White (Irish) American father. She had a sister who was 2 years younger, and she grew up and attended school in an affluent, predominantly White suburb in the northeast; family on both her mother and father's side lived within easy driving distance, and she was close to her extended family, especially cousins of her age.

The school district that Bonita had attended was becoming a little more diverse, although it was still predominantly White. Bonita was an honor roll student and took upper-level as well as Advanced Placement courses during high school. She was often either the only or one of just a few students of color in these classes. A friend in the school district's administration had shared with Bonita's father in her junior year that the students of color enrolled in academically rigorous courses were being singled out and touted as "special" for their academic achievements. This information was being included in special district reports to the state's department of education. Bonita and other "known" multiracial students on the honor roll and in advanced level classes were included in this special group of students of color because of their minority status. It greatly upset Bonita and her parents that she was being singled out because of her racial/ethnic identity statuses as African and Dominican American and without her consent. She had been taught about, was proud of, and celebrated all aspects of her background. She referred to herself and to her family as multiracial.

Bonita was involved in theatre, student government, and a number of school clubs and organizations. Although she had a diverse circle of friends in high school, the majority had been White. At school people had always asked her about her and her family's backgrounds. She had also been a witness to rude comments and racial slurs made by White students and directed at African and Latino American students. She recalled having one encounter where a racist slur was directed at her specifically, but there were other encounters where she was informed the comments did not apply to her because she was "different," a subtle reference to her being part White. Bonita's typical response to these encounters was to ignore them and to consider the source, as she had been taught by her family, but the comments hurt, and she'd found herself at times withdrawing from interactions with her White friends. Her Black and Latino friends were not particularly easy for her to be around either. Her Latino friends would poke fun at her for not fully understanding Spanish and some of the slang that they used; like her Black friends, they would often ridicule her for "acting" too White.

Applying for college was exciting for Bonita, especially because by her junior year she'd found herself ready to move on. Asked about her racial background when registering for the PSATs and SATs and on some of the college admissions applications and other forms, she'd been forced to select one option. She was interested in the medical sciences and received mail from schools all over the country but decided to stay in the northeast and to go to a school 2 hours from home.

Bonita received merit scholarship money for college, including two scholarships awarded by the school. One of these was for women and minorities in the sciences, the other for students of color with strong SAT scores, high school GPAs, and class ranks. Both required recipients to participate in campus programs offered by the university's multicultural affairs office. These provided scholarship recipients opportunities for networking and support for their academic endeavors. The other scholarship recipients were primarily Black

and Latino, and although her encounters with them were positive for the most part, she sometime felt as though her legitimacy to receive the scholarships and to be in the program was in question. These experiences made her starkly aware that people in the program questioned her racial background and perceived her as different.

Bonita had become friends with three girls from the scholarship program who identified as Black and had begun to spend a lot of time with them. During the time for housing selection for Bonita's second year of college, Bonita's White roommate and two of her other friends who were also White had decided to move into suite-style housing for the next year; they (including Bonita) had all agreed that they would pursue the suite-style housing together. On the day of the actual selection process, Bonita was informed that the girls had found a fourth person to live with them in the suite; they had assumed that since Bonita had become friends with the girls from the scholarship program, she would be living with them. Bonita had noticed prior to this that her roommate and the other girls were starting to exclude her from some of their social activities. One day she thought that she'd even overheard one of the girls making stereotypical comments about Blacks and Latinos. Dealing with issues and questions of race had become an annoyance for Bonita by her junior year of high school, and she had hoped that college would be different.

Bonita was finishing some work in one of the science labs one day, and the lab tech, an older White male student whom she'd chatted with before, came over and inquired where she had gotten the first name Bonita. This was the last straw for her. Although she knew that there were other students on campus like her who identified as multiracial, there had been no opportunities to connect with them. The multicultural affairs office that sponsored the programs she participated in for the scholarships seemed to have a lot of social and networking activities for monoracial students of color, but she had heard of nothing for multiracial students. Bonita was starting to feel angry, a reaction that typically resulted in her withdrawing into herself. She just wanted to feel accepted and connected with some like-minded people. She decided to call the counseling center to talk things out a bit.

Individual Counseling: Applications at the Microlevel

Working in a multicultural competent framework first requires counselors to be aware of their own assumptions, values, and biases (Sue, Arredondo, & McDavis, 1992). The counseling center staff member working with Bonita must be aware of the increasing numbers of multiracial students attending college and the challenges and concerns they face (Kellogg, 2006; King, 2008; Renn, 2004; Shang, 2008). They must also be aware of any personal biases or beliefs they hold about multiracial individuals and their families (Kenney, 2002; Wehrly et al., 1999). Perceptions of bias or lack of information and sensitivity greatly influence interactions and the potential for seeking help. Multiracial students who view the services provided by the center in this way refrain from seeking help or assistance when they need it (Constantine & Gainor, 2004; Renn, 2004; Sands & Schuh, 2004; Wong & Buckner, 2008).

Multiracial individuals may not always present for counseling to deal with issues related to their multiple heritages, but it is important for counselors to be aware that having multiple heritages may influence an individual's life and functioning at varying points over the life span. This may particularly be the case for younger multiracial individuals. Hence the counselor must be prepared to assess the role this may play in the concerns being presented in counseling (Jackson, 2010; Jackson et al., 2012; Wehrly et al., 1999). Bonita has sought counseling to discuss and to learn skills for dealing with and for addressing others' responses and reactions to her multiracial identity. For multiracial individuals, col-

lege can be a period where they are especially vulnerable to feelings of alienation or rejection (Paladino, 2004). The aforementioned themes espoused by Root (1994) and Jackson (2010) may prove significant in assessing the issues and concerns presented by multiracial individuals like Bonita, as they may shed light on their experiences and perceptions. Root's (2002, 2003a) model, ecological framework for understanding multiracial identity development, is a useful model for exploring and understanding the worldview experiences of both multiracial individuals and their families and can therefore be useful in helping the counselor to further conceptualize and understand Bonita's life experiences and her current issues and concerns. The model is borne out of the sociological constructs of interaction and identifies invisible and other variables that typically affect identity. These variables are framed in the model as lenses through which the experiences of multiracial individuals can be viewed. Although there may be some similarities in the experiences of multiracial individuals, the model illustrates how even siblings raised in the same family can have distinctly different experiences (Jackson, 2010; Root, 1994).

The foundational influences of identity (or what Root, 2003a, referred to as the *macro lenses of the model*) are regional and generational history of race relations, sexual orientation, gender, and class. These variables are the central contexts within which multiracial individuals learn sociocultural norms regarding their racial and ethnic identities. Regional and generational history of race relations speak to the varied historical and sociopolitical contexts of the United States and how these have shaped and influenced the experiences of multiracial individuals, including how they have chosen to identify. Additional challenges arise around sexual orientation in the context of race depending upon the individual's stage of life, circumstances, and other influencing experiences (Root, 2003a). Multiracial individuals attempting to negotiate their sexual identities have been more apt to find acceptance within White communities, as communities of color are often biased toward the gay community (Root, 2003a, 2003b). The power differentials and hierarchies typical of the variables gender, sexual orientation, and social class are further exacerbated when viewed from the perspective of race and may be further complicated for persons of multiple heritages (Root, 2003b).

Family functioning is further composed of consistency of parental availability; extended family acceptance; losses and disruptions; sense of belonging and acceptance; and extent of violence, abuse, and neglect (Root, 2002). Family functioning is salient to all aspects of an individual's development, particularly identity development, and has implications across the life span. The family functioning variable interrelates with family socialization and another middle lense variable, traits and aptitudes (Root, 2003a, 2003b).

According to Root (2003a), the family socialization variable consists of nonbiological inherited factors such as language, nativity, given names, parental identity, family identity, existence of extended family, home values, customs, spirituality, family racial socialization, and family racial and ethnic identity. Traits and aptitudes consist of personality characteristics and tendencies including temperament, social skills, coping skills, giftedness, health, learning difficulties, and physical attractiveness. Community attitudes and racial socialization is another interrelated middle lense variable that combines the relationships and interactions that exist in the categories of school or work, current community, friendship circles, and new communities. The extent to which an individual experiences acceptance, belonging, or oppression in each of these categories determines its significance (Root, 2003a).

The final middle lense variable is *identities*, and it includes ethnicities and races. According to Root (2003a, 2003b), five specific identity choices are possible based upon the individual's generational cohort. The first identity, *hypodescent/one-drop rule*, is a monoracial identity

assigned by society and has typically been viewed as a racial status of lesser value. The second identity, *monoracial fit/self-assignment*, represents a conscious decision on the part of multiple heritage individuals to identify with a specific monoracial aspect of their heritage based upon how it fits with their worldview experiences (Root, 2003a, 2003b). As referred to in the generational history variable, these first two identities were the only options afforded to multiple heritage individuals of older generations. The third identity, *new group/blended,* is one in which multiple heritage individuals are free to identify equally with all aspects of their heritages. In the fourth identity, *bi/multiracial*, multiple-heritage individuals identify with all aspects of their multiple heritages but without quantification or limits. Multiracial is viewed as a radical, progressive, and fluid identity status. The third and fourth identity options have become common for multiple heritage individuals of younger generational cohorts, including today's millenials (Root, 2003a, 2003b). The final and newest identity, *White with symbolic race,* is one in which multiple heritage individuals with White ancestry do not denigrate or reject their other racial heritages, but they identify more with the worldview values and lifestyles afforded to them by their White ancestry (Root, 2003a, 2003b).

Phenotype is a magnifying lense that cuts across all lenses and interacts with all variables of the model (Root, 2003a). Phenotype is a constant aspect of the experiences of multiple heritage individuals. Although it may not determine how the individual chooses to identify, it plays a critical role in their life experiences and interactions (Root, 2003b; Wijeyesinghe, 2001). Strategies including focused discussions, homework assignments, role-plays, journaling, and storytelling can be used to ascertain the context and worldview of a client like Bonita.

Further work with Bonita might include the use of the ecomap model (Logan, Freeman, & McCoy, 1987). This model incorporates the use of a genogram that can be used to explore family development, relationships and dynamics, roles, and significant life events. It can also be used in conjunction with the model to assess the racial and ethnic backgrounds of family members, the attitudes of immediate and extended family toward the multiracial individual, and overall family functioning (Root, 2002). The nature of relationships with social networks including community, neighborhood, schools, and other institutions may also be explored (Logan et al., 1987). The model uses connecting lines and symbols, similar to those used in a genogram, to illustrate relationships. The multiracial individual or his or her family may be shown in a large circle, with smaller circles drawn around to illustrate other family and social support networks (Logan et al., 1987). The value of this model is that it provides a powerful visual of the individual's and family's external support networks and connections. For multiracial individuals, especially college students like Bonita, this information can be a source of empowerment and lend to the enhancement of one's sense of self and to positive identity development (Paladino, 2009; Paladino & Davis, 2006).

Psychoeducation, using reading materials, movies, and websites addressing issues and concerns of relevance (such as their experiences related to Root's, 1994, and Jackson's, 2010, themes) can also be helpful in working with a college student like Bonita (Paladino, 2009). Whereas individual counseling intervention can be beneficial, Nishimura (1998) cited the usefulness of group counseling intervention in meeting the needs of multiracial college students. Group counseling can provide a sense of community, as well as be the source of empowerment and strength that is often lacking for this population of students on campus.

Advocacy Counseling: Applications at the Macrolevel

Advocacy is an essential role and function of the counseling profession (Ratts, Toporek, & Lewis, 2010) and is particularly critical in helping college students to navigate the system of

higher education (Sharkin, 2012). Multiracial college students must navigate through some unique situations, beginning with the college admissions process, where they may be expected to choose between their multiple racial heritages when responding to questions about their identities on standardized entrance exams and admissions applications (Gasser, 2002; Padilla & Kelley, 2005). Upon starting college these students, like their peers, must face all of the challenges inherent in making the transition to the new environment (Friedlander, Reid, Shupak, & Cribbie, 2007). However, they must do so while also attempting to integrate their multiple heritage identities and often find themselves navigating these experiences in an environment void of models that fit their worldviews (King, 2008; Renn, 2003, 2004; Sands & Schuh, 2004). Some multiracial college students find themselves being challenged regarding their identities. For some this may be the first encounter with questions about who or what they are, particularly if they come from home environments and communities where they and their families were known (Kellogg, 2006; King, 2008; Renn, 2003; Wallace, 2003).

In their roles as advocates, college counselors must not only educate themselves, they must educate the rest of the campus community on the issues, concerns, and challenges faced by the increasing population of multiracial college students like Bonita (Kenney, 2007). This would include taking the lead to provide professional development trainings and educational workshops, lecture series, cultural events, and forums (Kenney, 2000; Renn, 2003, 2004; Sands & Schuh, 2004). Counselors working with college students in the context of community mental health agencies may need to discover and familiarize themselves with community resources available to both educate themselves and to help them in assisting college students and other members of the multiracial population who may seek their services (Kenney, 2000; Kenney & Kenney, 2010; Wardle & Cruz-Janzen, 2004). In instances where resources are not available in the community, agency counselors may need to intervene by helping to establish them (DaCosta, 2007; Kenney & Kenney, 2010; Root & Kelley, 2003). Note, however, that a wealth of information and helpful resources for this population is available on the Internet (Kenney, 2000; Kenney & Kenney, 2010).

Multiracial college students also experience challenges similar to their monoracial minority peers, attempting to adjust to predominantly White campuses (Newman & Newman, 1999; Paladino, 2009; Von Steen, 2000). In some cases this means adapting to campuses with limited or no experience with diversity or where the services and social networks for students of color are either lacking or limited to the needs of monoracial students of color (Levine & Cureton, 1998). Multiracial students who previously might have had strong affiliations and identified with a monoracial minority group might encounter challenges to their cultural legitimacy and loyalty as well as their eligibility for services and support. They might also experience feelings of guilt for accepting services or support as a member of a specific group and might no longer feel comfortable with or accepted by the group's campus network (King, 2008; Renn, 2004; Sands & Schuh, 2004; Wallace, 2003). MAVIN Foundation has played a central grassroots advocacy role around issues and concerns of relevance to the multiracial population; so have several other organizations founded in the mid-1990s. The word *mavin* is Yiddish and means "one who understands." MAVIN was founded as a magazine resource on the "mixed race experience" by Matt Kelley during his years as a multiracial college student at Wesleyan College. In 2000, the MAVIN nonprofit foundation was started and has been an excellent resource to college campuses across the country in effective ways to advocate for multiracial students, including how to establish clubs, organizations, and services for multiracial students. MAVIN has also established itself as a community resource for multiracial individuals and families (Kenney, 2007; Kenney & Kenney, 2010; Root & Kelley, 2003).

Advocacy entails working across systems in a collaborative manner (Ratts et al., 2010). College counseling centers are typically situated in that part of the organizational structure of the campus known as the division of student affairs. This division encompasses a vast array of student support and other service areas. Professionals who work within student affairs divisions of college and university campuses are in a unique position by virtue of the level and type of contact they have with students to advocate for them and their needs and to do so by working collaboratively with other campus offices and departments (McClellan & Stringer, 2009). In working with multiracial college students, like Bonita, it is important for staff of the counseling center to familiarize themselves with other campus efforts that may exist for the purpose of addressing the needs of multiracial students, in order to make students aware of and get them connected to what is available. It is also very important for staff of the counseling center to work collaboratively with these other areas. In instances where programs and services do not exist, counseling center staff must work collaboratively with others in the campus community to establish services (e.g., mentoring programs, learning communities, networking groups, and social clubs) depending on the assessed needs of the multiracial student population (Kenney, 2007; Kenney & Kenney, 2010; King, 2008; Renn, 2003, 2004; Wong & Buckner, 2008). It is also important to engage faculty in discussions and to provide them with recommendations for how they can incorporate multiracial identity topics and issues in course curriculum and classroom dialogue (Kellogg & Niskode, 2008; King, 2008). Finally, counseling center staff should play a role in campus recruitment and hiring processes, making suggestions for the recruitment of faculty and staff of multiple-heritage backgrounds who can possibly add to the diversity of the campus and provide the necessary role modeling and mentoring for multiple-heritage students (King, 2008; Renn, 2004).

College counselors can play a major advocacy role for the multiracial student population by helping other campus officials to understand their need to be sensitive to the emotions that can arise for this population around issues of race and identity (Kellogg & Niskode, 2008). As advocates they must collaborate with campus officials responsible for addressing and implementing institutional policies related to how racial and ethnic data are collected (Kellogg & Niskode, 2008; Renn, 2004). This requires them to be aware of and knowledgeable about MAVIN Foundation's Campus Awareness and Compliance Project. This project has monitored and assisted colleges and universities in their efforts to allow students to check more than one racial category on admissions applications and other relevant forms (MAVIN Foundation, 2004). It is important that university staff are aware of public policy and legislation such as the U.S. Department of Education's mandate that beginning in the 2010–2011 academic year, institutions must allow multiracial students the opportunity to check more than one category as well as the department's mandate requiring institutions to provide unduplicated head count reports of students checking more than one race (Kellogg & Niskode, 2008). For students like Bonita, completing college admissions applications and other forms for the purpose of receipt of scholarships and financial aid and being able to indicate all aspects of their racial and ethnic heritages contributes significantly to students' sense of esteem, empowerment, and inclusion (Kellogg & Niskode, 2008; Renn, 2004).

Future Directions

The ever-increasing presence of multiple-heritage couples, individuals, and families in the United States requires the counseling profession to critically examine its role in providing culturally competent and effective counseling and advocacy services. To this end, research

on the various aspects of the multiple-heritage experience must be supported. Specifically, research is needed that helps with our understanding of the many ways of identifying across the life span and that addresses the complexities associated with claiming intersecting identities within a multiracial context. In addition, research is needed on new intervention strategies for working with the population.

Graduate and other training programs must be intentional in providing opportunities for students and professionals to develop the awareness, knowledge, and skills necessary for addressing the needs of this burgeoning population. This includes providing information on resources available within the multiracial community and ways that counseling professionals can work collaboratively with members of the multiracial community.

Resources

Critical Mixed Race Studies Association
http://criticalmixedracestudies.org/
Loving Day Organization
http://www.lovingday.org/
MAVIN Foundation
http://www.mavinfoundation.org/new/
Mixed Heritage Center
http://www.mixedheritagecenter.org/
Mixed Race Studies
http://www.mixedracestudies.org/

References

Aspinall, P. J. (2009). "Mixed race," "mixed origins," or what? Generic terminology for the multiple racial/ethnic group population. *Anthropology Today, 25*, 3–8.

Bean, F. D., & Stevens, G. (2003). *America's newcomers and the dynamics of diversity.* New York, NY: Russell Sage Foundation.

Bhugra, D., & DeSilva, P. (2000). Couple therapy across cultures. *Sexual and Relationship Therapy, 15*, 183–192.

Bracey, J. R., Bamaca, M. Y., & Umana-Taylor, A. J. (2004). Examining ethnic identity and self-esteem among biracial and monoracial adolescents. *Journal of Youth and Adolescence, 33*, 123–132.

Bramlett, M. D., & Mosher, W. D. (2002). *Cohabitation, marriage, divorce, and remarriage in the United States* (Vital and Health Statistics, Series 23, No. 22). Hyattsville, MD: National Center for Health Statistics.

Bratter, J. L., & King, R. B. (2008). "But will it last?": Marital instability among interracial and same-race couples. *Family Relations, 57*, 160–171.

Broderick, P. C., & Blewitt, P. (2010). *The lifespan: Human development for helping professionals.* Boston, MA: Pearson.

Bustamante, R. M., Nelson, J. A., Henriksen, R. C., Jr., & Monakes, S. (2011). Intercultural couples: Coping with culture-related stressors. *The Family Journal: Counseling and Therapy for Couples and Families, 19*, 154–164.

Carroll, J. (2007, August 16). *Most Americans approve of interracial marriages*. Princeton, NJ: Gallup New Service.

Cheng, C., & Lee, F. (2009). Multiracial identity integration: Perceptions of conflict and distance among multiracial individuals. *Journal of Social Issues*, *65*, 51–68.

Constantine, M., & Gainor, K. (2004). Depressive symptoms and attitudes toward counseling of biracial college women's psychological help-seeking behavior. *Women and Therapy, 27*, 147–159.

DaCosta, K. M. (2007). *Making multiracials: State, family, and market in the redrawing of the color line*. Stanford, CA: Stanford University Press.

Douglass, R. E. (2003). The evolution of the multiracial movement. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 12–17). Seattle, WA: MAVIN Foundation.

Fhagen-Smith, P. (2003). Mixed race youth between 8 to 11 years old. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 61–66). Seattle, WA: MAVIN Foundation.

Friedlander, L. J., Reid, G. J., Shupak, N., & Cribbie, R. (2007). Social support, self-esteem, and stress as predictors of adjustment to university among first-year undergraduates. *Journal of College Student Development, 48*, 259–274.

Gasser, H. S. (2002). Portraits of individuality: A qualitative study of multiracial college students. *Colorado State University Journal of Student Affairs, 11*, 42–53.

Henriksen, R. C., Jr., & Paladino, D. A. (2009a). *Counseling multiple heritage individuals, couples, and families.* Alexandria, VA: American Counseling Association.

Henriksen, R. C., Jr., & Paladino, D. A. (2009b). History of antimiscegenation. In R. C. Henriksen, Jr., & D. A. Paladino (Eds.), *Counseling multiple heritage individuals, couples, and families* (pp. 17–25). Alexandria, VA: American Counseling Association.

Henriksen, R. C., Jr., & Paladino, D. A. (2009c). History of racial classification. In R. C. Henriksen, Jr., & D. A. Paladino (Eds.), *Counseling multiple heritage individuals, couples, and families* (pp. 1–16). Alexandria, VA: American Counseling Association.

Jackson, K. F. (2009). Beyond race: Examining the facets of multiracial identity through a lifespan developmental lens. *Journal of Ethnic and Cultural Diversity in Social Work, 18*, 309–326.

Jackson, K. F. (2010). Living the multiracial experience: Shifting racial expressions, resisting race, and seeking community. *Qualitative Social Work, 11*, 42–60.

Jackson, K. F., Yoo, H. C., Guevarra, R., Jr., & Harrington, B. A. (2012). Role of identity integration on the relationship between perceived racial discrimination and psychological adjustment of multiracial people. *Journal of Counseling Psychology, 59*, 240–250.

Jackson-Nakazawa, D. (2003). *Does anybody else look like me? A parent's guide to raising multiracial children.* Cambridge, MA: Perseus.

Johnston, M. P., & Nadal, K. L. (2010). Multiracial microaggressions: Exposing monoracism in everyday life and clinical practice. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 123–144). Hoboken, NJ: John Wiley & Sons.

Jones, J. M. (2011, September 12). Record-high 86% approve of Black–White marriages. *Gallup*.

Kellogg, A. (2006). *Exploring critical incidents in the racial identity of multiracial college students* (Unpublished doctoral dissertation). University of Iowa, Iowa City.

Kellogg, A., & Niskode, A. S. (2008). Student affairs and higher education policy issues related to multiracial students. In K. A. Renn & P. Shang (Eds.), *Biracial and multiracial students* (pp. 93–102). San Francisco, CA: Jossey-Bass.

Kenney, K. (2000). Multiracial families. In J. Lewis & L. Bradley (Eds.), *Advocacy in counseling: Counselors, clients, community* (pp. 55–70). Greensboro, NC: ERIC/CASS.

Kenney, K. R. (2002). Counseling interracial couples and multiracial individuals: Applying a multicultural counseling competency framework. *Counseling and Human Development, 35*(4), 1–12.

Kenney, K. R. (2007). Strategies and counselor competencies in counseling multiracial students. In J. A. Lippincott & R. B. Lippincott (Eds.), *Special populations in college counseling: A handbook for mental health professionals* (pp. 77–88). Alexandria, VA: American Counseling Association.

Kenney, K. R., & Kenney, M. E. (2010). Advocacy with the multiracial population. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies: A social justice framework for counselors* (pp. 65–74). Alexandria, VA: American Counseling Association.

Kenney, K. R., & Kenney, M. E. (2012). Contemporary US multiple heritage couples, individuals, and families: Issues, concerns, and counseling implications. *Counselling Psychology Quarterly, 25*(2), 1–14.

King, A. R. (2008). Student perspectives on multiracial identity. In K. A. Renn & P. Shang (Eds.), *Biracial and multiracial students* (pp. 33–41). San Francisco, CA: Jossey-Bass.

Laszloffy, T. A. (2005, March–April). Multiracial families. *Family Therapy Magazine*, 38–43.

Levine, A., & Cureton, J. S. (1998). *When hope and fear collide: A portrait of today's college student.* San Francisco, CA: Jossey Bass.

Logan, S. L., Freeman, E. M., & McRoy, R. G. (1987). Racial identity problems of biracial clients: Implications for social work practice. *Journal of Intergroup Relations, 15*, 11–24.

Loving v. Virginia, 388 U.S. 1 (1967).

Ludwig, J. (2004). Acceptance of interracial marriage at record high. *Gallup Poll Tuesday Briefing*, 594.

MAVIN Foundation. (2004). *The campus awareness + compliance initiative.* Retrieved from http://mavinfoundation.org/projects/caci.html

McClellan, G. S., & Stringer, J. (2009). *The handbook of student affairs administration* (3rd ed.). San Francisco, CA: Jossey-Bass/Wiley.

Miranda, G. E. (2003). Domestic transracial adoption and multiraciality. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 109–115). Seattle, WA: MAVIN Foundation.

Newman, P. R., & Newman, B. M. (1999). What does it take to have a positive impact on minority students' college retention? *Adolescence, 34*, 483–492.

Nishimura, N. J. (1998). Assessing the issues of multiracial students on college campuses. *Journal of College Counseling, 1*, 45–53.

Padilla, A., & Kelley, M. (2005). *One box isn't enough: An analysis of how U.S. colleges and universities classify mixed heritage students*. Retrieved from www.mavinfoundation.org/news/OBIE_CommentCardPkt.doc

Paladino, D.A. (2004). *The effects of cultural congruity, university alienation, and self-concept upon multiracial students' adjustment to college* (Unpublished doctoral dissertation). University of Arkansas, Fayetteville.

Paladino, D. A. (2009). Counseling multiple heritage college students. In R. C. Henriksen, Jr., & D. A. Paladino (Eds.), *Counseling multiple heritage individuals, couples, and families* (pp. 101–110). Alexandria, VA: American Counseling Association.

Paladino, D. A., & Davis, H., Jr. (2006). Counseling and outreach strategies for multiracial college students. *Journal of College Student Psychotherapy, 20*(3), 19–31.

Passel, J. S, Wang, W., & Taylor, P. (2010). *Marrying out: One-in-seven new U.S. marriages is interracial or interethnic.* Washington, DC: Pew Research Center.

Poulsen, S. S. (2003). Therapists' perspectives on working with interracial couples. In V. Thomas, T. A. Karis, & J. L. Wetchler (Eds.), *Clinical issues with interracial couples: Theories and research* (pp. 163–177). New York, NY: Haworth.

Ratts, M. J., Toporek, R. L., & Lewis, J. A. (2010). *ACA advocacy competencies: A social justice framework for counselors.* Alexandria, VA: American Counseling Association.

Renn, K. A. (2003). Understanding the identities of mixed-race college students through a developmental ecology lens. *Journal of College Student Development, 44*, 383–403.
Renn, K. A. (2004). *Mixed race students in college: The ecology of race, identity, and community*. Albany: SUNY Press.
Root, M. P. P. (1992). *Racially mixed people in America.* Newbury Park, CA: Sage.
Root, M. P. P. (1994). Mixed-race women. In L. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 455–478). New York, NY: Guilford Press.
Root, M. P. P. (1996). *The multiracial experience: Racial borders as the new frontier.* Thousand Oaks, CA: Sage.
Root, M. P. P. (2001). *Love's revolution: Interracial marriage*. Philadelphia, PA: Temple University Press.
Root, M. P. P. (2002). Methodological issues in multiracial research. In G. C. Nagayama Hall & S. Okazaki (Eds.), *Asian American psychology: The science of lives in context* (pp. 171–193). Washington, DC: American Psychological Association.
Root, M. P. P. (2003a). Multiracial families and children: Implications for educational research and practice. In J. A. Banks & C. A. McGee Banks (Eds.), *Handbook of research on multicultural education* (2nd ed., pp. 110–124). San Francisco, CA: Jossey-Bass.
Root, M. P. P. (2003b). Racial identity development and persons of mixed race heritage. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 34–41). Seattle, WA: MAVIN Foundation.
Root, M. P. P., & Kelley, M. (2003). *Multiracial child resource book: Living complex identities*. Seattle, WA: MAVIN Foundation.
Rosenfeld, M. J., & Kim, B.-S. (2005). The independence of young adults and the rise of interracial and same-sex unions. *American Sociological Review, 70*, 541–562.
Salahuddin, N. M., & O'Brien, K. M. (2011). Challenges and resilience in the lives of urban, multiracial adults: An instrument development study. *Journal of Counseling Psychology, 58*, 494–507.
Sands, N., & Schuh, J. H. (2004). Identifying interventions to improve the retention of biracial students: A case study. *Journal of College Student Retention, 5*, 349–363.
Shang, P. (2008). An introduction to social and historical factors affecting multiracial college students. In K. A. Renn & P. Shang (Eds.), *Biracial and multiracial students* (New Directions for Student Services, No. 123, pp. 5–12). San Francisco, CA: Jossey-Bass.
Sharkin, B. S. (2012). *Being a college counselor on today's campus: Roles, contributions, and special challenges*. New York, NY: Routledge.
Sheets, R. H. (2003). Multiracial adolescent perception: The role of friendship in identification and identity formation. In K. Wallace (Ed.), *Working with multiracial students: Critical perspectives on research and practice* (pp. 137–154). Greenwich, CT: Information Age.
Shih, M., & Sanchez, D. T. (2005). Perspectives and research on the positive and negative implications of having multiple racial identities. *Psychological Bulletin, 131*, 569–591.
Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review, 28*, 78–106.
Sue, D.W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64–88.
Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: Wiley.

Suyemoto, K. L., & Dimas, J. (2003). Identity development issues for multiracial and multiethnic youth 15 to 17 years old. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 77–84). Seattle, WA: MAVIN Foundation.

Taylor, P., Funk, C., & Craighill, P. (2006). Guess who's coming to dinner: 22% of Americans have a relative in a mixed-race marriage. *Pew Research Center: A Social Trends Report*. Retrieved from http://www.pewsocialtrends.org/2006/03/14/

Townsend, S. S. M., Markus, H. R., & Bergsieker, H. B. (2009). My choice, your categories: The denial of multiracial identities. *Journal of Social Issues, 65,* 185–204.

U.S. Census Bureau. (2012, April 25). *2010 census shows interracial and interethnic married couples grew by 28 percent over decade*. Retrieved from http://www.census.gov/newsroom/releases/archives/2010_census/cb12-68.html

U.S. Office of Management and Budget. (1997). *Revisions to the standards for the classification of federal data on race and ethnicity*. Retrieved from http://www.whitehouse.gov/omb/fedreg_1997standards

Von Steen, P. G. (2000). Traditional-age college students. In D. C. Davis & K. M. Humphrey (Eds.), *College counseling: Issues and strategies for a new millennium* (pp. 111–132). Alexandria, VA: American Counseling Association.

Waldman, K., & Rubalcava, L. (2005). Psychotherapy with intercultural couples: A contemporary psychodynamic approach. *American Journal of Psychotherapy, 59*, 227–245.

Wallace, K. R. (2003). Contextual factors affecting identity among mixed heritage college students. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 87–93). Seattle, WA: MAVIN Foundation.

Wardle, F. (1999). *Tomorrow's children.* Denver, CO: Center for the Study of Biracial Children.

Wardle, F. (2001). Supporting multiracial and multiethnic children and their families. *Young Children, 56*(6), 38–39.

Wardle, F., & Cruz-Janzen, M. I. (2004). *Meeting the needs of multiethnic and multiracial children in schools.* Boston, MA: Pearson Education.

Ware, A. C. (2002). Pastoral counseling of multiracial families. In G. A. Yancey & S. W. Yancey (Eds.), *Just don't marry one: Interracial dating, marriage, and parenting* (pp. 28–38). Valley Forge, PA: Judson Press.

Wehrly, B., Kenney, K. R., & Kenney, M. E. (1999). *Counseling multiracial families*. Thousand Oaks, CA: Sage.

Wijeyesinghe, C. L. (2001). Racial identity in multiracial people: An alternative paradigm. In C. L. Wijeyesinghe & B. W. Jackson, III (Eds.), *New perspectives on racial identity development: A theoretical and practical anthology* (pp. 129–152). New York: New York University Press.

Wong, M. P. A., & Buckner, J. (2008). Multiracial student services come of age: The state of multiracial student services in higher education in the United States. In K. A. Renn & P. Shang (Eds.), *Biracial and multiracial students* (New Directions for Student Services, No. 123, pp. 43–51). San Francisco, CA: Jossey-Bass.

Wright, M. (2000). *I'm chocolate, you're vanilla: Raising healthy Black and biracial children in a race-conscious world.* Hoboken, NJ: Jossey-Bass.

Yancey, G. A. (2002). Debunking the top stereotypes about interracial couples. In G. A. Yancey & S. W. Yancey (Eds.), *Just don't marry one: Interracial dating, marriage, and parenting* (pp. 39–53). Valley Forge, PA: Judson Press.

Yancey, G. A., & Yancey, S. W. (Eds.). (2002). *Just don't marry one: Interracial dating, marriage, and parenting.* Valley Forge, PA: Judson Press.

Chapter 15

Social Justice Counseling Practices: Affirming Queer Pluralism With LGBQ Clients

Julian Rafferty McCullough and Alexander C. Winninghoff

Lesbian, gay, bisexual, and Queer (LGBQ) individuals represent diverse communities within the shared boundaries of sexual and gender minority statuses. However, within these margins, there are vast differences that constitute intersections and interplays of identity, contributing to the complexity of individuals who classify themselves as members of an LGBQ group. It is important that professional counselors working with members of LGBQ groups understand the complexities of the communities instead of considering people who identify as lesbian, gay, bisexual, or Queer to be homogenous.

This chapter provides an overview of historical references and contemporary issues that impact the experiences of individuals within LGBQ communities. Key concepts and characteristics of LGBQ populations are discussed to help illuminate systemic barriers interfering with the well-being of members of these groups. Additionally, we suggest microlevel and macrolevel counseling interventions that may help to increase positive outcomes for LGBQ individuals in counseling.

An Overview of LGBQ Communities

There are a number of common threads that create unity among LGBQ individuals, but these threads are woven into a much larger tapestry that reflects a uniquely diverse population. The term *Queer* is capitalized here and throughout this chapter to describe a broader cultural concept. Reducing LGBQ "community" or "culture" to singular terms has become inadequate when engaging in meaningful understandings of LGBQ populations. Throughout history, LGBQ people have been underrepresented and inaccurately depicted. As a result, same-sex-oriented individuals lack a diverse range of models that they themselves can draw from as they formulate and construct their own identities. Contemporary sociocultural shifts have allowed for more diverse, multidimensional, and expansive expressions of LGBQ identities, and as a result, there is no single LGBQ culture or community; there are LGBQ cultures and communities.

LGBQ identities intersect with all aspects of identity, including socioeconomic, racial, ethnic, generational, religious, spiritual, citizenship status, and ability. Beyond these intersectionalities, each signifying letter—L, G, B, and Q—holds a unique historical and cultural distinction. The term *Queer* is used to encompass the many identities and cultures of

LGBQ individuals. In this chapter we use both *LGBQ* and *Queer* interchangeably to offer broad definitions for individuals, communities, and cultures. Although *Queer* is often still regarded as a derogatory term, it has been adopted by many LGB communities and further legitimized by academics in Queer theory studies (D'Emilio, 2004). These many factors contribute to an ever-evolving social understanding of LGBQ individuals, communities, and cultures. To explain this evolution, it is valuable to reflect on the historical and contemporary contexts that have shaped Queer identities in the United States.

Queer History

Popular Perceptions

Throughout history LGBQ individuals have forged their identities from their positions as outsiders from the dominant culture. Though same-sex orientations have always existed, they are disproportionately underrepresented in historical accounts—often to the point of nonexistence (Turner, 2004). Two likely factors contribute to this invisibility: the active suppressions or passive exclusions of recorded Queer histories and sociocultural factors that have sent sexual minorities out of apparent view and into hiding. A lack of substantial proof of rich, expansive Queer cultures is the direct result of oppressive societal frameworks. The lack of a visible history also perpetuates oppression by denying LGBQ individuals the validation of fully illuminated connections to their pasts.

Popular historic portrayals of homosexuality within the United States have run the gamut of unfavorable and biased perspectives. From "sinner" (Sue, 2010) to "outlaw" (Mogul, Ritchie, & Whitlock, 2011), religious-based conceptions and criminalization of Queerness have affected culturewide perceptions and even the ways in which sexual minorities defined themselves (Bronski, 2012). Terms such as *deviant*, *sexual predator* (Mogul et al., 2011) and *insane* (Haldeman, 2012) are a few frequently applied terms that echo in the Queer psyche (Cowan, Heiple, Marquez, Khatchadourian, & McNevin, 2005).

A Brief LGBQ History: Mid-20th Century to the New Millennia

Leading up to the late 1940s, a number of political and sociocultural influences allowed for the systemic oppression of Queer identities. Puritanical values had long influenced the American social consciousness, and McCarthyism created an oppressive climate for LGBQ individuals. From the highest levels of the federal government down to local, urban police departments, Queer individuals and communities have been persecuted, threatened, and harassed (Carlin & DiGrazia, 2004). Police raids of gay establishments occurred with regularity throughout the 1950s and into the late 1960s (Mogul et al., 2011). Criminalization of Queer behavior posed a threat to individuals. Sodomy laws allowed for the legal persecutions of LGBQ individuals. (Many of these laws remained in effect until the 2003 *Lawrence v. Texas* Supreme Court case, which recognized such laws as unconstitutional; Fugelsang, 2010.)

These broad culturewide events affected the counseling profession. Even though Alfred Kinsey's research challenged negative perceptions of homosexuality, in the late 1940s and early 1950s the fields of counseling and psychology operated with extreme and oppressive biases against LGBQ communities. Kinsey's research on sexual orientation culminated in the landmark publication of *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953). His publications offered an analysis of bisexuality and homosexuality as normal variations and further posited that human sexuality exists on a fluid and often wide-ranging

spectrum. Kinsey's theories created tension within the counseling profession. According to Chiang (2008), "psychiatrists and psychoanalysts dismissed Kinsey's attempt to normalize homosexuality by arguing that statistical findings of the prevalence of a specific sexual behavior could not constitute sufficient grounds for establishing its normality" (p. 302). The year before Kinsey's second report was released, the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952) was published, listing "Homosexuality" as a "sexual deviation" (p. 39) under the category "sociopathic personality disturbance" (p. 38). This classification of homosexuality as a mental illness damaged and stigmatized Queer communities even after it was declassified in 1973 (Rubinstein, 1995).

Psychotherapeutic attempts to sexually "reorient" lesbian women and gay men to heterosexuality were based in beliefs that homosexuality was a pathological condition for which "treatment" was necessary. Such "treatments" included social shaming and aversive therapies by way of electric shock and chemical aversion, including the use of nausea-inducing drugs and repulsive-smelling substances (Haldeman, 1994; Murphy, 1992). Recorded tapes of aversion therapy cases highlight biased overtones of therapists who describe clients' sexuality as "disgusting" and "unpleasant" (Feldman, 1966). Other methods include orgasmic reconditioning, encouragement to visit prostitutes, heterosexual marriage, bicycle riding, sustenance deprivation, hormone therapy, and even surgeries such as castration or removal of the clitoris (Murphy, 1992).

Interference with the most intimate aspects of Queer lives continued to carry over into more public arenas. In the 1960s, police raids were met with increasing empowered resistance. As a result, by the late 1960s Queer communities fought back in many instances, particularly in urban centers with large LGBQ populations (Griffin, D'Errico, Harro, & Schiff, 2007). Most notably, a 1968 raid of the Stonewall Inn resulted in a multiday standoff between police and members of Queer communities (Griffin et al., 2007). This riot symbolized the beginning of the LGBQ movement in the United States. The histories of impoverished LGBQ people and Queer people of color are often erased or not acknowledged in the retelling of the Stonewall Rebellion, but it was mostly a working-class community of LGB individuals, and specifically transgender women of color, who broke down the proverbial closet door and catalyzed the gay liberation movement (Grevatt, 2001).

The 1970s became a "coming-out" era for Queer communities. Increased numbers of Queer individuals were able to live openly. This openness allowed for community cohesion and community differentiation. For instance, the gay community gained a cohesive culture and common norms and goals, which at the same time were often different from (or even in direct opposition to) the cultures, norms, and goals of lesbian communities. Lesbian involvement in the women's movement helped cultivate intentional "women-only" spaces, which developed as a response to what were viewed as patriarchal and oppressive forces—forces that were often exemplified by the real or perceived misogyny of gay male cultures (Carlin & DiGrazi, 2004). These divisions began to give way in the 1980s as the acquired immune deficiency syndrome (AIDS) epidemic permeated gay male communities and demanded a new solidarity among lesbian, gay, and bisexual individuals (Herek & Greene, 1995). The emergence of AIDS also came with the rise of a new homophobia, one that equated gayness with disease (Clarke, 2006). An early lack of medical research and adequate health care severely disenfranchised gay men, and communitywide outrage led to a resurgence of LGBQ political engagement (Goodwin, Jasper, & Polletta, 2009). Organizations such as ACT UP and Citizens for Medical Justice engaged in multipronged direct actions to advocate for AIDS research (Goodwin et al., 2009).

Throughout the 1990s and into the 2000s, LGBQ activism continued to progress. Social attention to issues such as military service and marriage equality became central political and media focuses. As public discourse increased, responses to systemic inequalities were demanded at the federal level (Bailey, 2013). One such response occurred in 1993 when the federal military policy underwent a significant shift. LGBQ individuals had long been barred from military service until the adoption of the policy commonly known as "Don't Ask, Don't Tell" (*Holmes v. California National Guard,* 1997). Although this shift opened previously closed doors for Queer communities, it also confirmed pervasive expectations that LGBQ communities were to live abbreviated, closeted lives. These systemic oppressions and examples of heterosexism were again exemplified at the federal level with the 1996 passage of the Defense of Marriage Act (DOMA; *Massachusetts v. United States Department of Health & Human Services*, 2012). DOMA, which defines marriage as "a legal union between one man and one woman" (p. 611), prevented federal recognition of same-sex marriages granted in states that recognize these marriages. Additionally, DOMA codified inaccessibility to more than 1,100 federal protections and responsibilities such as parenting rights, health care benefits, social security, veterans and survivor benefits, and immigration rights (Freedom to Marry, Inc., 2013). DOMA has had a catastrophic impact on the personal lives of same-sex couples, who are frequently denied a range of social and logistical privileges that are granted to heterosexual couples.

Current Issues for Queer Communities

It is nearly impossible to offer a truly current snapshot of LGBQ communities and cultures because of the deluge of political and social movements. Queer lives and issues are at the center of many social and political debates; therefore, contemporary issues shift on a daily basis. What is current one day is history the next. Among the many issues that concern LGBQ communities, perhaps the most pressing is the present encouragement of several groups, including House Democrats, the Obama administration, and health care stakeholders, to urge the Supreme Court to overturn DOMA (Freedom to Marry, Inc., 2013).

In recent years, LGBQ communities and supporters have experienced many victories in their efforts to achieve social and legal equality. Perhaps the most noteworthy has been the June 26, 2013, Supreme Court ruling which found Section 3 of DOMA unconstitutional (Freedom to Marry, Inc., 2013). The overturn of Section 3 is tremendously significant; it allows legally married same-sex couples access to over 1,100 protections and responsibilities that were previously denied. It also represents positive shifts in the socio-cultural climate for LGBQ acceptance in the United States.

As of February 2014, 18 states, plus Washington, D.C., allow same-sex couples to marry, and three states allow similar protections of marriage, such as domestic partnership or civil unions (Freedom to Marry, Inc., 2013). Nonprofit organizations, community members, and allies continue to mobilize in an effort to achieve the full repeal of DOMA, which would legally end federal marriage discrimination (Freedom to Marry, Inc., 2013). This progress is exciting for LGBQ communities, but many injustices that infringe on basic liberties remain.

According to the Federal Bureau of Investigation's (2011) most recent report, approximately 20.8% of all hate crimes reported in the United States have resulted from sexual-orientation bias. At present, 15 states with hate crime laws (Alabama, Alaska, Idaho, Indiana, Mississippi, Montana, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Virginia, and West Virginia) do not include crimes based on sexual orientation or gender identity. Five states with hate crime laws (Arkansas, Georgia, Michigan,

South Carolina, and Wyoming) do not protect vulnerable populations of any kind (National Gay and Lesbian Task Force, 2012). Given that 20 states do not currently report meaningful data to the federal government regarding instances of hate crimes against LGBQ individuals, the reported 20.8% is likely a gross underestimation of hate crimes related to sexual orientation bias.

Mainstream attention to LGBQ issues has grown through wider access to information and popular culture attention. Increasing support for LGBQ individuals has emerged in public sectors, which has mobilized not only insiders of LGBQ communities but allies at all levels, including churches and politicians (Valelly, 2012). Large companies, which are becoming increasingly aware of the buying power and shifting social acceptance of Queer communities, are strategically aligning with and publically voicing support for LGBQ rights (Oakenfull, 2013). When the Boy Scouts of America reaffirmed its longtime policy of banning boys who are gay identified from becoming members, and adults who are gay or lesbian identified from serving as leaders, a number of companies, such as UPS, INTEL, and AT&T, withdrew funding (Liebelson, 2013).

In recent years, there has been an increase of media attention on gay youth suicides and bullying and harassment of LGBQ and transgender (LGBTQ) youth in schools. Reported statistics suggest LGB youth are between 1.5 to 3 times more likely to report suicidal ideation. Some sources suggest that LGB youth are closer to 7 times more likely to attempt suicide than their non-LGB peers (Haas et al., 2010). Other reports assessed the correlation between suicide attempts and sexual orientation. In one study, 50% of youth reported that sexual orientation was related to their own suicide attempt (D'Augelli, Hershberger, & Pilkington, 2001). In an effort to reach out to LGBTQ youth facing harassment and to address LGB youth suicides and bullying in schools, syndicated columnist and author Dan Savage and his partner Terry Miller started a video project in September 2010 called It Gets Better Project. The project has received submissions from famous personalities such as President Barack Obama; former Secretary of State Hillary Clinton; Representative Nancy Pelosi; actors Anne Hathaway, Colin Farrell, Matthew Morrison; musicians Joe Jonas and Ke$ha; comedian Ellen DeGeneres; and many large companies (It Gets Better Project, 2013).

Many LGBTQ youth are homeless and are victims of violence and harassment. According to a collaborative report created by the National Gay and Lesbian Task Force and the National Coalition for the Homeless, an estimated 20–40% of all homeless youth identify as LGBT (Ray, 2006). As many as 354 agencies that provide services to homeless youth reported that LGBT youth accounted for 40% of the total youth population they served (Durso & Gates, 2012). Contributing factors to the LGBT youth homelessness epidemic were family rejection (46%); withdrawal of parents or caregiver housing and financial support (43%); or domestic victimization through physical, emotional, or sexual abuse (32%).

Key Concepts

Heterosexism

Heterosexism is the assumption that all people are heterosexual or that heterosexuality is somehow more favorable, desirable, or more "normal" than being lesbian, gay, bisexual, or Queer. Because of this omnipresent belief, same-sex relationships are seen as abnormal or deviant (Griffin et al., 2007). In a heterosexist system, heterosexual people are given certain privileges or advantages, whereas people who identify as LGBQ are oppressed (McGeorge & Carlson, 2011). This flawed system affects LGBQ individuals in the following ways: (a) they generally are not represented positively or at all in historic accounts or

school curricula; (b) in work environments, life events that are more commonly associated with heterosexuality are the primary ones that are recognized or celebrated (i.e., weddings or baby showers); and (c) LGBQ individuals are not seen as whole, complex people with various talents and interests but instead are oversexualized.

Heterosexism is pervasive in our culture and even infiltrates our legal, medical, educational, professional, and housing systems (Jung & Smith, 1993). LGBQ individuals face *institutionalized heterosexism* when they are deprived of certain rights because of their LGBQ identity. Examples include the current federal definition of marriage (a union of one man and one woman), the absence of federal laws that prohibit workplace discrimination on the basis of sexual orientation, and the absence of references to sexual orientation in hate crime laws across all states (Griffin et al., 2007).

Minority Stress

Minority stress is experienced by members of stigmatized social communities relative to dominant cultural oppression. The concept of minority stress is based on the assumption that Queer individuals, like other minorities, experience distress, sometimes leading to unfavorable mental health outcomes (Meyer, 1995). Minority stress occurs as a result of having cultural frameworks, desires, and needs that consistently conflict with prevailing societal norms. Meyer (1995, 2003) asserted that minority stress is unique in that it is chronic and occurs in addition to usual life stressors. A unique aspect of minority stress is that it originates from the dominant society and not from the LGBQ person. Therefore, an LGBQ individual's experience of minority stress is not a deficiency, a social maladjustment, or disorder, but rather a response to oppressive structures in which he or she functions.

Internalized Heterosexism

In LGBQ communities, minority stress often results in a more insidious form of heterosexism, called *internalized heterosexism*, where negative messages about LGBQ individuals are accepted and repressed by LGBQ individuals themselves. Herek, Gillis, and Cogan (2009) proposed a conceptual framework that illustrates internalized heterosexism as a multilayered self-stigma. The first self-stigma, referred to as *enacted stigma,* may be expressed through anti-LGBQ insults, hate crimes, and general exclusion. LGBQ individuals might respond to such actions by keeping their true identities a secret, pretending to be heterosexual, or working diligently to conform to specified heteronormative gender roles—ones in which men are expected to be masculine, women are feminine, and heterosexuality is the norm. Herek et al. (2009) referred to this as a *felt stigma*. The third manifestation of self-stigma is called *internalized stigma*, meaning that LGBQ individuals begin to accept the stigma as part of who they are or adapt "one's self-concept to be congruent with the stigmatizing responses of society" (p. 33). The LGBQ individual's acceptance of society's prejudices and negative messages about same-sex attractions and relationships is an example of both internalized heterosexism and internalized stigma.

Key Characteristics

LGBQ Gender and Orientation Pluralism

In LGBQ communities, as in many diverse communities, there exists controversy over terminologies adopted to define selves and communities. No consensus has been reached in relation to terms such as *Queer*, and connotative responses vary given individual cultural,

generational, and regional experiences. As is true across all cultures, it is valuable to understand each person's self-definition practices and right to self-identify using his or her preferred language (Brontsema, 2004).

From the six-point Kinsey Scale (Kinsey et al., 1948) to the seven variables of the Klein Sexual Orientation Grid (Weinrich, 2011), researchers of human sexuality have demonstrated that lesbian, gay, or bisexual identities are not the only alternatives to heterosexuality. *Queer* is not only used as an umbrella term that includes lesbians, gays, and bisexuals, but it also transcends their oft-perceived strict boundaries. The following factors may contribute to the definition of the term *Queer*: (a) the interplay of gender nonconformity and sexual orientation, (b) the potential fluidity of sexuality, (c) broad self-definition practices, and (d) the desire for community reclamation of derogatory language for empowerment and/or political subversion (Brontsema, 2004).

Gender and orientation exist as two distinctly different but often interacting aspects of identity. Orientation is clearly complex. Although gender is often conceptualized by discrete contrasts of masculinity and femininity, it is often expressed by transgender and gender nonconformists in wide-ranging expansions beyond binary terms (Monro, 2005). Binary terms such as *lesbian* (defined as a woman who is attracted to women) and *gay* (defined as a man attracted to men) rely on finite male and female genders. Many believe that *bisexuality* captures the sum of sexual orientations that are not straight or gay. However, this perspective is problematic because bisexuality is confined by binary conceptions of gender. Given the gender pluralism within LGBQ communities, the expansive nature of orientation, and the interplay between these aspects of identity, transcendent identities are often simply defined by the term *Queer* (Griffin et al., 2007).

Intersectionalities

LGBQ statuses alone cannot be examined in isolation from one's whole, complex identity. The development and understanding of LGBQ statuses occur in relation to a vast many layers of social, emotional, spiritual, and cultural contexts. Intersections of one's racial, ethnic, sex, ability status, age, religious beliefs and affiliation, citizen status, level of education, and socioeconomic class are among the identity factors that interact with, and inform, one's experience of Queerness. For example, a middle-aged, gay, African American male who lives in an urban setting may have a significantly different relationship to his Queerness than a White, suburban, 23-year-old bisexual woman has with hers.

LGBQ status alone marginalizes Queer individuals from the dominant culture. The oppression experienced by LGBQ individuals who possess multiple nondominant identities (e.g., persons of color, persons with disabilities, poor people, or noncitizens) may feel that their oppression is further compounded by these intersectionalities (Alimahomed, 2010). Moreover, individuals with multiple oppressed identities may feel isolated within Queer spaces that may not affirm or reflect all of their identities or the wholeness of their experiences (Alimahomed, 2010). If, for example, an LGBQ-friendly space or community generally reflects cultural norms consistent with Whiteness, able-bodied status, or socioeconomic stability, individuals may feel disenfranchised within the space that affirms their Queerness but that does not acknowledge their other identities that are inconsistent with the cultural norms.

Coming Out in Heteronormative Families

As a result of living in a society that favors and assumes heterosexuality, LGBQ individuals often exist as "invisible minorities" unless they explicitly "come out" (McGeorge &

Carlson, 2011). Coming out is a process that may begin at any age. It does not happen as a singular event but happens regularly throughout the course of a person's life. In each new social or professional context, LGBQ individuals must consider the possible ramifications of coming out (Heatherington & Lavner, 2008). As a result of heterosexism and LGBQ people's experiences of oppression, coming out is often a stressful experience. For these reasons, Queer individuals may choose to be out completely, to be out only in certain environments or with certain people, or to remain closeted. The terms *closeted* and *in the closet* are often used to describe persons who are not public about their sexual identity. Counselors working with LGBQ individuals should bear in mind the complexities of coming out and operate with respect for the clients' choice to disclose or not disclose their orientation.

When individuals have an awareness of their own Queerness, their coming out process may begin with their family. Rather than having an experience of home and family as a "safe haven" for identity expression, families of origin often represent the primary tension during the development and coming out process for LGBQ individuals (Twenge & Crocker, 2002). LGBQ individuals grow up in households that generally do not reflect or validate their Queer identities. This makes LGBQ communities unique when contrasted with many other marginalized communities, which often develop in contexts where values, norms, affirmation, resiliency, and self-definitions are reflected by their families of origin (Warner, 1991). By stark opposition, LGBQ individuals often feel that they must abide by familial and broad cultural heterosexist assumptions of their straightness.

Systemic Barriers

Educational

Just as systemic barriers interfere with learning and opportunities for other marginalized communities, LGBQ students also face similar oppressions, which create opportunity gaps. Hostile climates and unsafe conditions contribute to opportunity gaps that have potentially lasting impacts that extend into adult lives and affect postsecondary success. Young people who identify as (or who are perceived to be) LGBT or Queer report regular instances of assault, verbal and physical harassment, heterosexist language, and homophobic remarks (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). Recent national data are sobering:

- 81.9% of LGBT students report verbal harassment.
- 38.3% report physical harassment.
- 18.3% report physical assault in their school.
- 63.5% of LGBT students feel unsafe at school because of their sexual orientation.
- 43.9% feel unsafe because of harassment related to their gender expression (Kosciw et al., 2012).

Individual experiences of bullying and harassment vary given factors such as regional politics and individual school policies and climate. According to Poteat, Mereish, DiGiovanni, and Koenig (2011), intersections of racial identity and Queerness may result in greater resiliency or may further compound students' experience of oppression.

Employment

The real threat of unjust hiring and firing practices, and the current social climate in many work settings, are significant systemic barriers for LGBQ individuals and communities.

LGBQ communities and individuals face threats of underemployment or lack of employment as a result of discriminatory hiring practices and the right of employers to fire individuals because of their sexual orientation. Currently, there is no federal statute that protects LGBQ individuals from employment-based discrimination (Human Rights Campaign, 2013). At the state level, only 16 states and the District of Columbia have nondiscrimination laws that protect the employment of both sexual and gender minorities (Pizer, Sears, Mallory, & Hunter, 2012). The often heterosexist climate of many professional environments may decrease LGBQ individuals' senses of professional security, professional camaraderie, and ability to live authentic, whole lives. According to findings from the recent General Social Survey, nearly half of LGBT employees are not openly out to coworkers (Pizer et al., 2012).

Health Care

Because of systemic inequalities related to the collection and reporting of LGBQ-specific data, it is difficult to meaningfully examine gaps and health disparities that affect Queer communities (Mollon, 2012). A lack of clear data restricts efforts to effectively research LGBQ-specific health issues. Without accurate data, it is difficult to implement necessary interventions that would address current disparities (Adler & Rehkopf, 2008). Furthermore, the health care field has historically been a source of both overt and covert heterosexism and bias (Conron, Mimiaga, & Landers, 2010). There remain inequities in the treatment of patients who identify as LGBQ. Oversexualization or a medical emphasis on sexually transmitted infections may become a practitioner's focus with gay male patients, even when they seek medical care for reasons unrelated to sexual behavior. A lesbian woman may feel invalidated by a gynecologist who assumes that she is sexually active with men. Heterosexist language on medical forms may also invalidate Queer individuals and implicitly convey that the environment is not accepting of LGBQ communities. These inequities may prevent LGBQ individuals from fully accessing services or disclosing aspects of their lives that may pertain to their health care (Adler & Rehkopf, 2008).

Inaccessibility to adequate medical services also remains a systemic barrier given gaps in state and federal protections and lack of equal access to spousal and family health care benefits for LGBQ families (Adler & Rehkopf, 2008). LGBQ individuals may experience a lack of safety and advocacy, especially in environments that place restrictions on LGBQ family involvement (e.g., not allowing family visitation and decision-making privileges to those who do not have legal recognition as family members). Additionally, parents may face restrictions from full involvement in their child's medical care.

Family

In addition to marriage inequalities, LGBQ families experience further legal injustices in relation to parenting. Legal instabilities that threaten the most intimate relationship of LGBQ lives compromise the emotional and psychological well-being of families and children.

Information compiled by the American Civil Liberties Union (n.d.), Gay and Lesbian Advocates and Defenders, Lambda Legal, and the National Center for Lesbian Rights indicated that (a) 58% of LGBT communities live in states that have not clearly legislated or defined second-parent adoption laws, (b) 68% of LGBT populations live in states where LGBT parents cannot petition for second-parent adoption, and (c) 10% of LGBT populations live in states where they may face restrictions if they petition for second-parent rights (Family Equity Council, 2013).

According to the American Academy of Pediatrics' Committee on Psychosocial Aspects of Child and Family Health (2002), addressing existing laws and lack of legal protections is recommended for the security of children:

> Children who are born to or adopted by 1 member of a same-sex couple deserve the security of 2 legally recognized parents. Therefore, the American Academy of Pediatrics supports legislative and legal efforts to provide the possibility of adoption of the child by the second parent or coparent in these families. (p. 339)

Dana is a partnered, White, 41-year-old self-identified lesbian woman. Her partner of 5 years, Rafael, is a 27-year-old Latino male. He is also transgender and began to transition from female to male 3 years ago. They have been living together for 5 years and plan to marry as soon as they are legally able. So far, this has not been possible because they have not been able to afford the surgeries that are legally required in their state in order to change his legal gender designation to male on identification documents. Dana describes her relationship as loving and close, but sometimes she feels isolated and lonely. Whereas Rafael has been able to connect to some extent with a community of other transmen, Dana is having a difficult time remaining connected to old friends who were involved in the lesbian community whom she feels do not always validate her relationship. It has also been difficult making new friendships with people who may not see her clearly or validate her identity.

Dana has worked as a medical records coordinator at a local hospital for 12 years. She reports that she makes a good living but finds her work unfulfilling. Recently, she expressed feeling stagnant and having a long-held wish to return to school to become an elementary school teacher. Rafael previously worked as a women's advocate at a shelter for women and children. He was let go a little more than a year ago when supervisors suggested that he was making clients feel uncomfortable. Rafael continues with his weekly job search, but because his employment history reflects his previous name and designated gender, it is difficult to secure a position. His financial instability has caused stress on their relationship. Dana became the primary income earner, and she resented that she could not return to school due to their current financial and logistical constraints.

When Dana first came out to her parents at the age of 23, they were shocked and suggested that she was going through a phase. When she had her first serious relationship with a girlfriend, her parents told her that they did not approve of her "gay lifestyle" and would not condone her "behavior." Dana explained that her parents' involvement with the church caused her to feel further removed from them as they began to discuss her lesbianism as a "sin." Though Dana made attempts over the years to have a relationship with her parents, they had become even more distant; she had only occasional contact with her mother.

Recently, her mother reached out to her and they had coffee. When Dana spoke of her partner, Rafael, her mother was immediately pleased to hear that Dana was finally with a man and asked to meet him. Out of respect for Rafael, Dana never disclosed his transgender identity. The male hormones have made it possible for him to be viewed, physically, as male. When Dana's mom met Rafael, she was kind, but in private conversations later, expressed concern about Dana dating a person of color. She specifically asked if they were planning on having kids, and if so, was Dana worried about the kids feeling "accepted." Despite Dana's discomfort with these racist undertones, she desperately wanted to main-

tain her connection with her mother, now that she finally felt validated by her for the first time since coming out.

Dana and Rafael started to argue more often. He started to spend more time with his friends and Dana felt that she had no energy to deal with much more than going to work and coming home. She began sleeping about 12 or more hours per night yet still felt tired all the time and had trouble waking up in the morning. This has resulted in Dana being late for work four times in 3 weeks. Dana described herself as always having been professional and punctual in the past, and this new pattern worried her.

She began to spend more time alone, except for the occasional visit with her mom. The few friends that Dana had stayed in contact with complained for a while that she did not answer her phone or return calls, e-mails, or text messages; they have since stopped contacting her. Rafael recently expressed his concerns for her well-being. She confessed to him that she cried all the time and did not understand why; she thought that her coworkers were starting to notice that she frequently cried in the bathroom at work.

Dana said that Rafael thought she might be depressed and should try to talk to someone. She found out that her insurance plan included some coverage for mental health services, but she struggled to cover her copay of $30 per visit. Ultimately she decided to ask her mom for some money to help cover the costs. She felt conflicted accepting the money because she knew that if her mom found out that Rafael was transgender, she would withdraw both financial and emotional support. Dana also worried that her mom would accuse her of deceiving her. All of these factors would mean that she could lose this relationship again, and that would devastate her.

Individual Counseling: Applications at the Microlevel

When working with LGBQ clients, as well as with any client population, it is important to use language that communicates respect. When determining the type of language to use with clients, counselors should consider both the appropriateness of the terminology as well as the client's preferences. Terms such as *sexual preference* to describe a client's sexual identity, or *lifestyle* to describe a client's sexual orientation, conveys a lack of understanding and disrespect toward LGBQ clients. Instead, counselors should use the term *sexual orientation* because it is considered more respectful in LGBQ communities. The importance of using inclusive and respectful language cannot be overstated.

Because Dana is lesbian identified, her counselor should have thorough knowledge of the specific ways she has been stigmatized by institutions (family and society). Counselors assisting Dana should work to understand that systemic oppression might compound her difficulties and contributes to her experience of minority stress, discrimination, and stigma. These factors threaten not only Dana's visibility and sense of identity but also her social and emotional safety.

It is important to normalize and allow Dana the freedom to explore her identity in a safe place, realizing that sexual orientation can be a fluid reality. Dana may be having a difficult time not only with her family's rejection of her lesbian identity but also with her mother's new validation of her relationship with a man. A counselor may facilitate Dana's exploration of her feelings of not being seen clearly, help her navigate her identity in relation to her community, and normalize the all-encompassing nature of identity. Many assume that because she is with a man that she is not a lesbian. This may cause her to feel invisible and invalidated. An important part of being Queer identified is the feeling of validation that comes with shared Queer experiences, which are validated by other Queer-identified people.

Counseling approaches with individuals in Queer communities should allow clients to self-determine and make meaning out of their own experiences and self-defined identities. This should be facilitated without definitions being imposed upon them. Queer clients have the right to self-definition without being required to claim a position or identity and without being asked to reconcile previous statements, shifts, or evolutions in their identities. Dana has stated that her self-identity is that of a lesbian woman, but it would be important to discuss the dynamic and sometimes shifting nature of identity. Dana should feel comfortable examining her identity as one that is not static or defined by anyone other than herself.

Because Dana is a member of a stigmatized social group, she is likely experiencing minority stress from her family and the dominant culture. Some of her symptoms like depression, frequent bouts of crying, or chronic tiredness may be a result of this stress. It will be important for Dana's counselor to acknowledge this and help her understand that her symptoms of stress are not a disorder or maladjustment but a response to prevailing, oppressive heterosexist structures that affect her. These stresses occur in addition to the financial, relationship, family, and work stress that she is already experiencing.

Dana may already be internalizing the heterosexism that is currently affecting her life. Indeed, she is receiving messages from her mother that she is only lovable if she is heterosexual. It will be helpful to Dana if her counselor explores the impact of her family's conditional love for her and the effect of heterosexist norms on her. Although it is a valid choice not to disclose her partner's transgender identity to her mother, Dana is experiencing the founded fear that her mother will once again reject her. The energy Dana expends keeping up appearances likely affects her overall sense of well-being. Moreover, the internalized heterosexism and homophobia that Dana is experiencing, and the internalized transphobia and racism that her partner may be experiencing may contribute to their diminished relationship quality. Researchers (Frost & Meyer, 2009; Meyer, 1995) have suggested a negative relationship between internalized homophobia and overall relationship satisfaction. The counselor should be aware of this possibility and explore this experience with Dana.

As is true with Dana and other individuals who experience marginalization and institutionalized oppression, it is important for counselors to explore their own biases or attitudes about specific issues affecting targeted communities they are working with. To increase knowledge and develop LGBQ competencies, counselors should continue to develop their knowledge base through current trainings and scholarly literature, especially sponsored or written by LGBQ individuals themselves. Counselors should also consult with those who have specific experience providing best approaches in their work with LGBQ individuals. Above all, counselors working with LGBQ populations should be acutely aware of the incredibly diversity these communities contain. Furthermore, they should understand how the various intersectionalities of individuals' identities may affect their experiences of oppression.

Advocacy Counseling: Applications at the Macrolevel

In addition to developing strategies that may be advantageous in working directly with Dana, engaging in macrolevel advocacy counseling is also critical. Macrolevel advocacy on behalf of Dana and other marginalized individuals who identify as LGBQ may positively affect and optimize the psychological well-being of individuals and LGBQ communities at large.

LGBQ and heterosexual counselors can become steadfast advocates and allies for LGBQ communities. Allies can educate themselves about LGBQ histories, intersectionalities, and

cultures and work to stay current on the contemporary issues that affect Queer communities. Allyship is a status that is granted, not assumed. Positive intentions and even well-researched culturally competent practices alone do not make someone an ally. Allyship comes from the target groups' experience of an individual's support and consistently affirming behaviors. The contributions of allies are fundamentally invaluable, and meaningful progress toward change rarely occurs without partnership between target groups and their allies.

One of the primary steps counselor advocates can take is to interrupt anti-LGBQ or heterosexist language, particularly where LGBQ communities are being served, such as mental health agencies, health care settings, and schools. LGBQ clients benefit when mental health and school counselors build relationships within their schools and organizations. When counselors partner together within a school or organization, they may serve as a united force for challenging heterosexist language and practices. Counselors can identify policies, procedures, forms, records, and documents that contain overtly or covertly heterosexist language. They may advocate for more inclusive language that communicates supportive climates to LGBQ individuals and families. Inclusive language on forms (such as *parent* in place of *mother* and *father*, or diverse options for orientation and gender identification) communicates that the environment is an LGBTQ positive space. By modeling awareness of orientation and gender pluralism, counselors invite conversations with nonallies, thereby opening conversations that can lead to further discourse and positive change.

There are numerous avenues beyond counseling settings to engage in advocacy on behalf of LGBQ clients. Dana represents all those who struggle with multiple systems-level oppressions. She faces continuous circumstances that will, without fundamental systemwide changes, continue to negatively affect her life and the lives of those she loves. By connecting with organizations, community advocates, and social support services that work against oppressive systems, there is potential to create multifaceted support networks that serve clients more holistically. Some examples of organizations that advocate for LGBQ individuals are Safe Schools Coalition, the Gay & Lesbian Alliance Against Defamation, the Trevor Project, and the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling. A more comprehensive list of these resources can be found at the end of this chapter.

Systemwide oppressions conspire to promote norms that allow for the passive acceptance of heterosexism—norms that inform the belief systems in which Dana's family operate. Dana and her partner face legal and financial inequities that are a result of systemic oppressions. Social change agents would engage in political action, such as advocating for rights of same-sex couples to marry or adopt children. Writing policymakers to encourage states to report hate crimes committed against LGBQ individuals and otherwise using one's status within the counseling field to leverage health care, medical, other legal, and political equity are actions to take to remove barriers and promote positive mental health outcomes for LGBQ clients.

Future Directions

Working from a social justice framework is essential when counseling and advocating for LGBQ communities. The historic oppression of Queer cultures in general, and by mental health care providers in particular, may create barriers between clients and counselors if such barriers are not meaningfully, intentionally, and consistently addressed. Recognizing the multidimensionality of orientation, gender pluralism, and intersectionalities of identities are key elements to effective counseling and advocacy for LGBQ communities. Be-

cause counselors bear witness to the realities of their LGBQ clients' lives, they are uniquely situated to leverage their professional roles and advocate for the specific needs of Queer communities.

Resources

American Civil Liberties Union (ACLU), LGBT Rights: Lesbian Gay Bisexual & Transgender Project
http://www.aclu.org/lgbt-rights
American Psychological Association (APA) Lesbian, Gay, Bisexual and Transgender Concerns Office
http://www.apa.org/pi/lgbt/
Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC)
http://www.algbtic.org/
Gay & Lesbian Alliance Against Defamation (GLAAD)
http://www.glaad.org/
Gay, Lesbian & Straight Education Network (GLSEN)
http://www.glsen.org/
International Gay & Lesbian Human Rights Commission (IGLHRC)
http://www.iglhrc.org/
Lambda Legal
http://www.lambdalegal.org/
National Gay and Lesbian Task Force (NGLTF)
http://www.ngltf.org/
Parents, Families, & Friends of Lesbians and Gays (PFLAG)
http://community.pflag.org/Page.aspx?pid=194&srcid=-2
Safe Schools Coalition
http://www.safeschoolscoalition.org/index.html
The Trevor Project
http://www.thetrevorproject.org/

References

Adler, N. E., & Rehkopf, D. H. (2008). U.S. disparities in health: Descriptions, causes, and mechanisms. *Annual Review of Public Health*, *29*, 235–252. doi: 10.1146/annurev.publhealth.29.020907.090852

Alimahomed, S. (2010). Thinking outside the rainbow: Women of color redefining queer politics and identity. *Social Identities*, *16*, 151–168. doi:10.1080/13504631003688849

American Civil Liberties Union. (n.d.). *LGBT rights: Lesbian gay bisexual & transgender project*. Retrieved from http://www.aclu.org/lgbt-rights

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

Bailey, B. (2013). The politics of dancing. *Journal of Policy History*, *25*, 89–113. doi:10.1017/S089803061200036X

Bronski, M. (2012). *A queer history of the United States: Revisioning American history*. Boston, MA: Beacon Press.

Brontsema, R. (2004). A queer revolution: Reconceptualizing the debate over linguistic reclamation. *Colorado Research in Linguistics, 17*(1).

Carlin, D., & DiGrazia, J. (2004).What is queer theory? In D. Carlin & J. DiGrazia (Eds.), *Queer cultures* (pp. 1–2). Upper Saddle River, NJ: Pearson Education.

Chiang, H. (2008). Effecting science, affecting medicine: Homosexuality, the Kinsey reports, and the contested boundaries of psychopathology in the United States, 1948–1965. *Journal of the History of the Behavioral Sciences*, *44*, 300–318. doi:10.1002/jhbs.20343

Clarke, J. N. (2006). Homophobia out of the closet in the media portrayal of HIV/AIDS 1991, 1996, and 2001: Celebrity, heterosexism and the silent victims. *Critical Public Health*, *16*, 317–330.

Committee on Psychosocial Aspects of Child and Family Health. (2002). Coparent or second-parent adoption by same-sex parents. *Pediatrics: The Official Journal of the Academy of Pediatrics*, *109*, 339–340. Retrieved from http://pediatrics.aappublications.org/content/109/2/339.full.pdf html

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*, *100*, 1953–1960. doi:10.2105/AJPH.2009.174169

Cowan, G., Heiple, B., Marquez, C., Khatchadourian, D., & McNevin, M. (2005). Heterosexuals' attitudes toward hate crimes and hate speech against gays and lesbians: Old-fashioned and modern heterosexism. *Journal of Homosexuality*, *49*, 67–82. doi:10.1300/J082v49n02_04

D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (2001). Suicidality patterns and sexual orientation-related factors among lesbian, gay, and bisexual youths. *Suicide and Life Threatening Behavior, 31*, 250–264.

D'Emilio, J. D. (2004). After Stonewall. In D. Carlin & J. DiGrazia (Eds.), *Queer cultures* (pp. 3–37). Upper Saddle River, NJ: Pearson Education.

Durso, L. E., & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.

Family Equity Council. (2013, March 17). *Second-parent adoption laws*. Retrieved from http://www.familyequality.org/get_informed/equality_maps/second-parent_adoption_laws/

Federal Bureau of Investigation. (2011). *Hate crimes statistics 2011: Incidents and offenses*. Retrieved from http://www.fbi.gov/about-us/cjis/ucr/hate-crime/2011/narratives/incidents-and-offenses

Feldman, M. P. (1966). Aversion therapy for sexual deviations: A critical review. *Psychological Bulletin*, *64*, 77. doi: 10.1037/a0027787

Freedom to Marry, Inc. (2013). *History and timeline of the freedom to marry in the United States*. Retrieved from http://www.freedomtomarry.org/pages/history-and-timeline-of-marriage

Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology*, *56*, 97–109. doi:10.1037/a0012844

Fugelsang, S. J. (2010). Reconciling *Lawrence v. Texas* with "Don't Ask, Don't Tell": The value of the *Cook v. Gates* intermediate-deferential approach. *George Mason University Civil Rights Law Journal*, *20*, 237–278.

Goodwin, J., Jasper, J. M., & Polletta, F. (2009). Rock the boat, don't rock the boat, baby: Ambivalence and the emergence of militant AIDS activism. In J. Goodwin, J. M. Jasper, & F. Polletta (Eds.), *Passionate politics: Emotions and social movements* (pp. 135–157). Chicago, IL: University of Chicago Press.

Grevatt, M. (2001). Lesbian/gay/bisexual/transgender liberation: What's labor got to do with it? *Social Policy*, *31*, 63–65.

Griffin, P., D'Errico, K. H., Harro, B., & Schiff, T. (2007). Heterosexism curriculum design. In M. Adams, L. Bell, & P. Griffin (Eds.), *Teaching for diversity and social justice* (2nd ed., pp. 185–218). New York, NY: Routledge.

Haas, A., Eliason, M., Mays, V., Mathy, R., Cochran, S., D'Augelli, A., . . . Fisher , P. (2010). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendation. *Journal of Homosexuality*, *58*, 10–51. doi: 10.1080/00918369.2011.534038

Haldeman, D. C. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology, 62*, 221–227.

Haldeman, D. C. (2012). Sexual orientation conversion therapy: Fact, fiction, and fraud. In S. H. Dworkin & M. Pope (Eds.), *Casebook for counseling lesbian, gay, bisexual, and transgendered persons and their families* (pp. 297–306). Alexandria, VA: American Counseling Association.

Heatherington, L., & Lavner, J. A. (2008). Coming to terms with coming out: Review and recommendations for family systems-focused research. *Journal of Family Psychology*, *22*, 329–343. doi:10.1037/0893-3200.22.3.329

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*, 32–43.

Herek, G. M., & Greene, B. (1995). *AIDS, identity, and community: The HIV epidemic and lesbians and gay men.* Newbury Park, CA: Sage.

Holmes v. California National Guard, 124 F.3d 1126 (9th cir. 1997). Constitutional law—First amendment and equal protection—Ninth circuit upholds `Don't Ask, Don't Tell: Policies for gays and lesbians in the military. *Harvard Law Review*, *111*, 1371

Human Rights Campaign. (2013, January 3). *Issues: Federal advocacy. Employment non-discrimination act*. Retrieved from http://www.hrc.org/laws-and-legislation/federal-legislation/employment-non-discrimination-act

It Gets Better Project. (2013). *What is the It Gets Better Project?* Retrieved from hhttp://www.itgetsbetter.org/

Jung, P. B., & Smith, R. F. (1993). *Heterosexism: An ethical challenge*. New York: State University of New York Press.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia, PA: Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. M. (1953). *Sexual behavior in the human female*. Philadelphia, PA: Saunders.

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). *The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools*. New York, NY: GLSEN.

Liebelson, D. (2013, February 6). Timeline: The Boy Scouts' long history of anti-gay discrimination. *Mother Jones*. Retrieved from http://www.motherjones.com/politics/2013/02/timeline-boy-scouts-gay-ban-policy-history

Massachusetts v. United States Department of Health & Human Services, 682 F.3d1 (1st Cir. 2012). Equal protection—Sexual orientation—First circuit invalidates statute that defines marriage as legal union between one man and one woman. *Harvard Law Review*, *126*, 611–618. Retrieved at http://harvardlawreview.org/2012/12/first-circuit-invalidates-statute-that-defines-marriage-as-legal-union-between-one-man-and-one-woman-ae-massachusetts-v-united-states-department-of-health-human-services-682-f-3d-1-1st/

McGeorge, C., & Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy*, *37*, 14–26. doi:10.1111/j.1752-0606.2009.00149.x

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health & Social Behavior, 36*, 38–56.
Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697. doi:10.1037/0033-2909.129.5.674
Miller, T. (2009, March 15). *Gay students risk truancy, dropping out: Bullying and intimidation from peers key factor in attendance and performance problems*. Retrieved from http://www.nea.org/home/34457.htm
Mogul, J. L., Ritchie, A. J., & Whitlock, K. (2011). *Queer (in)justice: The criminalization of LGBT people in the United States* (pp. 45–52). Boston, MA: Beacon Press.
Mollon, L. (2012). The forgotten minorities: Health disparities of the lesbian, gay, bisexual, and transgendered communities. *Journal of Health Care for the Poor and Underserved*, *2*, 1–6. doi: 10.1353/hpu.2012.0009
Monro, S. (2005). Beyond male and female: Poststructuralism and the spectrum of gender. *International Journal of Transgenderism*, *8*, 3–22.
Murphy, T. F. (1992). Redirecting sexual orientation: Techniques and justifications. *Journal of Sex Research, 29*, 501–523.
National Gay and Lesbian Task Force. (2012, March 12). *Hate crime laws in the U.S*. Retrieved from http://www.thetaskforce.org/downloads/reports/issue_maps/hate_crimes_06_13_color.pdf
Oakenfull, G. W. (2013). What matters: Factors influencing gay consumers' evaluations of "gay-friendly" corporate activities. *Journal of Public Policy & Marketing, 32*, 79–89.
Pizer, J. C., Sears, B., Mallory, C., & Hunter, N. D. (2012). Evidence of persistent and pervasive workplace discrimination against LGBT people: The need for federal legislation prohibiting discrimination and providing for equal employment benefits. *Loyola of Los Angeles Law Review*, *45*, 715–779.
Poteat, V., Mereish, E. H., DiGiovanni, C. D., & Koenig, B. W. (2011). The effects of general and homophobic victimization on adolescents' psychosocial and educational concerns: The importance of intersecting identities and parent support. *Journal of Counseling Psychology*, *58*, 597–609. doi:10.1037/a0025095
Ray, N. (2006). *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness*. New York, NY: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless.
Rubinstein, G. (1995). The decision to remove homosexuality from the *DSM*: Twenty years later. *American Journal of Psychotherapy*, *49*, 416–427.
Sue, D. W. (2010). *Microaggressions in everyday life, race, gender, and sexual orientation*. Hoboken, NJ: John Wiley & Sons.
Turner, W. (2004). History. In M. Stein (Ed.), *Encyclopedia of lesbian, gay, bisexual and transgendered history in America* (Vol. 2, pp. 38–43). Detroit, MI: Charles Scribner's Sons.
Twenge, J., & Crocker, J. (2002). Race and self-esteem: Meta-analyses comparing Whites, Blacks, Hispanics, Asians, and American Indians and comment on Gray-Little and Hafdahl (2000). *Psychological Bulletin, 128*, 371–408.
Valelly, R. M. (2012). LGBT politics and American political development. *Annual Review of Political Science*, *15*, 313–332. doi:10.1146/annurev-polisci-061709-104806
Warner, M. (1991). Fear of a queer planet. *Social Text*, *29*, 3–17.
Weinrich, J. (2011). Data analysis terminable and interminable: My collaboration with Fritz Klein. *Journal of Bisexuality, 11*, 448–452. doi:10.1080/15299716.2011.620481

Chapter 16

Counseling Transgender Clients

Varunee Faii Sangganjanavanich

The word *transgender* evokes ambiguity and uncertainty for many people. This reaction may come from various reasons, including people's preconceived notions or a lack of factual knowledge and information about the population. Many people respond to transgender individuals with anxiety and fear because they have negative perceptions of them as prostitutes, mentally ill, or victims of crime and abuse in television and movies. These images can lead to the belief that these stereotypes represent the transgender community and that all transgender people are the same. In fact, diversity within the community exists.

Transgender is an umbrella term used to describe people who do not adhere to a traditional view of gender. A traditional (binary) view of gender posits that only two genders, female and male, exist. Gender-nonconforming behaviors and expressions challenge the gender binary belief system that permeates society. This variation of gender makes transgender people vulnerable to discrimination and violence in many settings (e.g., the family, education, workplace, health care, and criminal justice).

Similar to other cultural groups, the transgender community has unique needs concerning mental health and counseling services. Therefore, it is essential that professional counselors are knowledgeable and understand those needs in order to better serve this population. In this chapter, I describe the historical development, current status, and cultural context (e.g., terms and definitions, community characteristics) of the transgender population, followed by an outline of key characteristics of transgender individuals that make them a target of oppression and discrimination. A case study is presented to illustrate some of the issues that might arise when counselors work with transgender populations in individual counseling and advocacy counseling; ways of advocating for the transgender population inside and outside of the counseling context are explored.

History of the Transgender Population in the United States

The transgender community has been a historically marginalized cultural group in the United States. Transgender individuals are those whose gender expression and gender identity are variations from traditional gender norms and cultural expectations. Many transgender individuals try to conform to societal expectations of their desired gender, but some prefer to live a gender-nonconforming life. Similar to other cultural groups, there is

rich diversity among the transgender population. This section provides a brief historical perspective and describes current experiences of the transgender client population.

Before the 1950s, the public knew transgender people as a group whose gender identity did not match their biological sex, which resulted in *gender discomfort* (Benjamin, 1966). The larger society recognized their existence; however, there was no formal terminology to describe transgender people and no understanding of their unique needs. Although early transgender activist groups began to call for anti-discrimination laws to protect transgender people, transgender-identified individuals continued to experience discrimination in many areas (e.g., employment, health care, and housing) and often remained underprotected in society. In 1952, Dr. Harry Benjamin identified the transgender state as a medical condition, which he referred to as *transsexualism*. Dr. Benjamin was the first physician to prescribe hormone therapy to help a transsexual patient, Christine Jorgensen, formally known as Gorge William Jorgensen, prepare for her sex reassignment surgery. (Sex reassignment surgery is a surgical procedure that some transgender individuals undergo to alter their bodies to the gender with which they identify.) Dr. Benjamin later credited Jorgensen as an inspiration to his work, *The Transsexual Phenomenon,* published in 1966:

> The case of Christine Jorgensen focused attention on the problem as never before. Without her courage and determination, undoubtedly springing from a force deep inside her, transsexualism might be still unknown—certainly unknown by this term—and might still be considered to be something barely on the fringe of medical science. To the detriment if not to the desperation of the respective patients, the medical profession would most likely still be ignorant of the subject and still be ignoring its manifestations. Even at present, any attempts to treat these patients with some permissiveness in the direction of their wishes—that is to say, "change of sex"—is often met with raised medical eyebrows, and sometimes even with arrogant rejection and/or condemnation. (p. 4)

Although Jorgensen was not the first transsexual woman who underwent sex reassignment surgery, she was the first person whose personal life was publicized and received attention from mainstream society. The case of Jorgensen launched social movements to advocate for the rights of transgender individuals (e.g., advocacy for legal rights of transgender people, prevention of violence and hate crimes toward transgender people). Dr. Benjamin's work contributed significantly to the development of the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Coleman et al., 2011).

Within the mental health profession, the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III*; American Psychiatric Association, 1980) first identified *transsexualism* as a mental illness in 1980. In 1994, *gender identity disorder* (GID) later replaced *transsexualism* in the 4th edition (*DSM–IV;* American Psychiatric Association, 1994*)*. In the text revision of the manual's 4th edition (*DSM–IV–R*; American Psychiatric Association, 2000), GID is characterized by a strong and persistent cross-gender identification; discomfort with one's sex (without presenting a biological intersex condition); and significant impairment in social, occupational, and other important areas of functioning. In the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013), GID was replaced with *gender dysphoria* and was described in the following terms:

> the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. (p. 451)

Many critics and organizations (e.g., National Health Service) argue that classifying the transgender experience as a mental disorder is an attempt by the medical profession to pathologize transgender people. Classifying transgender people as having a mental illness is problematic because it assumes that being transgender is undesirable and poses risks for one's psychological, social, and occupational functioning without considering the role of prejudice and oppression. This stigma has long been embedded in U.S. society and has influenced society's perception of the transgender community. The medical community, however, believes that this identification can lead to appropriate treatment options for transgender individuals (American Psychiatric Association, 2013). For example, a person diagnosed with GID may be qualified to receive treatments related to sex reassignment surgery (e.g., counseling, hormone therapy) with insurance or third-party reimbursement, whereas a person without the diagnosis may not be able to do so. It is important to note, however, that insurance companies deny coverage for individuals diagnosed with GID because of the high cost of treatment.

Current Experiences

Currently, an estimated 697,529 transgender adults live in the United States; they form 0.3% of the population (Gates, 2011). One of the most controversial issues facing the transgender community is whether gender dysphoria is a form of mental illness. The *DSM–5* continues to list gender dysphoria as a mental illness (American Psychiatric Association, 2013), but various advocacy efforts, led by GID Reform Advocates, have focused on changing that designation. Whereas the medical community takes a deficit model approach to gender-nonconforming individuals, the transgender community argues that being transgender is a variation of rather than a deviation from the norm. To deviate from the norm has a negative connotation; it implies that being male or female is the norm and that anything else is suspect. Many critics (e.g., Bartlett, Vasey, & Bukowski, 2000; Ehrensaft, 2011) have argued that the medical model perspective of transgender populations is rooted in transphobia and transprejudice, not biological and psychological disorders of human development.

Protection of transgender rights is an ongoing process that involves cultural, legal, and sociopolitical factors. Since 2008 or so, many transgender organizations such as the National Gay and Lesbian Task Force (NGLTF), the Human Right Campaign (HRC), the National Center for Transgender Equality (NCTE), and the National Transgender Advocacy Coalition (NTAC) have advocated that discrimination based on gender identity and gender expression should be made illegal because it violates the very basic rights of every individual. Some states, with Minnesota being the first, passed state laws prohibiting employment discrimination based on gender expression. (See the National Center for Lesbian Rights, 2010, for a full list of states that have passed gender expression nondiscrimination laws.) The gender expression nondiscrimination laws allow transgender people to be legally protected against discrimination related to employment, education, housing, and health care; however, this group continues to experience discrimination (e.g., employment, marriage) and violence (e.g., physical and sexual assaults, hate crimes).

Transgender individuals have historically been grouped with the lesbian, gay, bisexual and queer community in part because they too face discrimination and oppression around gender and sexuality. However, the experiences of sexual minorities are vastly different from those in the transgender community.

Recently, organizations such as NGLTF, HRC, NCTE, and NTAC have made concerted efforts to recognize the difference in experiences between transgender people and lesbian, gay, and

bisexual (LGB) populations. For instance, the coming out process is different for LGB individuals and transgender individuals. For LGB clients, coming out involves being public about their sexual orientation, whereas for transgender clients this process involves being public about the gender with which they identify. The unique experiences of sexual minorities and transgender individuals require different advocacy strategies and resources to serve the unique needs of each population. As an example, the use of public restrooms is often an issue transgender clients struggle with in part because of the failure of schools and organizations to allow transgender individuals the freedom to use restrooms of their choosing. Many organizations (e.g., NGLTF, HRC, NCTE, and NTAC) have made organized efforts from the grassroots level to an institutional level to advocate for systemic changes in many service areas (e.g., health care, education, employment, criminal justice) to exclusively serve the unique needs of the transgender population.

Key Multicultural Concepts and Characteristics

Key Multicultural Concepts

Although gender dysphoria is considered a mental disorder in the *DSM–5* (American Psychiatric Association, 2013), many mental health practitioners (e.g., professional counselors, social workers, psychologists) do not adopt this medical point of view when working with transgender individuals. In addition, many transgender individuals themselves oppose the medical profession's view of them as having a medical and psychological disorder; they believe they have ordinary behaviors and are entitled to express themselves differently. Therefore, it is critical that counselors understand key concepts and terms that can assist them to better serve transgender clients.

- *Androgyny*—the presence of male and female characteristics in one individual. Androgynous individuals describe themselves as *ambigender*, *polygender*, or *genderless*.
- *Cisgender*—the correspondence of the gender one was assigned to at birth, one's body, and one's "personal identity." These individuals are also called *gender normative* or *gender straight*.
- *Cross-dresser*—an individual who wears clothing of the opposite gender for enjoyment, excitement, and pleasure.
- *Female-to-male (FtM)*—transgender or transsexual individuals born as biological females but whose gender identity is male. These individuals are also referred to as *transmen*.
- *Gender*—the condition of being male, female, or neuter.
- *Gender binary*—the traditional belief system that there are two genders, female and male, and that one should conform to one or the other.
- *Gender expression*—the way that a person's internal sense of gender is expressed in daily life (e.g., clothing, gestures).
- *Gender identity*—a recognition that one is male or female and the internalization of this knowledge into one's self-concept.
- *Gender queer*—gender identity that does not fit into a traditional view of gender or a gender binary belief system (female and male).
- *Gender transition*—a process where a person decides to begin living as a member of the desired gender and may seek surgical procedures to alter one's primary and secondary sex characteristics to match the desired gender.
- *Intersexuality*—the condition of possessing the sexual characteristics of both sexes, particularly secondary characteristics and in some cases partial development of the internal or external sex organs.

- *Male-to-female (MtF)*—transgender or transsexual individuals born as biological males but whose gender identity is female. These individuals are also referred to as *transwomen*.
- *Outness*—the extent to which individuals have informed others that they are transgender or openly adopt gender-nonconforming lives.
- *Passing*—a term used in the transgender community to mean that individuals are viewed and perceived by others as having the gender with which they identify.
- *Sex*—the traits that distinguish between males and females.
- *Sex reassignment surgery*—medical and surgical procedures that alter one's primary (e.g., genitals) and secondary (e.g., facial structure, body hair) sexual characteristics to match one's gender identity. Sex reassignment surgery can be categorized as reversible (e.g., hormone therapy) or irreversible (e.g., genital reconstruction) procedures. This term is sometimes used interchangeably with newer terms, including *sex change*, *gender reassignment surgery*, and *gender confirmation surgery*.
- *Sexual orientation*—an individual's physical, emotional, spiritual, or romantic attraction to another person.
- *Transgender*—an umbrella term for individuals whose gender identities differ from culturally determined gender roles and biological sex.
- *Transitioning persons*—transsexual individuals who are going through gender transition from their assigned gender at birth to the gender that matches their gender identity.
- *Transphobia*—an irrational fear and belief rooted in stereotypes and prejudice that can lead to discrimination toward individuals who do not conform to gender norms and cultural expectations.
- *Transsexual*—individuals who feel strongly that they do not belong to their assigned gender at birth and decide to function as a desired gender and pursue gender transition.
- *Transvestite*—an individual who wears clothing of the opposite gender to achieve sexual arousal and pleasure.
- *Two-spirit*—a term whose origins are Native American and refers to individuals who perceive they have spiritual gifts—their body houses both femininity and masculinity and fulfills both gender roles.

These aforementioned terms are key concepts that counselors who work with transgender clients must understand. A more comprehensive list of terms is available in the American Counseling Association's Competencies for Counseling with Transgender Clients (2010) and the World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Coleman et al., 2011).

Key Characteristics

Similar to other cultural groups, the transgender community has unique characteristics and needs. Common characteristics of this population include having gender-nonconforming lives, discomfort with one's body, passing ability, gender identity and sexual orientation, and decision to change gender. These common characteristics lead the group to deal with particular issues and unique needs.

Gender-Nonconforming Lives

When compared with dominant groups (i.e., those who maintain traditional gender roles), transgender people do not conform to binary notions of gender. Described as *gender deviant* (and later as *gender variant*) by the dominant group, transgender people face prejudice,

discrimination, and oppression because they do not adhere to stereotypes of how people with their birth sex should look or act. This variation often creates obstacles in many areas of their life, including relationships, family, safety, health care, education, and career. Many transgender people choose to be in "the closet" (i.e., not let others know about their identified gender) because they are afraid that others will harm, reject, or hate them.

Discomfort With One's Body

The common concern that transgender (and particularly transsexual) people present are feelings of discomfort in their own bodies. For some, such as transsexual people, achieving emotional and psychological stability means going through sex reassignment surgery to be able to identify better with their self-concept rather than their biological gender. Transsexual people undergo surgery to alter their bodies in order to conform to their self-concept (e.g., breast augmentation and mastectomy). The feeling of discomfort in their own body and wanting to have a biological sex other than the one they were born with starts in early childhood or before adolescence (Ehrensaft, 2011). Because they feel different, gender-nonconforming children, adolescents, and adults are often misdiagnosed by medical and mental health professionals with some form of mental and emotional disorders such as depression, anxiety, or mood disorders.

Passing Ability

Individuals who are known or recognized as transgender by others are called *visual nonconformers* (Grant et al., 2010). Being a visual nonconformer poses potential risk for discrimination and violence. For example, coworkers may have discomfort around a transgender woman who attempts to pass in the workplace because she may present with masculine characteristics (e.g., excessive body hair and taller than other women) and a nonstereotypical gender presentation (e.g., walking and sitting pattern) when compared with biological women. This transgender woman may be at risk of experiencing employment discrimination in her workplace.

Gender Identity and Sexual Orientation

One of the common misconceptions about transgender individuals is that they struggle with their sexual orientation; in fact, many do not experience a struggle at all. Not every transgender individual is attracted to individuals who belong to their assigned gender at birth; for example, transgender women (who were born biological males) may be attracted to women instead of men. This is because gender identity is different from sexual orientation (also known as *affection orientation*). Therefore, it is important that professional counselors not assume that all transgender people are heterosexuals or have similar affection orientation.

Sex Reassignment Surgery

It is important to note that "for some, the journey traveled from birth sex to their current gender may involve primarily a social change but no medical component; for others, medical procedures are an essential step toward embodying their gender" (Grant et al., 2010, p. 3). One cannot assume that every transgender person will seek sex reassignment surgery. Many transgender people cannot achieve their goal of bringing their biology in line with their self-concept because of family, health, and financial constraints, and some choose to remain in their assigned body for personal reasons (e.g., feeling content).

Systemic Barriers

Transgender individuals face systemic barriers that affect their psychological and emotional well-being. These barriers are described in the following sections.

Institutionalized Oppression

According to Thesen (2005), *institutionalized oppression* refers to "discriminating practices built into the very structure of society" (p. 49) resulting in "exclusion, unjust distribution of resources, limited democratic participation, limited self-determination, and limited voice and choice" (p. 50). The institutionalized oppression of transgender people results from prejudice and society's understanding of the gender binary system. The idea that one must rigidly fit in one gender (and one gender only) produces oppressive consequences for those who are gender nonconforming. For instance, in the United States, men are expected to dress in "appropriate" male attires (i.e., pants, not skirts), adopt masculine roles (i.e., strong, dominant), and date members of the other sex (i.e., women). Gender-nonconforming people, therefore, are labeled as deviants and are forced to cope with prejudice and institutionalized power on a daily basis and in typical activities, such as pursuing education, seeking employment, and obtaining medical care. These individuals (who might also experience internalized oppression) have limited access to social resources and power, resulting in unfair treatment and ongoing discrimination.

Identification Documents

Identification documents (e.g., driver's licenses, birth certificates, and passports) are essential to one's life. Although identification documents vary in terms of the appearance (e.g., size, format) and the extent of the information included (e.g., personal characteristics), the main components (name, gender, and photograph) are similar and help to indicate a person's identity. When identification documents do not match the transgender individual's physical characteristics, others might respond in ways that lead the individual to feel misunderstood and discriminated against (not to mention being unable to accomplish tasks that require identification).

A lack of accurate identification is one major issue that transgender people face on a daily basis. Generally, gender presentation differs from identification documents for transgender people because many identification documents cannot be changed (e.g., birth certificates). Some but not all states allow changes to gender designation in identification documents (e.g., driver's licenses) for transgender people undergoing or completing gender transition with an appropriate evaluation (e.g., GID diagnosis) and treatment (e.g., psychotherapy, hormonal and surgical procedures) from licensed mental health counselors and physicians. Some transgender individuals (e.g., cross-dressers) are not interested in pursuing hormonal and surgical transition procedures, and so changing the gender designation in identification documents is not relevant for them. Tobin (2011) commented:

> For transgender people, identification documents and other official records frequently function as something akin to a scarlet letter, with the "F" or "M" designation contradicting the holder's appearance and social identity and outing him or her as transgender. State and federal policies in the United States today make it impossible for many transgender people to update these documents to reflect their lived gender. These restrictive policies create not only an enormous indignity but [also] a significant barrier to economic and other opportunities and at times even compromise personal safety. [para. 3]

The issue of identification documents that reflect one's assigned gender at birth rather than gender identity leads transgender people to experience discrimination, harassment, and violence (National Center for Transgender Equality and the National Gay and Lesbian Task Force, 2009) in various aspects of their life, such as employment, health care, housing, travelling, and partnership.

Discrimination

The combination of institutionalized power and transprejudice allows systematic oppression and discrimination toward transgender people in many aspects of their daily living. The NCTE and NGLTF conducted a study with more than 7,000 participants to examine types of discrimination and their effects on the lives of transgender people (Grant et al., 2010). The findings indicated that transgender women and men are discriminated against in many important life areas, including housing, employment, health and health care, education, public accommodation, family life, criminal justice, and identity documents. In addition, approximately 41% of the participants reported attempting suicide over issues related to unemployment, low income, and assaults (Grant et al., 2010).

Discrimination can be overt and covert. *Overt discrimination* refers to an obvious and direct act (e.g., verbal harassment, physical assault) of discrimination against the target, whereas *covert discrimination* refers to a more hidden and subtle intention or action (e.g., prejudice) of discrimination against the target (Whitley & Kite, 2010). These are strategies that the mainstream or dominant group uses to make transgender people feel ostracized and disenfranchised as well as to limit them from accessing social resources.

Concerning employment, although diversity has been increasingly promoted in various workplace settings and business industries, transgender employees continue to face overt and covert discrimination on the individual and organizational levels. Sangganjanavanich (2009) suggested that discrimination on an individual level may include distancing, gossiping, and marginalizing. Discrimination on an organizational level may include employment demotion, termination, and denial. Transgender employees are discriminated against across workplace settings and business industries; discrimination based on one's gender identity and expression violates Title VII of the Civil Rights Act of 1964 (Transgender Law Center, 2012).

Transgender people are likely to be discriminated against when seeking health care services including access to health insurance and transfriendly health care providers. The NCTE and NGLTF conducted a national transgender discrimination survey to examine transgender individuals' perceptions of the health care services they received. They found that participants faced refusal of care, harassment and violence, and lack of provider knowledge about transgender care in medical settings (Grant et al., 2010). Grant and colleagues concluded that the more aware the providers were of patients' transgender status, the more likely that transgender patients would experience discrimination.

In terms of mental health services and counseling, scholars (e.g., Chavez-Korell & Johnson, 2010; Sangganjanavanich & Cavazos, 2010) have noted that practitioners did not provide quality counseling services to transgender individuals. Many professional counselors lack awareness, knowledge, and skills about transgender mental health as a result of education that ignored the existence of transgender individuals. Bockting, Knudson, and Goldberg (2006) reported common mental health disorders among transgender individuals including depression, anxiety, self-harm, and suicidality. In particular, depression and anxiety often directly stemmed from gender identity issues. Bockting et al. noted that, besides employment concerns, common psychological concerns that transgender individuals, experience included "image problems, multiple losses resulting in cumulative grief, sexual concerns, social isolation and resultant social skill deficits, spiritual or religious concerns, substance use issues, and difficulty coping with historical or current violence/abuse" (p. 29). These psychological and mental health concerns are the results of discrimination that transgender individuals face in their daily living and are not a function of the gender identity itself.

Violence and Abuse

Most counselors will probably find it difficult to imagine having to worry about becoming a target of abuse and violence based on gender expression. For transgender women and men, the threat of being exposed to physical violence such as harassment (e.g., intimidation, hostility), hate crimes (e.g., murder, rape), and verbal and emotional violence (e.g., psychological bullying) is an ongoing concern.

Lombardi, Wilchins, Priesing, and Malouf (2001) conducted a study with 402 transgender individuals to examine gender violence that they experienced. More than 50% of participants had experienced some form of harassment or violence; past or current experiences of violence and abuse affected their psychological well-being. Although there is an increase in trauma caused by violence and abuse toward transgender people, clinical guidelines to examine and treat trans-specific trauma issues are still absent (Bockting et al., 2006).

Incompetent Counselors

Unfortunately, counselors can also contribute to transgender clients' feelings of dehumanization and being unwelcome. Even counselors who are well-intentioned but ill-equipped when it comes to counseling transgender clients can do more harm than good. Many transgender clients have sensed their therapists' discomfort with discussing transgender issues and have expressed anger at having to educate therapists on transgender issues while paying for services.

Personal Voices
The Story of Jane

Jane, formally known as Kevin, was a transgender woman who decided to pursue gender transition. Jane had been seeing Alexis, a licensed professional counselor, for eight sessions in preparation for sex reassignment surgery. Throughout these sessions, Jane and Alexis discussed gender transition options and steps that Jane had thought about pursuing. After lengthy and in-depth discussions, Jane felt very comfortable pursuing the next step of gender transition, the "real world experience" where she would begin living full time as a woman.

Jane was the marketing director of a nationally known company where she had loyally and diligently worked for the past 10 years (since her early 30s). She enjoyed her work and the interactions with coworkers and supervisees; she felt supported by the administration and had excellent performance records. Feeling positive about her transition efforts, she decided to "come out" at work—and learned that she misjudged the support she hoped to receive there.

Jane related to Alexis that she met with the human resource director, Kathy, to discuss issues relating to her transition in the workplace. After discussing detailed information about her plan, Kathy asked Jane, "Kevin, do you think it may be a better idea to find a new job? I want to be supportive of you, but in reality, I don't know how people will react. I don't even think they know how to." Two hours after her conversation with Kathy, Jane received a couple of e-mails from her coworkers. One of the emails was from Mark, who Jane considered a good friend. Mark stated, "Hey Kevin, I have seen a lot of things in my life. People in our age sometimes have a little doubt in what we do and who we are. Look at Jack, he turned to alcohol after his divorce. It is just a mid-life crisis that you are going through and dude, you are not alone! It is not too late to think about this some more and announce changes in your plan. You know we are coming up for a promotion in a couple years!"

After reading Mark's e-mail, Jane was furious and stormed into Kathy's office to confront her. Kathy apologized to Jane and said her intention was to help smooth Jane's transition, not to spread rumors; she wanted to consult with Mark and thought he would be an advocate. She concluded, "To tell you the truth, to my knowledge, nobody supports your transition so far and I don't see that happening."

Feeling discouraged with reactions from her coworkers, Jane mentioned to Alexis during the last counseling session, "I thought I was going to get support from my colleagues. I was very disappointed and hurt when this support did not occur. Do you think it will be better for me to find a job somewhere else? Or should I even continue with my transition at all? This has been a really hard time for me."

Alexis facilitated Jane's exploration of her feelings associated with this experience. Jane felt that she experienced workplace discrimination for the very first time as she voiced her decision to come out. Alexis allowed Jane to process the feelings of disappointment, confusion, and betrayal while acknowledging transoppression—an unjust behavior indicating a misuse of power toward transgender people—in many settings, including the workplace (e.g., covert and overt discrimination). In the following session, Alexis shared resources with Jane about ways to deal with workplace discrimination and referred her to a local attorney who specialized in transgender issues.

Alexis worked with Kathy and the company to address Jane's needs in the workplace (e.g., gender neutral restroom, employee records, dress code). Alexis further offered to provide a brief one-day training on the needs of transgender people in the workplace. Two months later, Alexis received a phone call from her state senator asking her to testify for legal requirements that accommodate transgender people; she promptly agreed because she believed that she had a duty to advocate for Jane—her client—and other transgender individuals.

Individual Counseling: Applications at the Microlevel

Professional counselors can advocate for transgender individuals by providing and promoting quality transspecific counseling services. Strategies that can be used in the office setting and session include creating a trans-positive and affirmative environment, acknowledging transoppression, gaining knowledge and developing competencies, identifying resources, and seeking supervision and consultation. Each of these is discussed in the following sections.

Creating a Transpositive and Affirmative Environment

A transpositive atmosphere is one in which transgender women and men feel safe and affirmed in the counseling environment. There are many strategies that professional counselors can consider implementing to create this environment. For example, office staff (e.g., clinicians, receptionists) should be educated in the transgender culture and the unique needs of transgender clients, including identity documents, different names used, and privacy in health care records. It is important that professional counselors and office staff use trans-affirmative language to show respect to client's gender identity. This includes inquiring about client's preference on the use of names and gender pronouns (e.g., gender neutral pronouns or preferred pronouns) that align with client's gender identity and gender expression. Office areas (e.g., waiting rooms) should also be trans-affirmative by displaying reading materials (e.g., magazines, posters) or media (e.g., DVDs, TV channels) that reflect the transgender community, culture, and people. Having a visible Safe Space emblem indicates a safe and welcoming environment for transgender clients.

Acknowledging Transoppression

When working with transgender clients, it is important that professional counselors examine their attitudes, assumptions, and beliefs related to the population. Counselors' attitudes, assumptions, and beliefs can either hinder or enrich their perceptions and understanding of transgender clients. It is equally important to acknowledge the deep-rooted culture of oppression toward transgender people; doing so helps to provide a wider context to facilitate the counseling process. This acknowledgement can serve as a tool to allow transgender clients to understand that counselors are open to hearing about the oppressive experiences of discrimination that they face in everyday life. Counselors who are aware of the systemic barriers transgender clients experience can use this understanding to educate transgender clients about the oppression they might have experienced. This process of education can lead to an awakening of sorts for transgender clients who may have internalized their oppression.

Gaining Knowledge and Developing Competencies

Professional counselors should be knowledgeable about the standards (e.g., Coleman et al., 2011), competencies (e.g., American Counseling Association, 2010), and best practices (e.g., Bockting et al., 2006) relevant to counseling transgender client populations. Attending professional workshops and conferences on transgender-specific issues can also be helpful in developing competence in working with gender-nonconforming clients, whose needs are uniquely different from other populations. In addition, within the transgender community, there are a variety of issues. For instance, a professional counselor working with a transitioning client (a transsexual individual who pursues sex reassignment surgery or a client who seeks hormone medication) needs to be knowledgeable about the types (e.g., psychological vs. surgical transition), characteristics (e.g., abrupt vs. gradual gender transition), and impacts (e.g., social support, career development) of gender transition in order to facilitate the client's understanding of treatment options and their magnitude. In many states clients are required to attend therapy and obtain a letter of support from a mental health counselor before a physician prescribes hormone medication. Counselors who write letters of support for the use of hormone medication would do well to explore with clients the pros and cons of medication and transitioning, identify support systems, and ensure that the client has sufficient "real life experiences" living in the gender of identification. Possessing transgender-specific knowledge and competencies can help clients become aware of their choices and, ultimately, make informed decisions.

Identifying Transgender Resources

Professional counselors must be aware of available resources for transgender clients that can facilitate informed decision making. Too often, transgender clients are isolated, ostracized, or unable to find resources. Professional counselors should identity available resources and referrals that pertain to transgender health (e.g., hormone therapy, surgical options, voice therapy, support groups). If such resources do not exist in the community, counselors should consider taking the lead and creating such resources. It is also critical that professional counselors develop and participate in referral or resource-sharing networks in order to stay current and involved with other transgender health providers.

The Internet can aid transgender clients in better understanding their experiences without the fear of being "outed." Sharing online resources from such organizations as the

HRC and NGLTF allows clients to explore their own development from the privacy of their homes. Meeting transgender individuals online can be a normalizing experience for clients. Discussing with clients the pros and cons of Internet use can help ward off any potential risks that might result from using the Internet to meet others for support.

Seeking Supervision and Consultation

Supervision and consultation are vital to the professional and personal development of counselors. Supervision can help professional counselors become more effective and competent when serving transgender clients. For example, supervision can help counselors become more aware of any unintended biases and prejudices they may have toward transgender clients (e.g., not acknowledging oppression, unable to provide empathy). Being cognizant of one's biases and prejudices is the first step toward becoming more effective with transgender clients.

Consulting a counselor who specializes in transgender issues is one way to obtain advice on brief and specific ways to effectively serve clients at both the individual (e.g., individual and couples counseling) and group (e.g., group counseling, training programs) levels. For example, counselors working with a client undergoing the "real life experience" may seek consultation on how to approach this issue with the client. Seeking consultation from a counselor who specializes in transgender issues, especially social transition, can be helpful for counselors and the clients they serve.

Advocacy Counseling: Applications at the Macrolevel

Counselors may not realize that they can also support transgender clients beyond their duties in the counseling sessions. Advocacy outside the office setting is one of the integral functions of professional counselors. Counselor advocacy outside of the office setting can strengthen what counselors do in the office. Advocacy is particularly important considering that many issues faced by transgender clients are often systemic. Professional counselors can implement advocacy strategies to help transgender people achieve optimal psychological development and well-being. These advocacy strategies include being a transgender ally, increasing public awareness, volunteering and offering pro bono work, using a multidisciplinary approach, and participating in legislative efforts. Each of these advocacy strategies is highlighted below.

Being a Visible Transgender Ally

An *ally* refers to a person from the dominant group who advocates for members of an oppressed group or community in order to promote social justice and peace. Serving as a visible ally is an important role of transgender advocates. By virtue of their position in society, counselors can educate the public to gain a better understanding of the issues facing this population. For example, being an ally can be as simple as sharing with family and friends about how to correctly and respectfully refer to a transgender person (e.g., using gender neutral pronouns) during a general conversation or interaction with a transgender person. This action may seem minuscule when compared with other areas or methods of advocacy; however, small steps can lead to large changes.

Increasing Public Awareness

The dominant group in the United States perceives transgender culture as an underground culture. This perception not only prevents dominant groups from seeking to understand

the transgender community, but it also inhibits more visibility and acceptance of them. Professional counselors can provide educational outreach to increase awareness of the transgender community in various settings such as schools, workplaces, and spiritual communities. (An example of educational outreach was provided in the Personal Voices: The Story of Jane section.)

Volunteering and Offering Pro Bono Work

Volunteering one's talent and time can be helpful to transgender organizations in the community. Typically, local transgender organizations have monthly or annual meetings or events in which people from the community can volunteer and participate. Professional counselors can use this opportunity to get in touch with these organizations in order to help support the transgender community. Counselors who do not have time to volunteer or participate in such meetings or events can instead choose to offer pro bono or free counseling services to transgender clients. Many transgender people are unable to access mental health and counseling services because their income is low or they lack health insurance. Giving back to the community through volunteer or pro bono work can go a long way in creating a more safe and welcoming environment for a community that is in dire need of advocacy.

Using a Multidisciplinary Approach

The *Standards of Care* for transgender health (Coleman et al., 2011) suggest that healthcare providers should participate in a multidisciplinary team to provide an integrative and comprehensive care for transgender clients. Mental health and counseling services are one of the important parts in the multidisciplinary team caring for the biopsychosocial aspects of transgender individuals. Collaboration with other professions (e.g., physicians, voice therapists) can help transgender clients achieve their optimal functioning. For example, a counselor may be in contact with a surgeon who performs feminization procedures for the transgender client in order to understand results and demands (e.g., physical needs) of those procedures and to determine how this may affect the client's psychological health.

Participating in Legislative Efforts

Participating in legislative efforts and policymaking may seem out of reach to some professional counselors. In fact, technology makes such efforts easy. Some of these efforts are initiated by the community, county, and state, but many can be done online through advocacy websites. With just one click, counselors can support policy and social changes that promote transgender people's quality of life.

Future Directions

Whereas the transgender community has slowly gained public acceptance, it continues to face violence, oppression, and discrimination based on gender identity and gender expression. Violence, including physical and psychological violent acts, directed toward transgender people impact their well-being and quality of life. Oppression at the microlevel (e.g., family), mesolevel (e.g., community), and macrolevel (e.g., society) is ongoing. Covert and overt discrimination toward transgender people exist in many settings, including education, workplace, health care, and mental health. Although violence, oppression, and discrimination are considered lawful acts in many states, some states have begun to address the very basic of human rights of transgender people.

Current trends in many states (e.g., Massachusetts, New York) suggest that laws preventing discrimination based on gender expression will be adopted by other states. These laws mean that transgender individuals are better protected from employment discrimination based on gender identity and gender expression. This hope, however, relies upon advocacy efforts of many parties, including professional counselors. Therefore, it is important that professional counselors continue to advocate on behalf of transgender clients in order to promote their quality of life and well-being.

Just as important, trans-specific counseling service is much needed in order to better serve this population. Ironically, professional counselors are ill-prepared to serve the transgender population because they lack appropriate training. Given the increase of transgender population (Gates, 2011), training and educational efforts regarding working with transgender population are required. Specific education and training will equip professional counselors to better serve this population.

Resources

Articles

American Psychiatric Association. (2013). *Gender dysphoria*. Washington, DC: Author. Retrieved from http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf

Human Rights Campaign. (2008). *Statewide employment laws and policies.* Washington, DC: Author. Retrieved from http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/statewide_employment_5-2014.pdf

Human Rights Campaign. (2010a). *Cities and counties with non-discrimination ordinances that include gender identity.* Retrieved from http://www.hrc.org/resources/entry/cities-and-counties-with-non-discrimination-ordinances-that-include-gender

Human Rights Campaign. (2010b). *Employment non-discrimination act.* Retrieved from http://www.hrc.org/campaigns/employment-non-discrimination-act

Human Rights Campaign Foundation. (2008). *Transgender inclusion in the workplace* (2nd ed.). Washington, DC: Author.

Websites

GID Reform Advocates
http://www.gidreform.org

National Gay and Lesbian Taskforce
http://www.thetaskforce.org

National Gay and Lesbian Taskforce Institute for Welcoming Resources
http://www.welcomingresources.org/transgender.xml

World Professional Association for Transgender Health
http://www.wpath.org

References

American Counseling Association. (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling, 4,* 135–159. doi: 10.1080/15538605.2010.524839

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

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

Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles, 43*, 753–785. doi: 10.1023/A:1011004431889

Benjamin, H. (1966). *The transsexual phenomenon*. New York, NY: Julian Press.

Bockting, W., Knudson, G., & Goldberg, J. M. (2006). *Counselling and mental health care of transgender adults and loved ones*. Vancouver, BC: Vancouver Coastal Health-Transgender Health Program.

Chavez-Korell, S., & Johnson, L. T. (2010). Informing counselor training and competent counseling services through transgender narratives and the transgender community. *Journal of LBGT Issues in Counseling, 4*, 202–213. doi: 10.1080/15538605.2010.524845

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7th version). *International Journal of Transgenderism*, *13*, 165–232.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children*. New York, NY: Experiment.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* The William Institute. Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf

Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). *National transgender discrimination survey: Report on health and health care.* National Center for Transgender Equality and National Gay and Lesbian Task Force. Retrieved from http://transequality.org/PDFs/NTDSReportonHealth_final.pdf

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*, 89–101. doi: 10.1300/J082v42n01_05

National Center for Lesbian Rights. (2010). *State by state guide to laws that prohibit discrimination against transgender people*. Retrieved from http://www.lgbtagingcenter.org/resources/pdfs/StateLawsThatProhibitDiscriminationAgainstTransPeople.pdf

National Center for Transgender Equality and the National Gay and Lesbian Task Force. (2009). *National transgender discrimination survey.* Retrieved from http://transequality.org/Resources/NCTE_prelim_survey_econ.pdf

Sangganjanavanich, V. F. (2009). Career development practitioners as advocates for transgender individuals: Understanding gender transition. *Journal of Employment Counseling, 46*, 128–135. doi: 10.1002/j.2161-1920.2009.tb00075.x

Sangganjanavanich, V. F., & Cavazos, J., Jr. (2010). Workplace aggression: Toward social justice and advocacy in counseling for transgender individuals. *Journal of LGBT Issues in Counseling, 4*, 187–201. doi:10.1080/15538605.2010.524844

Thesen, J. (2005). From oppression towards empowerment in clinical practice—offering doctors a model for reflection. *Scandinavian Journal of Public Health, 33*(Suppl 66), 47–52. doi: 10.1080/14034950510033372

Tobin, J. H. (2011). Fair and accurate identification for transgender people. *LGBTQ Policy Journal at the Harvard Kennedy School*. Retrieved from http://isites.harvard.edu/icb/icb.do?keyword=k78405&pageid=icb.page414493

Transgender Law Center. (2012). *Groundbreaking! Federal agency rules transgender employees protected by sex discrimination law*. Retrieved from http://transgenderlawcenter.org/archives/635

Whitley, B. E., Jr., & Kite, M. E. (2010). *The psychology of prejudice and discrimination* (2nd ed.). Belmont, CA: Wadsworth.

Chapter 17

Counseling Women

Jennifer L. Pepperell, Jennifer Londgren, and Laura A. Maki

As with the population at large, the population of women in the United States continues to grow more diverse. Women have assumed numerous and diverse roles in society, and their identities are often tied to their careers, families, and communities. Nearly all women experience changes and challenges related to employment, relationships, and decisions about how, when, or whether to have children. Additionally, women experience changes and challenges regarding career building and child rearing, issues for which strong social norms prevail in the United States. It is beyond the scope of this chapter to discuss the experiences of all diverse groups of women, and we do not attempt to do so; we recognize that the statements made in this chapter might not fully capture the experiences of all women. Here we provide a preliminary understanding of some of the broad concepts that impact women as a group and how counselors can be most effective when working with women. We discuss specific challenges that counselors face regarding social justice issues related to women as well as the resources available to facilitate counselors' efforts to advocate for women with whom they are working.

Historical Overview

Women have experienced—and have generated—many cultural shifts throughout history. These shifts have been brought about in part by historical inequities that have at best disadvantaged women and at worst violently oppressed them. These inequities have included absence of representation in the political system (Manning & Shogan, 2012), wage and gender discrimination in the workplace (Cohen & Huffman, 2003; Maume, 2004), and fettered access to education (Allan, 2011; Nankervis, 2011). Some of the most notable challenges that women have faced in the history of the United States can be understood through the lenses of power and oppression, resources and opportunities, and bias and discrimination. Women have been in nearly constant struggle to resist oppression and to thwart discriminatory and biased practices and to claim power and equal access to resources and opportunities (Stainback, Ratliff, & Roscigno, 2011). These efforts have taken place in political, employment, and educational contexts.

Although women's efforts to gain legitimate power through equal political representation began long before women's suffrage, the 19th Amendment marked a definite turning

point in women's journey for representation in the political system. With the addition of the 19th Amendment in 1920, women began to claim their rights to a host of other privileges that were once only available to White men. Nearly 100 years have elapsed since the passage of the 19th Amendment; however, women still struggle for equal status in several notable contexts, including in employment (Cohen & Huffman, 2003; Shapiro, Ingols, & Blake-Beard, 2008). The Department of Labor established the Women's Bureau to monitor and safeguard the working conditions of women: to "formulate standards and policies which shall promote the welfare of wage-earning women, improve their working conditions, increase their efficiency, and advance their opportunities for profitable employment" (United States, 1965, n.p.).

The passage of the 19th Amendment and the establishment of the Women's Bureau marked a period of increased accountability regarding the treatment of women in the work force and opened the door for women to demand equal pay for equal work. It wasn't until 1963 that Congress passed the Equal Pay Act making it illegal for an employer to pay a woman less than a man for the same work (United States, 1965). Although promising in principle, the Equal Pay Act has not prevented a persistent and pernicious gap in wages between men and women. Since 1963, the wage gap has closed at a rate of less than 1 cent per year, or from women earning 59 cents to 77 cents of every dollar earned by a man (National Committee on Pay Equity, 2012). Although arguments attempting to explain the wage gap abound, 12-year longitudinal research indicates that persistent inequality in wages for women and non-White workers still exists (Maume, 2004).

Building on the Equal Pay Act of 1963, the Title IX Education Amendment of 1972 has provided women protection from discrimination and exclusion from participating in educational programs or activities receiving federal funding (U.S. Department of Education, 2012). The passage of the Title IX Amendment provided recognition that women were not granted equal opportunities in education; however, institutions of higher education still have "gatekeeping mechanisms" (Allan, 2011, p. 37) that affect access to admissions (Nankervis, 2011). Equal access to education affects subsequent opportunities for women to gain entry into occupations and careers and to demand equal pay for equal work.

Equal political representation, equal wages, and equal access to education are all issues that women have faced throughout modern history; however, these issues persist for women, and just as gaining the right to vote did not level the political playing field for women, there are no guarantees that women will continue to achieve or even retain the rights for which they have struggled for so long. Power, social change, and historical contexts are inextricably intertwined, and the ability to effect change and empower oppressed groups is diminished when the interplay of power in history is not examined (Reich, Pinkard, & Davidson, 2008).

Current Experiences

Over the past several decades, norms and expectations for women have changed, yet current experiences still reflect struggle and inequity based on gender. Despite many positive changes for women within the past 5 years, women experience many of the same historic oppressions on a daily basis. Many women still struggle to strike a balance between work and family—especially as more women return to work—but still contend with lower pay than their male counterparts. This gap can be particularly damaging for single mothers who are working to support their children. For each hour they work, they earn less than their male counterparts, which means they must work longer to make the equivalent total

salary. Women are using and becoming addicted to substances at higher rates than in prior years and have less access to treatment than men (Briggs & Pepperell, 2009). Moreover, women live in a very violent culture, much of which is targeted toward them and is, for many, experienced at home.

Historically, women have had very little voice in the political realm or in the social script that has been written. Slowly, they have begun to have a voice, but they are still very behind; men are the primary advocates. Even though women constitute just over 50% of the population, they compose only 17% of the U.S. Congress (Manning & Shogan, 2012). Women of color make up 29.9% of the women serving in Congress, or 4.5% of the total membership (Manning & Shogan, 2012). There is only one lesbian woman, newly elected, serving in the Senate. The result of this imbalance is that issues that most affect women—such as birth control, abortion, and rape protection—are decided primarily by men.

Culturally, women have experienced large shifts in the workplace. The notion of women in the workplace is no longer new, and women are no longer limited to career choices based on gender. Although women are in the workplace as often as men, their experiences are not equal. Women experience harassment and discrimination at much higher rates than men. Women also experience microaggressions—seemingly small indignities targeted toward someone of a nondominant group—at very high rates simply because of their group association (Sue et al., 2007). These microaggressions include not being taken seriously, having their perspective questioned, being talked over in meetings, and other aspects of what is described as a "chilly climate" (Maume, 1999). In addition to workplace stress, women currently earn only about 80% of the salary that men earn, and although this is an improvement over the past few years, it still relegates women to an inferior position. This becomes particularly problematic for women who are single parents or heads of households and therefore are already disadvantaged. Women are also disproportionally responsible for the work within the home, often being the one to take on traditional roles, even while working outside of the house. This increase in work causes stress and increases anxiety and a sense of needing to be perfect and "do it all."

With this increase in stress, responsibility, and equality, women's use and abuse of substances has risen within the last several years to the point where women are using at a level almost equal to men (Greenfield, 2002). In the early 1980s, male:female lifetime prevalence for experiencing an alcohol use disorder was 5.17:1. By the early 1990s, that rate was 2.45:1. Women come into substance use for different reasons—often because of a partner or to connect with others—so their substance use often looks different, but the consequences can be very high (Briggs & Pepperell, 2009). Women who develop addictions are at greater risk for being ostracized from their families, for being sentenced to prison, and for losing their children. With a treatment system that does not support women, they often suffer alone. Women with substance abuse issues must care for children while they are using, and they often lose their jobs, their housing, and their health. Treatment centers often do not include care for children and frequently are located in areas difficult for women to reach, especially if they are trying to work, lack access to transportation, and shoulder parenting responsibilities. When women do seek treatment, it is often with centers that use the Minnesota model of treatment, a 12-step traditional program that is not as supportive of the needs of women and that does not take a holistic approach to treatment (Briggs & Pepperell, 2009).

A small portion of what drives women's addictive behavior is the pressure that women feel from outside sources. Whereas many of the pressures are the same for all women, there are some differences for women of color and for lesbian women. For women of color, racism and social pressures such as economic disadvantage may drive their addiction. For lesbian

women, there is a culture of addiction built from living in a homophobic society that often puts pressure on them (Briggs & Pepperell, 2009). For White women, there is a pressure to look and act a specific way. (However, all women may share this pressure.) It has been well known that the media has had a significant influence on society, specifically on how women are influenced to dress, look, and act. What has changed more recently has been the constant barrage of media images that come at young girls and women and the type of body and lifestyle images that are being shown to women as representations of the acceptable way to be. The very thin, active, heterosexual, White, wealthy, sexual, and virginal woman has become the one type that women aspire to. This impossible goal has all women struggling to find their place socially. This is especially true for women who do not feel that they fit these gender norms: women who either struggle with their gender identity or who simply recognize that their gender is more fluid than the norm. Women who do not comply with the socially accepted gender norm often struggle with mental health concerns, including depression and anxiety, are more commonly bullied and harassed, and have a more difficult time at work.

Women also continue to struggle in massive numbers in violent relationships and by sexual assaults. The World Health Organization identified violence against women as a major public health and human rights issue that accounts for between 5% and 20% of healthy years of life lost to women between the ages of 15 and 44 (Alhabib, Nur, & Jones, 2010). It was only in the late 1980s that women's organizations began to organize and demand federal legislation and protection from the violence they were experiencing (Alhabib et al., 2010; Prah, 2011). Although some reports of national figures show declining rates of intimate partner violence over the last few decades, experts believe that those reports may be misleading because they do not include full definitions of intimate partner violence; for example, several states do not include dating violence in those figures (Prah, 2011). Even with what may be a drop in violence, current estimates indicate that each day, three women are killed by their partners or ex-partners and thousands of women are raped or assaulted (Prah, 2011). The mental health impact of this violence is significant and is still being studied. Whether women are in a violent relationship, have been raped, or are just acutely aware of the risk that being a woman brings, the stress of this—the fear for many women—is very difficult to manage.

Key Multicultural Concepts and Characteristics

The following concepts and characteristics are described generally for women as a broad cultural group and summarize in general terms the themes of struggle and disparity that women experience.

Key Multicultural Concepts

Power

Power is defined as "an individual's relative capacity to modify others' states by providing or withholding resources or administering punishments (Keltner, Gruenfeld, & Anderson, 2003, p. 265). In U.S. society, power is seen as finite, with everyone competing for a portion of the power available. Men and women have equal but different needs for power (Maroda, 2004); men are more likely to pursue power for individual ambitions whereas women pursue power in ways that help others (Maroda, 2004). Men and women also display power very differently. It is often assumed that men have more power and thus are more likely to use their power directly and openly, leaving women to attempt to gain power indirectly (Evans, 2010). One of the ways in which men are able to hold their power is to deny power to women. Women themselves are often hesitant in seeking power and

reluctant to admit and many times even deny that they need power (Dimen, 2003) because being powerful is considered unfeminine. Perpetuated gender norms contribute to denying power to women.

Patriarchy

Patriarchy is the social relationship between and among men that allows them to create an interdependent system for domination over women. This system puts men in a higher status over women and creates a hierarchy for men (Hartmann, 2004). Maintaining the system of hierarchy includes enacting the dominant role for men in the household. Men set the tone for how most homes are run, and they often delegate household chores, child rearing, and other domestic tasks to women (Hartmann, 2004). Men may also see themselves as having physical and emotional domination over their spouses or partners as well, which contributes to high levels of domestic violence, sexual assault, and rape.

Marginalization

Marginalization is defined by Merriam-Webster (2013) as "to relegate to an unimportant or powerless position within a society or group." Women have been marginalized in society for hundreds of years, many times in hostile and overt ways, but also in more subtle and covert ways. Each time women's civil, economic, political, and societal rights are violated, another layer of marginalization is revealed. Media and social media contribute to the marginalization of women by promoting traditional gender norms and gender discrimination and by objectifying women. Women who violate gender ideals are more likely to be sexually harassed in their social and work lives (Berdahl, 2007), and this highlights the role of sexual harassment as a way of keeping the sexes unequal and in perpetuating stereotypical gender roles. Feminist theorists assert that sexual objectification and other forms of oppression may cause or exacerbate psychological distress and leave women feeling isolated, confused, and misunderstood (American Psychological Association, 2007). Women who abuse substances, who are victims of battering and domestic violence, and who are not from the dominant White group are apt to experience marginalization to a greater and far more damaging extent.

Sexism

Sexism, which can be defined simply as any inequality based on sex, is at the heart of the marginalization of women. Deeply connected to sexism and the process of marginalizing women is *heterosexism*, the assumption that the male is the "normal" or the presumed sex. The result of this in society is that we compare all things to a male norm. Heterosexism and sexism are both deeply connected to gender and how women (and men) present themselves. Gender norms are driven by pervasive sexism within a Western culture. The notion that women should be more emotional, should look a specific way, should be more vulnerable, or should work for unequal pay are all built on a male norm. This concept of sexism is not new, but it is critical for counselors to recognize the ways in which sexism impacts the mental health of women in very small ways. Women do not always know that sexism or heterosexism affects their experiences. For example, women may sit in a meeting at work and not see that the men in the meeting most often dominate the conversation. Sexism is often subtle, but it is pervasive.

Key Characteristics

Career

The world of work for women has drastically changed in the past few decades, but gains in the workplace remain uneven, and career-related issues remain unresolved. Women

have made great strides in participating in the labor force, attending college and earning advanced degrees, and obtaining high-status professional positions; however, they remain underrepresented in high-status positions in leadership, receive unequal pay for their equal efforts, and shoulder responsibility for a disproportional amount of domestic duties (England, 2006; Rudman & Phelan, 2010). Even when women achieve success in traditionally male-dominated careers, they are viewed negatively, liked less, and are more personally derogated compared with equivalently successful men (Heilman, Wallen, Fuchs, & Tamkins, 2004). These negative feelings toward successful women can have serious consequences for their personal and professional lives. Even when women make it to the top echelons of power, they still struggle (Heilman et al., 2004), which subtly indicates their violation of gender-stereotypical norm prescriptions.

Interpersonal Violence

Today women have more political, economic, social, and workplace freedoms than in previous decades, yet they are told that they should not walk to their car alone at night, should not drink too much (or at all) at a bar, should not leave a drink unattended, and in many instances, are not safe in their homes. Additionally, women's experiences with violence, particularly sexual violence, have been constructed through a male-dominated, patriarchal lense. The result of having sexual violence viewed through this male-dominated lense is that women's experiences have been minimized at best, and at worst, women are viewed as compliant in the violence perpetrated against them (Sheffield, 2004). The experience of violence for women—and in particularly the fear of sexual violence—leaves women in a subjugated role and in a state of anxiety that can lead to mental health difficulties.

Chemical Use and Addiction

Women's abuse of substances is complex and interrelated with their relationships, mental health, and social and emotional environments. Substance use has been identified as a powerful means for women to cope with distress, struggles, violence, and emotional pain (Fillmore & Dell, 2001), and for women, substance abuse is more often linked to mental health problems and traumatic experiences. Women who abuse substances report much higher levels of anxiety, depression, and other psychiatric disorders than do men (Beckwith, Rozga, & Sigman, 2002) and are more likely to report a history of childhood sexual abuse (National Centre on Addiction and Substance Use at Columbia University, 2006) and physical abuse. They also experience higher levels of guilt and shame surrounding their abuse and addiction and the impact it may have on their relationships (Briggs & Pepperell, 2009). The themes of women who abuse substances are often themes of violence, trauma, pain, and emotional distress (Briggs & Pepperell, 2009).

Systemic Barriers

Like other marginalized groups in the United States, women face a variety of challenges and systemic barriers that influence the paths they take as well as their successes along those paths; these barriers include unequal political representation and lack of access to equal employment opportunities and to resources such as education and health care. Gaining and maintaining access to resources in these areas creates a ripple effect for women's overall success and well-being for current as well as for future generations. In the absence of power to effect change in political and occupational realms (Reich et al., 2008; Stainback et al., 2011), women as a group continue to be blocked by these systemic barriers.

Political Barriers

One of the persistent barriers that women face is a lack of political representation as well as lack of support for the systemic elimination of discrimination. For example, as of 2013, the United States has yet to ratify the treaty adopted 30 years ago by the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (Ramdas & Janus, 2011). This failure on the part of policymakers in the United States communicates a strong message that the leaders of our nation are not willing to commit to eradicating discrimination against women despite other efforts to rectify biases in laws and policies.

Occupational Barriers

Longitudinal research has indicated that women continue to face occupational discrimination and segregation (Dick & Nadin, 2006), persistent wage discrimination (Maume, 2004), and wage devaluation based on gender (Cohen & Huffman, 2003). The Equal Pay Act of 1963 is one such example of a policy that has reduced some of the deficit in pay that women face; however, the system of pay inequity is complex. Even though nearly 40 years have passed since the enactment of the Equal Pay Act, women still face systemic barriers to equal pay and equal opportunities in occupations.

Educational Barriers

The inequalities described in preceding sections arise, in part, from inequities in other systems, including access to education. Systemic discriminatory practices in admissions criteria, such as in standardized tests used to determine potential for success (Nankervis, 2011), result in differential access to educational opportunities. Even when women do enter college, they are not necessarily receiving equal access to a quality education (Allan, 2011). Moreover, as women break through barriers in admissions and quality education, the very policies created to protect their access, such as Title IX, are being called into question (Allan, 2011). Before long, women may once again face barriers to educational opportunities.

Family–Career Balance Barriers

In addition to the challenges that women face in obtaining equal access to quality education and compensation for their work, women are perceived as primary caregivers for children and family members, which poses a challenge and creates a career double bind in which women must choose between maintaining their career trajectories and starting a family (Shapiro et al., 2008). This double bind is created by a system that values work and career over family (and, therefore, implicitly values men over women) and does not credit women for the time they take away from work to have or to raise children. And when women put their careers on hold for even a year, they face the challenge of proving that they are as experienced and as worthy of equal pay as the man who has not had significant time away from work. This particular barrier contributes to a cycle in which women struggle to earn pay equal to men but then are discredited in their work histories because they have taken time off to have children.

The challenges and barriers described here create high levels of stress and anxiety for women. In light of the stress that women face, it is not surprising that they are experiencing higher rates of chemical use and addiction than previously seen (Briggs & Pepperell, 2009). For women to successfully cope with stressors and with substance abuse, researchers and practitioners must approach treatments from the perspective of women. A barrier

to these treatments is a lack of representative research on interventions and mental health treatment that is specific to women. As Briggs and Pepperell (2009) have noted, "Addiction cannot be treated in isolation (i.e., separated from other mental health issues, from cultural influences, or from biological conditions)" (p. 5). In other words, women's struggles with systemic barriers surrounding equal access to employment, education, and mental health and substance abuse treatment are interrelated and must be addressed holistically to be addressed successfully.

Personal Voices
The Story of Eva

Eva, a 27-year-old single biracial Latina and White woman with three children, checked herself into a residential treatment center for alcohol and marijuana consumption. Pregnant at the time of treatment, she reported that one of her goals was to leave a physically and emotionally abusive relationship. She had left and returned to this partner several times; she reported that her major reason for returning was that she had nowhere else to live and did not want to uproot her children from their home. She would call the police when her partner's attacks were especially vicious, but once the police arrived she would be too afraid to disclose the extent of the abuse.

Eva had very little support in her relationship and worked two jobs in order to support herself, her partner, and her children. At the time she was admitted to the treatment center, she had a job as a maintenance staff at a local hotel and also as a cashier at a gas station. Eva reported feeling frustrated with her work; she had been at both jobs for significant periods of time and had seen several male employees advance to higher positions more quickly than she had. She had also been harassed at work to the point where she felt unsafe working with some of her other coworkers.

Eva had a high school diploma and attended some college, but she dropped out because she had difficulty managing her domestic and employment responsibilities. She started drinking more heavily in order to cope with her feelings of being overwhelmed, powerless, and stuck in her situation with her partner. She went for counseling and reported symptoms of depression, panic attacks, and intense anger and rage.

Individual Counseling: Applications at the Microlevel

To fully honor each client, counseling approaches should be adapted to fit the individual at the microlevel. In feminist counseling, the establishment of an egalitarian relationship is critical, and clients are viewed as having expertise and authority about themselves (Brown, 2004). Power differentials are avoided, and women's perspectives are valued and "given voice." In therapy with Eva, it would be crucial for the counselor to maintain a collaborative, open relationship with her and to be aware of the inherent power differential involved in a therapeutic relationship (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). In selecting treatment options, the counselor should consider the social, emotional, and political context of the client.

Counselors are expected to have the skills and knowledge to advocate for a client as well as the ability to help clients advocate for themselves. The American Counseling Association Advocacy Competencies model organizes advocacy into three levels: individual, systems, and societal level (Ratts, Toporek, & Lewis, 2010). At the individual level, advocacy occurs with the client and may include involvement with or on behalf of the client

(Lewis, Ratts, Paladino, & Toporek, 2011). The counselor's primary goal at this level is to work with the client toward empowerment (Lewis et al., 2011). Empowerment is central to the work of advocacy and encompasses social, political, and material resources and inequities in the environment, the strengths of individuals and communities, and the enhancement of well-being through supporting an individual's natural inclination to strive for positive change (Zimmerman, 2000). This may involve assisting the client in naming the barrier and helping the client identify resources or strengths to remove environmental barriers. Working with Eva toward empowerment would involve assisting her in identifying environmental barriers in her life and collaborating with her to develop solutions to address these barriers. Empowerment involves an element of teaching skills to the client, and in Eva's case, the counselor might work with her on such skills as asserting herself, coping with stress, confronting oppression, and problem solving. The counselor's strategy might also include helping Eva identify her strengths, helping her understand her life in context (which can lead to critical consciousness), facilitating the development of self-advocacy skills, and collaborating with her to develop and implement a self-advocacy plan of action (Lewis, Arnold, House, & Toporek, 2003).

Goal setting is another important aspect of empowerment; it gives clients the space to think about what they want and need and to verbalize it. Goal setting would help Eva find her voice and her personal agency. At times it is appropriate for the counselor to use his or her power to advocate on behalf of a client, which is another component of advocacy at the client level. In Eva's case, it would be critical for the counselor to have adequate skills, training, and knowledge of Eva's personal and social context to be able to advocate effectively on her behalf. Such advocacy might take the form of negotiating relevant services, helping her gain access to resources, identifying her barriers, recognizing allies, and carrying out a plan of action (Lewis et al., 2003).

Another important aspect of therapy that has historically disempowered women in counseling is the manner in which they are diagnosed and assessed. Counselors are more likely to diagnose women with depression and histrionic and borderline personality disorders compared to men with similar symptoms (Caplan & Cosgrove, 2004), which suggests that counselors may infer different meanings based on the client's gender rather than on their presenting symptoms. Counselors should be aware that their client's behaviors may be attributable to gender socialization; in other words, women may react to stressors in ways that they have been socialized to react. Additionally, reframing Eva's symptoms as reasonable coping strategies for a woman who is managing painful feelings while attempting to maintain her connections will be helpful in viewing her as a collaborator in therapy.

Advocacy Counseling: Applications at the Macrolevel

Feminist counseling subscribes to the notion that "the personal is political" (Good, Gilbert, & Scher, 1990). From a feminist perspective, counselors serve clients well when they advocate for change at the macrolevel as well as the microlevel. Working at the macrolevel includes working with, or on behalf of, clients to create awareness and change at the public level. This can include policy and legislative changes as well as the education of the public about an issue (Lewis et al., 2011). The counselor's role, particularly within the public domain of the Advocacy Competencies, is crucial to enacting lasting social change for clients.

When looking at the case of Eva, there are several ways in which counselors can advocate at the macrolevel on her behalf. Within the Advocacy Competencies, there are two domains that focus primarily on the macrolevel: the public information domain and the

social/political domain (Lewis et al., 2011). With Eva, a counselor can advocate on her behalf in the public information domain by helping to share information with the public about the causes and treatment of female addiction. Counselors can accomplish this by conducting workshops, speaking at public events, or providing trainings for local police officers. A counselor could also provide education to a treatment center around some of the unique needs of women in treatment, such as childcare and transportation. In addition, a counselor could facilitate trainings on domestic violence for the different groups often involved, such as police, members of the court system, social workers, and other interested members of the public. All too often, individuals who do not have a strong understanding of the cycle of violence are the ones who are a part of the system that women in violent relationship have to navigate. All of these educational opportunities connect to some of the barriers that Eva faced during her treatment and can help both Eva and other women.

From the social/political domain, a counselor can begin to work with local legislators on education funding for women who may have struggled with addiction, funding for treatment, and funding for childcare to help women who are in treatment. Counselors can research the training of current addiction providers to supply information about their comfort with advocacy and perhaps push for a change in treatment models and training. Counselors can also assist with larger community awareness projects that are aimed at ending violent relationships.

At the macrolevel, it would also be important for the counselor to involve Eva in some of this advocacy work. She could participate in the sharing of information in ways that she felt safe and comfortable. This will allow her to begin to build the skills to advocate for herself. Counselors must also begin to consider how they have typically practiced and be willing to make adjustments to their work to ensure that they have a lasting and global impact. The only way to truly begin to change the lives of clients is to broaden the reach of counselors. Change cannot occur for clients unless this work is included in each counselor's daily effort.

Future Directions

As counselors look to working with women, they certainly need to recognize some of the challenges that women face in society. Advocacy efforts that address the lack of access to resources, including education, childcare, and treatment services, will be key in meeting women's counseling needs. Counselors can work with legislators and other policymakers to effect widespread systemic changes that will improve the health and well-being of generations of women. Working to implement policies, such as the United Nation's Convention on the Elimination of All Forms of Discrimination Against Women, is one such step that advocates can take to indicate a commitment to eradicating discrimination against women.

In terms of clinical practice, it will be important for counselors working with women clients to be familiar with feminist theory. Counselors who are trained only in more traditional counseling theories are often left working with women from a perspective that does not allow for an experience that truly supports women in their process. Feminist theory naturally builds in advocacy work, helping to ensure that the advocacy competencies are infused in a clinical practice.

As part of a clinical practice, counselors should become well informed on some of the key issues that affect women, issues that have been discussed in this chapter—such as equity, violence, and substance use—and how all of these affect women differently than men. Finally, in practice, recognize that every woman has her own experience and remember to really listen to her story, being careful to leave assumptions aside and allow her to share how her

gender affects other dimensions of her identity. The most effective counseling with women comes with compassion, an equal and open environment, and a willingness to learn.

Resources

Community-Based Resources

Local college, university, and community women's centers

Provide referrals for women who experience sexual violence, abuse, harassment, and discrimination; want information about personal growth and healthy relationships; or have eating, body image, self-esteem, assertiveness, career, financial, or legal issues.

Local Junior League affiliate

www.ajli.org; 800-955-3248

An educational and charitable organization of women committed to promoting voluntarism, developing the potential of women, and improving communities through the effective action and leadership of trained volunteers.

National Organizations

The American Association of University Women

http://www.aauw.org/

A nonprofit and nonpartisan organization whose mission is to empower women and girls through advocacy, education, philanthropy, and research on educational, social, economic, and political issues.

Equal Rights Advocates

http://www.equalrights.org/; 800-839-4372

A nonprofit legal organization that works to eliminate gender discrimination and is dedicated to protecting and expanding economic and educational access and opportunities for women and girls until equality is secured for all.

The National Council of Women's Organizations

http://www.womensorganizations.org/; 202-293-4505

A nonprofit and nonpartisan coalition working to address issues of concern to women, including family and work, economic equity, education, affirmative action, older women, corporate accountability, women and technology, reproductive freedom, women's health, younger women, and global progress for women's equality.

The National Organization for Women

http://now.org/; 202-628-8669

The largest organization of feminist activists whose goals include taking action to bring about equality for all women; working to eliminate discrimination and harassment in the workplace, schools, the justice system, and all other sectors of society; securing reproductive rights for all women; ending all forms of violence against women; eradicating racism, sexism and homophobia; and promoting equality and justice in our society.

References

Alhabib, S., Nur, U., & Jones, R. (2010). Domestic violence against women: Systemic review of prevalence studies. *Journal of Family Violence, 25,* 369–382.

Allan, E. J. (2011). Women's status in higher education: Equity matters. *ASHE Higher Education Report, 37*, 1–125. doi: 10.1002/aehe.3701

American Psychological Association. (2007). Guidelines for psychological practice with girls and women. *American Psychologist, 62,* 949–979.

Beckwith, L., Rozga, A., & Sigman, M. (2002). Maternal sensitivity and attachment in atypical groups. *Advances in Child Development and Behaviour, 30*, 231–274.

Berdahl, J. (2007). The sexual harassment of uppity women. *Journal of Applied Psychology, 92*, 425–437.

Briggs, C. A., & Pepperell, J. L. (2009). *Women, girls, and addiction: Celebrating the feminine in counseling treatment and recovery*. New York, NY: Routledge.

Brown, L. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*, 464–471.

Caplan, P. J., & Cosgrove, L. (Eds.). (2004). *Bias in psychiatric diagnosis.* Northvale, NJ: Aronson.

Cohen, P. N., & Huffman, M. L. (2003). Occupational segregation and the devaluation of women's work across U.S. labor markets. *Social Forces, 81*, 881–908.

Dick, P., & Nadin, S. (2006). Reproducing gender inequalities? A critique of realist assumptions underpinning personnel selection research and practice. *Journal of Occupational and Organizational Psychology, 79*, 481–498.

Dimen, M. (2003). *Sexuality, intimacy, power*. Hillsdale, NJ: Analytic Press.

England, P. (2006). Toward gender equality: Progress and bottle-necks. In F. D. Blau, M. B. Brinton, & D. B. Grusky (Eds.), *The declining significance of gender?* (pp. 245–264). New York, NY: Russell Sage.

Equal Pay Act of 1963, Pub. L. No. 88-38, 77 Stat. 56.

Evans, P. (2010). *The verbally abusive relationship: How to recognize it and how to respond.* Avon, MA: Adams Media Corporation.

Fillmore, C., & Dell, C. (2001). *Prairie women, violence and self-harm.* Winnipeg, Canada: Elizabeth Fry Society of Manitoba.

Good, G. E., Gilbert, L. A., & Scher, M. (1990). Gender aware therapy: A synthesis of feminist therapy and knowledge about gender. *Journal of Counseling & Development, 68*, 376–380.

Greenfield, S. F. (2002). Women and alcohol use disorders. *Harvard Review of Psychiatry, 10*, 76–85.

Hartmann, H. (2004). Towards a definition of patriarchy. In L. Heldke & P. O'Connor (Eds.), *Oppression, privilege, & resistance: Theoretical perspectives on racism, sexism, and heterosexism* (pp. 143–163). New York, NY: McGraw-Hill.

Heilman, M., Wallen, A., Fuchs, D., & Tamkins, M. (2004). Penalties for success: Reactions to women who succeed at male gender-typed tasks. *Journal of Applied Psychology, 89*, 416–427.

Jordan, J., Kaplan, A., Miller, J. B., Stiver, I., & Surrey, J. (1991). *Women's growth in connection*. New York, NY: Guilford Press.

Keltner, D., Gruenfeld, D. H., & Anderson, C. (2003). Power, approach, and inhibition. *Psychological Review, 110*, 265–284.

Lewis, J., Arnold, M. S., House, R., & Toporek, R. (2003). *Advocacy competencies*. Retrieved from http://www.counseling.org/docs/competencies/advocacy_competencies.pdf?sfvrsn=3.

Lewis, J., Ratts, M., Paladino, D., & Toporek, R. (2011). Social justice counseling and advocacy: Developing new leadership roles and competencies. *Journal for Social Action in Counseling and Psychology, 3*, 5–16.

Manning, J. E., & Shogan, C. J. (2012). *Women in the United States Congress: 1917–2012*. Washington, DC: Congressional Research Service.

Marginalize. (2013). In *Merriam-Webster's online dictionary*. Retrieved from http://www.merriam-webster.com/dictionary/marginalize

Maroda, K. (2004). A relational perspective on women and power. *Psychoanalytic Psychology, 21*, 428–435.

Maume, D. J., Jr. (1999). Occupational segregation and career mobility of White men and women. *Social Forces, 77*, 1433–1459. doi:10.2307/3005882

Maume, D. J., Jr. (2004). Wage discrimination over the life course: A comparison of explanations. *Social Problems, 51*, 505–527.

Nankervis, B. (2011). Gender inequities in university admission due to the differential validity of the SAT. *Journal of College Admission*, *213*, 24–30.

National Centre on Addiction and Substance Use at Columbia University. (2006). *Women under the influence.* Baltimore, MD: John Hopkins University Press.

National Committee on Pay Equity. (2012). *The wage gap over time: In real dollars, women see a continuing gap*. Retrieved from http://www.pay-equity.org/info-time.html

Prah, P. M. (2011). Domestic violence: Do teenagers need more protection? In *Issues for debate in family violence: Selections from CQ Researcher* (pp. 35–57). Thousand Oaks, CA: Sage.

Ramdas, K. N., & Janus, K. K. (2011). Ratifying women's rights. *Policy Review, 169*, 29–38.

Ratts, M. J., Toporek, R. L., & Lewis, J. A. (Eds.). (2010). *ACA Advocacy Competencies: A social justice framework for counselors*. Alexandria, VA: American Counseling Association.

Reich, S. M., Pinkard, T., & Davidson, H. (2008). Including history in the study of psychological and political power. *Journal of Community Psychology, 36*, 173–186.

Rudman, L., & Phelan, J. (2010). The effect of priming gender roles on women's implicit gender beliefs and career aspirations. *Social Psychology, 41*, 192–202.

Shapiro, M., Ingols, C., & Blake-Beard, S. (2008). Confronting career double binds: Implications for women, organizations, and career practitioners. *Journal of Career Development, 34*, 309–333.

Sheffield, C. J. (2004). Sexual terrorism: The social control of women. In L. Heldke & P. O'Connor (Eds.), *Oppression, privilege, & resistance: Theoretical perspectives on racism, sexism, and heterosexism* (pp. 164–182). New York, NY: McGraw-Hill.

Stainback, K., Ratliff, T. N., & Roscigno, V. J. (2011). The context of workplace sex discrimination: Sex composition, workplace culture, and relative power. *Social Forces, 89*, 1165–1188.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M., & Nadal, K. L. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286.

United Nations. (1979). *Convention on the elimination of all forms of discrimination against women*. Retrieved from http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

United States. (1965). *1965 handbook on women workers*. Washington, DC: U.S. Department of Labor, Wage and Labor Standards Administration, Women's Bureau.

U.S. Department of Education. (2012). *Title IX and sex discrimination*. Retrieved from http://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html

Zimmerman, M. A. (2000). Empowerment theory: Psychological, organizational, and community levels of analysis. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 43–63). New York, NY: Kluwer Academic/Plenum.

Chapter 18

A Social Justice Perspective on Counseling and Poverty

Rebecca Reed and Laura Smith

Many Americans are raised with the myth of the "American Dream," the idea that those who work hard will inevitably achieve prosperity. Although this narrative motivates many Americans toward great accomplishments, it also perpetuates a more harmful myth that those who do not reach prosperity must be "dependent, defective, and delinquent" (Iceland, 2006, p. 12) and, therefore, possibly undeserving of public support. In turn, this view promotes indifference to the institutional barriers that can trap people in a cycle of poverty. Mental health professionals are not immune to the unconscious harboring of views such as these, and those who seek to treat poor clients effectively must overcome their biases and acknowledge the history, current lived experiences, and circumstances of the American poor.

A Brief History: Being Poor in America

The contemporary sociocultural configuration of poverty in America has roots in economic changes that began in the 19th century. As American society became more industrialized, economic production shifted from the home to the factory, and workers left their farms for jobs in cities (Iceland, 2006). Although many privileged Americans continued to treat poverty as punishment for deficient personal characteristics, growing numbers have begun to recognize poverty as an institutional and societal ill.

During the Great Depression, a large group of people, previously untouched by poverty, joined the ranks of America's poor. The administration of President Franklin Roosevelt enacted the New Deal to help feed and clothe struggling Americans, but it could not prevent the feelings of shame, isolation, and self-blame caused by the experience of poverty. Many suffering Americans abandoned their families; in their desperation, some even committed suicide. Despite the support for poverty offered in the 1930s, the economic boom that was initiated by World War II derailed the government's focus on the topic. Because most poor people were not part of major political interest groups and held limited (if any) political power, the government was not pressured to take on their causes (Patterson, 2000).

Herzog (1969) described the characteristics attributed to people living in poverty: children out of wedlock, lack of motivation, and inability to believe that their children could achieve academically. In the 1960s, parents living in poverty wanted their children to

achieve, yet neither parents nor the general public believed it was possible. These false expectations were reflective of the societal views that permeated the country and set the foundation of public policies. During these years, antipoverty and welfare programs were created with the assumptions that people living in poverty did not have aspirations of their own, disregarded hard work, and lacked self-respect (Newman, 1969). Sociologist Deborah Newman (1969) wrote that in order to create successful programming, the creators of policies need to disregard these negative assumptions.

Between the 1970s and the 2000s, the inequality of wealth distribution in the United States increased dramatically. The most affluent Americans began exponentially increasing their wealth as the net worth of people at other economic positions remained stagnant or fell (Collins & Yeskel, 2005), enabling an increase in high-end spending and an ability to garner power in the political system. In addition, more and more people joined the ranks of those living in poverty, including many who contradicted common stereotypes of "welfare poor." People with disabilities, the elderly, and mothers with small children were no longer the only people affected by poverty. Increasingly, many able-bodied working adults found that they could not earn wages that would lift their families above the poverty line (Patterson, 2000).

In August 2005, poverty was featured front and center within American dialogue in the aftermath of Hurricane Katrina's direct hit on the Mississippi Delta. As the media captured the impact of the disaster on those living in poverty, middle-class people across the country found themselves shocked by the images of inadequate housing, transportation, health care, and employment that characterized a major American city (although such conditions had existed for decades; Caldwell, 2009). Without a disaster like Hurricane Katrina to keep problems related to poverty in the headlines, they seem to have dropped from the national radar screen.

Current Experiences

To determine the percentage of Americans living in poverty, the U.S. Department of Commerce (2012) calculated a poverty rate based upon family income and poverty threshold levels (a numerical combination of family size and age of members). The *2012 Current Population Survey Annual Social and Economic Supplement* (DeNavas-Walt, Proctor, & Smith, 2012) revealed the following data about people living in the United States in 2011:

- 15% of people (46.2 million) lived in poverty.
- Among racial-ethnic groups, there were higher percentages of people of color living in poverty: 9.8% of non-Hispanic Whites lived in poverty compared with 27.6% of Blacks, 12.3% of Asians, and 25.3% of Hispanics.
- 15.7% of Americans had no health insurance.
- 28.8% of adults (4.3 million) with a disability lived in poverty (as compared with 12.5% of adults without a disability).
- 15.5% of adult women lived in poverty (compared with 11.8% of men).
- 21.9% of children lived in poverty.

Poverty affects the everyday social experiences of the poor, in ways that go beyond statistics: laws, policies, and general attitudes regarding poverty result in the social exclusion of poor families (Smith, 2013b). Wealthy people[1] tend to hold most of the power in our system of government, and they have regulated the ways that people living in pov-

[1]The terms *wealthy*, *upper class*, and *owning class* are used interchangeably throughout this chapter. These terms refer to people at the highest levels of the social class hierarchy, those who maintain higher amounts of financial, political, and cultural power relative to those in other social classes (see Smith, 2010).

erty should be treated in comparison to other social classes. Through these formal and informal regulations, many poor people have been made to feel like trespassers in their own cities. For example, civic ordinances have increasingly criminalized the homeless by creating laws forbidding sitting, sleeping, or eating in public places. Consequently, law enforcement officials have forced homeless people out of public spaces, causing people to lose their belongings and even their medication (National Law Center on Homelessness and Poverty and The National Coalition for the Homeless, 2009). By contrast, it would be hard to even imagine a middle-class person being forced to leave a public space for sitting down (Smith, 2013b). This is just one example of many that are presented in this chapter to show how people living in poverty can be excluded and made to feel like "the other" as a result of their class status.

Key Multicultural Concepts

Classism

Classism has been defined as the oppression of the poor through discriminatory "practices, attitudes, assumptions, behaviors, and institutional rule" (Bullock, 1995, p. 119). This concept expands to include *institutional classism* (institutions and their policies neglecting and limiting the poor) and *interpersonal classism* (biases and discriminatory behaviors; Lott & Bullock, 2007). As such, *classism* is a complex term that encompasses not only the day-to-day subtle and outward denigration of the poor but also includes a broader spectrum that is embedded in American structures, institutions, and policies. As the wealthy gain additional power in society, the poor are increasingly treated as "less than" on both individual and systemic levels.

Social Class Privilege

McIntosh (1988) defined *privilege* as unmerited advantages and powers held by a dominant social group. In the case of social class privilege, middle-class and wealthy people hold dominant positions in society and tacitly represent the parameters of normalcy. The French sociologist Pierre Bourdieu (1984) wrote extensively on this topic, explaining that people in higher social classes classify notions of good and bad for the rest of society. People in less powerful social classes often attempt to conform to these styles and practices in an effort to reproduce the prestige and influence of the wealthy. The perspectives, customs, and images that characterize an affluent lifestyle are, of course, displayed before the poor as well, yet the poor are the least able to reproduce them, leaving them utterly unable to participate in the lifestyle that the rest of society seems to value. Moreover, people in poverty can suffer harm from the pervasive sociocultural messages they receive regarding their inferiority and their outsider status. (Bourdieu referred to this as *symbolic violence* against marginalized groups.)

Isolation and Exclusion

People living in poverty can be socially excluded by the laws, urban planning, and social norms established by people with social class power (who tend to be wealthier people). Although the U.S. governance system can be described as a participatory democracy, poor people are rarely consulted or included in making any of the decisions that directly impact their lives. Instead, people in other walks of life decide what the needs of poor families are, they create policies that regulate the lives of the poor, and they tell the poor how those policies will be enacted. People living in poverty are excluded from many mainstream re-

sources that middle-class people take for granted, such as housing, health care, education, the Internet, and transportation. Other examples of their exclusion are quite specific and concrete. For example, throughout the United States, many cities have adopted ordinances that create invisible boundaries between the poor and people in the middle and upper classes. These barriers place restrictions on the ways that homeless people may use public property by prohibiting such actions as sharing food or lying down —and in some cases, the ordinances force the poor out of public spaces entirely. Others who associate with the poor can also face sanctions: When Orlando, Florida, adopted such restrictions, a person was arrested for sharing food with a homeless individual (National Law Center on Homelessness and Poverty and The National Coalition for the Homeless, 2009).

Key Characteristics of Life in Poverty

Experiences of Classist Microaggressions

Microaggressions are brief and common messages of hate toward people in a specific minority social group. They occur along three dimensions: microassaults (intentionally harmful messages); microinsults (indirectly harmful messages); and microinvalidations (messages that disregard a person's feelings and reality; Sue et al., 2007). Smith and Redington (2010) outlined how these three levels of microaggressions can be specifically classist. For example, the term *white trash* is a classist microaggression used in everyday language and on television. Microinsults occur when a person gives a poor friend "better clothing." Finally, microinvalidations include the media's focus on middle- and upper-class lifestyles in ways that convey to viewers a world that does not include anyone of interest who is poor (Smith & Redington, 2010), an "invisibilizing" of poor people's very existence. These messages are often painfully clear to their recipients and can give rise to the distress that causes people to seek therapy.

Poverty as a Pathogen

Ali and Lees (2013) wrote that disadvantaged people's problems often stem from outside forces; in other words, they are not solely psychological in nature. In fact, distress that originates with the experience of being poor can underlie a client's presenting problem (Smith, Chambers, & Bratini, 2009). People's oppressive experiences with poverty can go on to become pathogenic (Belle & Doucet, 2003), giving rise to research findings representing the link between poverty and psychological distress (e.g., Cutrona, Wallace, & Wesner, 2006; Evans & English, 2002). Therefore, when working with poor people, counselors are "working with people whose psychological distress—as well as any interventions offered to them—must be understood within the context of their experiences of oppression" (Smith & Romero, 2010, p. 13).

Lack of Poverty-Related Training Among Practitioners

Poor people are among the diverse marginalized social groups with a history of being underserved by health professionals. For example, boys from poor urban neighborhoods are often not diagnosed properly (Caldwell, 2009), resulting in overdiagnoses of such disorders as attention-deficit/hyperactivity disorder (Tucker & Dixon, 2009). This is not surprising; most clinicians have not been trained to work with poor people, and limited knowledge exists with regard to relevant, appropriate counseling approaches for use in the context of poverty (Caldwell, 2009). What accounts for this state of affairs? At least part of the answer

lies in counseling theories' origins in middle- and owning-class culture. Counseling theories were largely created by middle- and owning-class theorists, who unintentionally designed them around their own experiences of life. As such, mainstream counseling theory provides only scattered support for the training of clinicians to engage productively with poor clients (Lott, 2002; Smith, 2005), leaving poor clients underserved by the profession.

Barriers to Entering Therapy

People living in poverty face obstacles to treatment that include both specific and bias-related barriers. Physical access to therapy can be a challenge for the poor, given that they often do not have flexible work schedules and frequently cannot afford even sliding-scale clinics' prices; they would have to give up hourly wages to fit into counselors' schedules (Appio, Chambers, & Mao, 2013; Caldwell, 2009; Goodman, Pugach, Sklonik, & Smith, 2013). Moreover, because the poor are frequently excluded from the full benefit of professional mental health practice, they may appropriately question whether counselors are open to working with them (Appio et al., 2013).

Systemic Barriers Facing the Poor: Manifestations of Classism

> Financial hardships are exacerbated by institutional practices and policies that create barriers to necessary resources and prevent equitable participation in work-place decision making and political processes for poor people. This is fully apparent in the educational, legal, and health disparities those living in poverty face. (Appio et al., 2013, p. 153)

The systemic barriers that face poor families stem from the social, cultural, and institutional practices that perpetuate the exclusion of the poor from opportunities and experiences that other take for granted. As the examples below illustrate, they stem from the operations of classism.

Negative Societal Perceptions of the Poor

Social science research has demonstrated the negative perceptions that exist regarding people living in poverty. Cozzarelli, Wilkinson, and Tagler's (2001) research participants described the poor as *lazy, stupid, dirty*, and *immoral*. Similarly, Smith, Allen, and Bowen (2010) found that their participants perceived the poor to be criminals and civic offenders more often than people of other classes. Working from a neuroscientific standpoint, Fiske (2007) used magnetic resonance imaging to measure participants' brain reactions to people living in poverty and found that the brain activity of participants who were shown images of the poor reflected disgust and avoidance. In fact, in many cases, when participants viewed a homeless person, their brains' normal reaction to the sight of another human was not even activated. These attitudes toward the poor are reflected in the ways that middle-class people formulate policies, structure institutions, and interact (or do not interact) with the poor.

Education

Social critic bell hooks observed (1994) that "nowhere is there a more intense silence about the reality of class difference than in educational settings" (p. 177). The stratification of the American education system leaves poor children and adolescents without the educational resource and opportunities of their wealthier counterparts, even though education is often promoted as the pathway out of poverty. Teachers tend to receive lower salaries when they work in poor

communities, and poor students have fewer computers, books, classes, and extracurricular activities (Kozol, 2005). Moreover, poor communities have fewer parks, resources, and shopping and are more often near garbage dumps, facilities that work with toxic waste, and other "dirty industries" that can contribute to health problems (Gibbs & Melvin, 2008). All of these factors likely contribute to the high teacher turnover rates in poor neighborhoods (Ingersoll, 2004).

Health Care

Medicaid and the State Children's Health Insurance Program offer health care to most poor children. Poor adults, however, are often left with no coverage. Even though emergency rooms are available to all, they are often overcrowded and primarily useful only when health problems have become urgent; preventive care is difficult to obtain without insurance (Weil, 2007). For this reason the poor are less likely to have cancer screenings such as mammograms or colonoscopies (Schootman, Jeffe, Baker, & Walker, 2006), resulting in the escalation of illnesses that are treatable in early stages.

Judicial Inequities

Although limited federal and state funds are set aside for legal counsel, budget cuts have left many poor people without basic legal representation (Johnson, 2012). As Jim Sandman, president of the National Legal Service Corporation, observed:

> We're talking about access to justice here. Access to justice is a fundamental American value. We have a great legal system in the United States, but it's built on the premise that you have a lawyer. And if you don't have a lawyer, the system often doesn't work for you. (Johnson, 2012)

For instance, although all people accused of crimes are eligible for a defense lawyer, this does not include civil disputes such as evictions, resulting in unnecessary evictions of poor citizens who could not afford to hire the lawyers who could have saved their homes (Johnson, 2012). Unlike many forms of classism, judicial inequities seem apparent to many in U.S. society: In 1999, the American Bar Association found that almost half of the American public believed that the law disadvantages people of color and the poor, and 90% of those polled in that survey believed that the wealthy and big businesses have advantages in the court system (Greenhouse, 1999).

Segregated Communities

The poor and the wealthy most often live in separate and unequal communities (Dwyer, 2010). Many poor people live in neighborhoods without basic resources (i.e., dependable public transportation, health care facilities, quality housing, and consistent police protection) and in fear of community violence. Under these conditions, people may be more vulnerable to depression when negative events occur (e.g., losing a job). Evans and English (2002) have explained that physical and psychosocial stressors in poor communities lead to psychological and psychophysiological stressors. In addition, poor communities are more likely to have unhealthy food selections and may be overpopulated with fast food outlets, which contributes to obesity and other health concerns (Block, Scribner, & DeSalvo, 2004).

The Absence of a Living Wage

Shipler (2004) wrote extensively about the experiences of the working poor. He depicted the process by which the employment circumstances of the poor contribute to the ongoing challenges and difficulties that poor workers face.

> [The mother] . . . seemed doomed to a career of low pay without the chance of significant promotion, no matter how important her jobs might be to the country's well-being. At her level in the economy, . . . hard work alone would not pay off. But unless employers can and will pay a good deal more for society's essential labor, those working hard at the edge of poverty will stay there. (pp. 45–46)

And what is a low-wage workers' "level of the economy"? Our federal minimum wage of $7.25 per hour in 2013 (United States Department of Labor, n.d.) does not allow for even small families to climb out of poverty. From an ethical standpoint, these insufficient wages may also not be acceptable payment for work that our nation depends upon every day. People who work at minimum wage jobs take care of children, pick up the garbage, and deliver food for the rest of us—yet a full-time position at this level cannot lift these families above the poverty line (Smith, 2013a).

Classism and Mental Health Practice

The historical, political, and social marginalization of people living in poverty gives rise to struggles that are largely unknown to middle-class individuals, a fact that is in turn associated with the lack of adequate training for counselors who work with poor people (Bullock, 2004; Smith, 2005; Smith, Li, Dykema, Hamlet, & Shellman, 2013). Because counselors often have no personal or professional experience with poverty, they may encounter a poor person for the first time in session (Smith et al., 2013) and struggle to comprehend the unpredictable living conditions and general needs of the poor (Bullock, 2004). Unprepared to assimilate the complex challenges of poverty, these clinicians may also not appreciate how their own placement in society affects the ways they interact with poor clients. All of us have a part in the interplay of social class dynamics in society, and without conscious understanding of these structures, our clinical sessions with clients from marginalized social groups may reproduce their experiences of oppression.

Along these lines, Dougall and Schwartz (2011) found that mental health clinicians' professional judgments were affected by their clients' class status. More pathology was attributed to poor clients—and at the same time, their issues were considered less significant than those of their wealthy counterparts. In another study, counselors who held stronger just-world beliefs (i.e., those who believed that people tend to get what they deserve in life) anticipated that sessions with poor clients would be less comfortable and less meaningful than sessions with people of other social class groups. These counselors were also more likely to view poor clients as having more symptoms and being lower functioning (Smith, Mao, Perkins, & Ampuero, 2011). In addition, Smith et al. (2013) interviewed clinicians who work in poor communities. Before they had begun their work with poor clients, some of these clinicians reported that they had avoided people in poverty, held negative stereotypes about the poor, and believed that poverty and mental illness were linked. They also reported that these views were changed by their experiences with poor people themselves:

> Initially and before I came here, working with this type of patient, my outlook and my prejudice was that they are low-income, uneducated . . . and junkies, addicts. Working with them now, I realize that they are people. They have family. They have issues. They weren't *born* into addiction. (Smith et al., 2013, p. 148)

Clinicians can improve their competence by reflecting on their own social class group membership, becoming aware of their biases, obtaining information on the psychosocial impact of poverty, and learning effective intervention strategies (Smith et al., 2013).

From a more structural perspective, clinicians must also expand the multicultural and social justice skills that allow them to challenge traditional therapeutic methods (Smith et al., 2009). One consideration is the capacity to address structural factors of oppression within counseling practice. Balmforth (2009) found that working-class people viewed middle-class counselors as lacking an understanding of their life experiences, their access to opportunities, and the connection between money and life choices. Correspondingly, mental health professionals should actively seek to increase their understanding of social class experiences, including from the perspectives of poor and working-class people themselves.

A natural home for this skill development is within the multicultural training experiences in which most counselors-in-training participate. Formal and informing training would enable counselors to increase their awareness of class-related biases and stereotypes, which could help counselors avoid enacting such preconceptions within the counseling dyad. It would give counselors an understanding of the breadth of experiences that people living in poverty bring into session and uncover ways to address their life situations in a clear and supportive manner. In addition, counselors may need to seek outside knowledge to plan for interventions and practices within specific neighborhoods. Because the daily realities of communities can be quite different from each other, counselors should informally train themselves to use city and state websites and other Internet searches to obtain the most accurate information (Smith, 2013a).

Before moving to a case example, it will be helpful to bring a theorist from outside the counseling profession into the discussion: the revolutionary Brazilian educator, Paulo Freire. In his *Pedagogy of the Oppressed* (1970), Freire outlined the concept of *false generosity:* the well-intentioned help from the privileged that is offered without any acknowledgement of the power differentials and dynamics that exist between the two people. In such encounters, "the extant power hierarchy remains unchallenged, and the 'helpful' interaction ultimately re-enacts power-over dynamics between a middle-class counselor and a poor client" (Smith & Romero, 2010, p. 13). Social class power differentials between poor and middle-class clients are active and evident, whether they are addressed or not. Appio et al. (2013) found that poor clients *want* to speak about these social class issues and differences; however, they often wait for the counselor to raise it. Without evidence of a counselor's ability to engage in this dialogue, clients may be apprehensive that they will not be understood by the counselor or feel ashamed to fully disclose their life experiences. This experience of invalidation can reproduce the isolation and discrimination that poor clients face in their daily lives (Appio et al., 2013).

Personal Voices
The Story of Stacy

Stacey was a 35-year-old African American woman living in a small one-bedroom apartment in a poor urban community within a large city in the northeastern United States. She lived with her aunt, her 12-year-old nephew, and 14-year-old son, Dylan. Her aunt, who had a physical disability, had limited mobility and was unable to work. Even though Stacey supported the household financially, she herself had had trouble maintaining steady employment because her asthma had resulted in periodic hospitalizations. Recently, Stacey had a windfall of good fortune: She was able to secure a job driving the night shift for the crosstown bus in Harlem. Even though she was thrilled to have this job, she realized that the job was dangerous and was anxious about putting her life in danger when she had three people at home who depended on her. Nevertheless, the night shift paid more than the daytime shifts, so Stacey accepted it.

Stacey's mother also had chronic asthma, and when Stacey was 6 years old, her mother unexpectedly died from an asthma attack. After 911 was called, it took more than an hour for the ambulance to arrive at the apartment, which Stacey reported was typical in her neighborhood. After her mother's death, Stacey and her grandmother lost the apartment and moved into a shelter for a short period of time. In the aftermath of these events, Stacey's grades began to drop, and she remembered that it had been difficult for her to concentrate in school. When she was 19, she found that she was undercredited for graduation and became embarrassed that she would soon be 20 years old and still in high school. At about this time, she became pregnant and dropped out of school. Stacey later regretted that decision, and she returned to school and earned her GED a few years ago. She did not know many people who had attended college, but she frequently daydreamed about what it would be like.

A few weeks ago, Stacey went through Dylan's backpack and found three notes from the principal asking her to contact the school. (Her phone had been shut off for the past few months for lack of funds.) The next day, she went straight to the school from her night shift. She waited for 2 hours to see the principal, because she had not had access to a phone to make an appointment. Upon meeting her, the principal expressed his annoyance with her for not being reachable by phone and told her that she had missed a recent parent–teacher conference. She was also informed about concerns that teachers had expressed about Dylan, including his skipping classes and turning in handwritten assignments that were supposed to be typed. In addition, the school had decided to evaluate him for special education classes. The principal told Stacey that he did not understand why she had not been monitoring Dylan's attendance and performance on the school's online system, which had been set up for parents to track their students from home.

The principal offered no explanation of what it meant to evaluate Dylan for special education classes, and Stacey remembered that kids in special education were always put in a separate part of the building. Dylan had previously been a great student, and Stacey became concerned about what he was doing when he was skipping school: Could it be that he was getting mixed up in gangs? After talking to Dylan, she found out that he had been embarrassed to tell his teacher that he had no computer at home to do his assignments, and he had started skipping school when some kids made fun of him for wearing old clothing. Dylan expressed his frustration that, with four people in their one-bedroom apartment, there was nowhere to sit and do his homework.

Stacey went to counseling because she felt helpless. She loved her family but reported that she was not able to provide the kind of life that she wanted them to have. She realized that she should visit her nephew's school and was afraid of what she might hear. She had been having trouble sleeping but was thinking of taking an additional part-time job so that she could try to buy a computer for Dylan and her nephew.

Individual Counseling: Applications at the Microlevel

Taking a social justice perspective, we address Stacey's individual situation in the context of the environmental factors, including experiences of oppression, that have shaped her life. The account of Stacey's life makes clear that she had been isolated and excluded in many ways, including her lack of access to the Internet, technology, and education. Although these experiences were painful and largely out of Stacey's control, the principal reflexively blamed her for her circumstances, an example of the classist microaggressions that appear in the daily lives of poor people. As a result, Stacey felt hopeless, shamed, and

isolated. Tragically, she internalized these blaming narratives so deeply that she held herself responsible for all the obstacles that faced her family.

The counselor must apply multicultural training toward consideration of the many identities enacted in the office (i.e., those deriving from both Stacey's and the counselor's own racial, gender, sexual, and other group memberships). With regard to social class, the counselor must establish with Stacey a time and payment schedule that work for her. The counselor may also consider adapting a home-visit model with Stacey to address possible issues of scheduling and transportation. Most often associated with social workers, home visits have been associated with positive results among practitioners who work with children and families (Allen & Tracy, 2004; Cortes, 2004; Yorgason, McWey, & Felts, 2005). However, Stacey may not necessarily welcome counseling from her home, so such an intervention would require discussion with her.

Additionally, the counselor should not assume that a conventional psychotherapeutic stance is beneficial for Stacey. Because Stacey's interactions with middle-class people may have conveyed exclusionary messages, she may be wary that a professional counselor will repeat these experiences. The counselor must understand the power dynamic in the room and ideally should have already examined his or her own personal biases and stereotypes about poor people before working with her. This self-examination should continue throughout the course of therapy. The counselor should learn about the daily life experiences of the poor and how community organizations and governmental programs address those issues. At the same time, the counselor must remember that Stacey is coming to therapy not only for a list of resources, but also to explore the feelings and concerns that derive from her life experiences.

This counseling work could be carried out within many different theoretical orientations. Smith (2010) and Appio et al. (2013) have suggested the use of relational-cultural therapy when working with poor clients; this form of therapy addresses feelings of powerlessness, shame, isolation, and fear through mutuality and empathy. When clients are able to work with counselors within a dyad that strives toward power-sharing, they are able to grow and feel a sense of human connection within themselves and with others (Jordan, 2001). In relational-cultural therapy, the counselor is not the only person helping, and the client is not the only person developing; therapy is seen as a *mutual* developmental process.

> When clients are able to see and experience the effect that they have had on the counselor, a sense of mutual connection and empathy is initiated through which people can heal from sadness, shame, and self blame that are the corollaries of isolation and disconnection. (Smith, 2010, p. 106)

Through relational-cultural therapy approaches, both the counselor and the client contribute knowledge and strength to the counseling relationship.

If Stacey's counselor used this therapy approach, he or she would help Stacy recognize her strengths as well as the wisdom and knowledge that she brings to the therapeutic relationship. The counselor might use therapeutic authenticity (developed through understanding and care) to support Stacy in addressing the negative feelings she experiences (Jordan, 2001). Through mutual understanding, empathy, and care, Stacey and her counselor can work to establish a greater sense of connection (Miller, 1997), which can mitigate her feelings of isolation and shame.

Advocacy Counseling: Applications at the Macrolevel

The work of social justice-minded clinicians extends outside the individual client relationships. Clinicians who hold relatively more power and privilege than their mar-

ginalized clients have an obligation to use their power to advocate for social equity. *Community praxis* (Smith, 2010; taken from Freire's term *praxis*) has been proposed as an intervention that actually incorporates advocacy at a societal level. Participatory action research projects can serve as a vehicle for community praxis. In this approach, community members and facilitators join together to unpack a body of knowledge salient to the community members. Through collaboration, the group chooses a community problem to study and address and then works as a team to research and take action against the problem (Kidd & Kral, 2005). Although participatory action research is most often thought of solely as an approach to the creation of knowledge, its "conceptual foundations represent a general model for . . . mutuality and collaboration. [Participatory action research] inherently subverts some of the damaging consequences of poverty and classism such as social exclusion and voicelessness" (Smith & Romero, 2010, p. 13). Through participatory action research or other community praxis activities, "practitioners create partnerships with groups of community members or representatives in a process of reflection and learning in which all grow and all participate in the creation of socially just action" (Smith, 2010, p. 105). Working alongside community members to fight for justice is one of the most profound and significant things a counselor can do. It not only supports individual people in discovering their own power to act, it addresses systematic barriers faced by the community of people. Counselors themselves will be changed by the experience through a deeper knowledge of themselves and an enhanced awareness of their own capacity to pursue justice (Smith & Romero, 2010).

Community praxis is also represented by Ali and Lees's (2013) anti-oppression advocacy approach to facilitating therapeutic change and economic justice. In anti-oppression advocacy, clinicians advocate for poor clients, who are also supported in taking action to initiate social change. This approach calls for counselors to partner with community-based organizations and be trained within a social justice framework. Through social justice advocacy, the counselor acknowledges clients' experiences of being poor and how that plays out in the counseling relationship. This forges a stronger dynamic between the counselor and client and allows for effective change. In addition, clients and counselors are encouraged to join advocacy groups, so the client feels empowered and the counselor is able to support the clients' experiences outside of the typical session. Anti-oppression advocacy thereby allows clients who are accustomed to being silenced to engage in dialogue, amplify their voices, and act as agents of change (Ali & Lees, 2013).

Future Directions

Research

It is an ongoing challenge for counselors to support diverse clients who have been historically underrepresented in counseling literature. Most counseling approaches apply primarily to clients who fit certain parameters, which usually do not correspond to poor people (Caldwell, 2009). At the most basic level, the most effective way to conduct research with poor communities may simply be to ask the poor about their needs. For example, through their interviews with poor men and women, Appio et al. (2013) derived key elements impacting the experiences of poor people in therapy, including the acknowledgement of class differences in the therapeutic relationship, feelings of shame and disconnection, and the yearning for counselors to understand how their life experiences have impacted their concerns. Such research could ultimately create best practices for working with the poor (Smith et al., 2013).

Training and Education

The counseling field's training programs have not extensively addressed poverty, not even in multicultural counseling training (Smith et al., 2011; Smith et al., 2013). Clinicians in training should learn about social class, recognize the strengths of those living in poverty, and learn culturally sound methods that incorporate the social and material needs of the poor (Appio et al., 2013). Training should address not only practical skills but also counselors' emotional reactions (e.g., feeling hopeless or overwhelmed) that can accompany an experience in a poor community. Smith et al. (2013) called for graduate training that expands to include poverty and class issues, a connection to resources to support the poor, and clinician and society education about poverty.

Clinical Supervision

Smith (2009) discussed the need for supervisory approaches that explicitly address issues of poverty within a social justice framework, and clinicians who work with poor clients also reported this need (Smith et al., 2013). Through supervision, counselors can process their own class-related assumptions and biases, analyze feelings of helplessness, examine feelings of humanitarian distress, formulate a social justice way of understanding clients, and advocate for flexibility in the methods used to support the client (Smith, 2009).

Conclusion

Sociocultural barriers have prevented people living in poverty from being fully included in society, which may be among the reasons a client comes to counseling. Counselors working in poor communities should recognize how experiences of poverty can contribute to psychological pain. When counselors work from a social justice framework, they create space for clients living in poverty to feel supported and respected. It is not a simple matter for many middle-class counselors to actively learn about personal biases and the lives of people they may know little about. However, a commitment to such personal learning may be a powerful tool in meeting the needs of clients living in poverty.

Resources

Books

hooks, b. (2000). *Where we stand*. New York, NY: Routledge.

Jenson, B. (2012). *Reading classes: On culture and classism in America*. New York, NY: ILR Press.

Keller, B. (2005). *Class matters*. New York, NY: Holt, Henry.

Leondar-Wright, B. (2005). *Class matters: Cross-class alliance building for middle-class activists.* British Columbia, Canada: New Society.

Lui, M., Robles, B, Leondar-Wright, B., Brewer, R., & Adamson, R. (2006). *The color of wealth*. New York, NY: News Press.

Newman, K., & Chen, V. T. (2007). *The missing class: Portraits of the near poor in America*. Boston, MA: Beacon Press.

Smith, L. (2010). *Psychology, poverty, and the end of social exclusion: Putting our practice to work*. New York, NY: Teachers College Press.

Websites

Class Action
http://www.classism.org/
National Coalition for the Homeless
http://www.nationalhomeless.org/
US.gov
http://www.usa.gov/index.shtml

References

Ali, A., & Lees, K. E. (2013). The therapist as advocate: Anti-oppression advocacy in psychological practice. *Journal of Clinical Psychology, 69*, 162–171.

Allen, S. F., & Tracy, E. M. (2004). Revitalizing the role of home visiting by school social workers. *Children & Schools*, *26*, 197–208.

Appio, L., Chambers, D. A., & Mao, S. (2013). Listening to the voices of the poor and disrupting the silence about class issues in psychotherapy. *Journal of Clinical Psychology, 69*, 152–161.

Balmforth, J. (2009). "The weight of class": Clients' experiences of how perceived differences in social class between counselor and client affect the therapeutic relationships. *British Journal of Guidance and Counseling*, *37*, 375–386. doi:10.1080/03069880902956942

Belle, D., & Doucet, J. (2003). Poverty, inequality and discrimination as sources of depression among women. *Psychology of Women Quarterly*, *27*, 101–113.

Block, J. P., Scribner, R. A., & DeSalvo, K. B. (2004). Fast food, race/ethnicity, and income: A geographic analysis. *American Journal of Preventative Medicine*, *27*, 211–217.

Bourdieu, P. (1984). *Distinction: A social critique of the judgment of taste*. Cambridge, MA: Harvard University Press.

Bullock, H. E. (1995). Class acts: Middle-class responses to the poor. In B. Lott & D. Maluso (Eds.), *The social psychology of interpersonal discrimination* (pp. 118–159). New York, NY: Guilford Press.

Bullock, H. E. (2004). Diagnosis of low-income women. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 115–120). Lanham, MD: Rowman & Littlefield.

Caldwell, L. D (2009). Counseling with the poor, underserved, and underrepresented. In C. M. Ellis & J. Carlson (Eds.), *Cross cultural awareness and social justice in counseling* (pp. 283–300). New York, NY: Routledge.

Collins, C., & Yeskel, F. (2005). *Economic apartheid in America: A primer on economic inequality and insecurity*. New York, NY: New Press.

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *Family Journal, 12*, 184–188.

Cozzarelli, C., Wilkinson, A. V., & Tagler, M. J. (2001). Attitudes toward the poor and attributions for poverty. *Journal of Social Issues*, *57*, 207–228.

Cutrona, C. E., Wallace, G., & Wesner, K. A. (2006). Neighborhood characteristics and depression: An examination of stress processes. *Current Directions in Psychological Science*, *15*, 188–192.

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2012). *Income, poverty and health insurance coverage in the United States* (Current Population Reports, P60-243). Retrieved from http://www.census.gov/prod/2012pubs/p60-243.pdf

Dougall, J. L., & Schwartz, R. C. (2011). The influence of client socioeconomic status on psychotherapists' attribution biases and countertransference reactions. *American Journal of Psychotherapy*, *65*, 249–265.

Dwyer, R. E. (2010). Poverty, prosperity, and place: The shape of class segregation in the age of extremes. *Social Problems*, *57*, 114–137.

Evans, G. W., & English, K. (2002). The environment of poverty: Multiple stressor exposure, psychophysiological stress, and socioemotional adjustment. *Child Development*, *73*, 1238–1248.

Fiske, S. T. (2007). On prejudice and the brain. *Daedalus*, *136*, 156–160.

Freire, P. (1970). *Pedagogy of the oppressed.* New York, NY: Continuum.

Gibbs, C. G., & Melvin, J. L. (2008). Structural disadvantages and concentration of environmental hazards in school areas: A research note. *Crime, Law and Social Change*, *49*, 315–328. doi: 10.1007/s10611-008-9104-x

Goodman, L. A., Pugach, M., Skolnik, A., & Smith, L. (2013). Poverty and mental health practice: Within and beyond the 50-minute hour. *Journal of Clinical Psychology*, *69*, 182–190.

Greenhouse, L. (1999, February 24). 47% in poll view legal system as unfair to poor and minorities. *The New York Times*. Retrieved from http://www.nytimes.com/1999/02/24/us/47-in-poll-view-legal-system-as-unfair-to-poor-and-minorities.html

Herzog, E. (1969). Perspectives of poverty 3: Facts and fictions about the poor. *Monthly Labor Review*, *92*, 42–49.

hooks, b. (1994). *Teaching to transgress.* New York, NY: Routledge.

Iceland, J. (2006). *Poverty in America: A handbook.* Berkeley: University of California Press.

Ingersoll, R. A. (2004). *Why do high poverty schools have difficulty staffing their classrooms with qualified teachers?* Retrieved from http://www.americanprogress.org/wp-content/uploads/kf/ingersoll-final.pdf

Johnson, C. (2012, June 15). Legal help for the poor in "state of crisis." *National Public Radio*. Retrieved from http://www.npr.org/2012/06/15/154925376/legal-help-for-the-poor-in-state-of-crisis

Jordan, J. V. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic, 65,* 92–103.

Kidd, S. A., & Kral, M. J. (2005). Practicing participatory action research. *Journal of Counseling Psychology*, *52*, 187–195. doi: 10.1037/0022-0167.52.2.187

Kozol, J. (2005). *Shame of the nation*. New York, NY: Crown.

Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist*, *57*, 100–110. doi: 10.1037//0003-066x.57.2.100

Lott, B., & Bullock, H. E. (2007). *Psychology and economic injustice.* Washington, DC: American Psychological Association.

McIntosh, P. (1988). *White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies* (Working Paper No. 189). Wellesley, MA: Wellesley Centers for Women.

Miller, J. B. (1997). *The healing connection*. Boston, MA: Beacon Press.

National Law Center on Homelessness and Poverty and The National Coalition for the Homeless. (2009). *Homes not handcuffs: The criminalization of homelessness in U.S. cities*. Retrieved from http://www.nationalhomeless.org/publications/crimreport/CrimzReport_2009.pdf

Newman, D. K. (1969). Perspectives on poverty 1: Changing attitudes about the poor. *Monthly Lab Review*, *32*, 32–36.

Patterson, J. (2000). *America's struggle against poverty in the twentieth century*. Boston, MA: Harvard University Press.
Schootman, M., Jeffe, D. B., Baker, E. A., & Walker, M. S. (2006). Effect of area poverty rate on cancer screening across U.S. communities. *Journal of Epidemiology and Community Health*, *60*, 202–207.
Shipler, D. K. (2004). *The working poor: Invisible in America*. New York, NY: Random House.
Smith, L. (2005). Psychotherapy, classism, and the poor. *American Psychologist*, 60, 687–696.
Smith, L. (2009). Enhancing training and practice in the context of poverty. *Training and Education in Professional Psychology*, *3*, 84–93.
Smith, L. (2010). *Psychology, poverty, and the end of social exclusion: Putting our practice to work*. New York, NY: Teachers College Press.
Smith, L. (2013a). Counseling and poverty. In D. W. Sue & D. Sue (Eds.), *Counseling the culturally diverse: Theory and practice* (pp. 517–526). Hoboken, NJ: John Wiley & Sons.
Smith, L. (2013b). So close and yet so far away: Social class, social exclusion, and mental health practice. *American Journal of Orthopsychiatry*, *83*, 11–16. doi.10.1111/ajop.12008
Smith, L., Allen, A., & Bowen, R. (2010). Expecting the worst: Exploring the associations between poverty and misbehavior. *Journal of Poverty*, *14*, 33–54.
Smith, L., Chambers, D., & Bratini, L. (2009). When oppression is the pathogen: The participatory development in socially just mental health practice. *American Journal of Orthopsychiatry*, *79*, 159–168.
Smith, L., Li, V., Dykema, S., Hamlet, D., & Shellman, A. (2013). "Honoring somebody that society doesn't honor": Therapists working in the context of poverty. *Journal of Clinical Psychology, 69*, 138–151.
Smith, L., Mao, S., Perkins, S., & Ampuero, M. (2011). The relationship of clients' social class to early therapeutic impressions. *Counselling Psychology Quarterly*, *24*, 15–27. doi: 10.1080/09515070.2011.558249
Smith, L., & Redington, R. (2010). Class dismissed: Making the case for the study of classist microaggressions. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestations, dynamics, and impact* (pp. 269–285). Hoboken, NJ: John Wiley & Sons.
Smith, L., & Romero, L. (2010). Psychological interventions in the context of poverty: Participatory action research as practice. *American Journal of Orthopsychiatry*, *80*, 12–25.
Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*, 271–286.
Tucker, C., & Dixon, A. L (2009). Low-income African American male youth with ADHD symptoms in the United States: Recommendations for clinical mental health counselors. *Journal of Mental Health Counseling*, *31*, 309–322.
United States Department of Commerce. (2012). *How the Census Bureau measures poverty*. Retrieved from https://www.census.gov/hhes/www/poverty/methods/measure.html
United States Department of Labor. (n.d). *Wages*. Retrieved from http://www.dol.gov/dol/topic/wages/minimumwage.htm#.ULd1vbT3D-Y
Weil, A. (2007). A health plan to reduce poverty. *The Future of Children*, *17*, 97–116.
Yorgason, B., McWey, L. M., & Felts, L. (2005). In-home family therapy: Indicators of success. *Journal of Marital & Family Therapy, 31*, 301–312.

Chapter 19

Engaged Spirituality: A Heart for Social Justice

Craig S. Cashwell and Jodi L. Bartley

Spirituality is one of the most numinous concepts in modern society and one that draws reactions, often emotional reactions, from many people. For some, the term conjures forth images of mystics and saints. For others, it conjures images of loyal servants, such as Mother Teresa, or groups of people whose primary expression is one of condemnation, judgment, and oppression. In short, spirituality is complex. All of these forms, both sacred and profane, exist as expressions of spirituality. That is, the mystic experiencing the divine in a deep meditative state in a remote cave; the loyal servant serving the poorest of the poor in Calcutta, India; and the man or woman picketing outside a gay, lesbian, bisexual, transgender, and queer (GLBTQ) community center are all expressing their spirituality. What, then, distinguishes the loyal servant from the oppressor?

In this chapter, we explore spirituality as it relates to both oppression and social justice. Specifically, we discuss *engaged spirituality*, a term used to describe a process whereby people seek to serve and transform the world in positive ways while finding direction, hope, and meaning through their spiritual beliefs, practices, and experiences (Stanczak, 2006). To this end, we define both *spirituality* and *religion* and differentiate between the two. We explore how various developmental models help explain the paradoxical ways in which spirituality and religion fuel social justice for some while fueling hatred and oppression for others. We then explore engaged spirituality as a force for social justice and include examples of teachings within many of the major world religions evidencing engaged spirituality. We end the chapter with a case study to highlight the applications at both the microlevel and macrolevel to promote engaged spirituality.

Spirituality and Religion

Perhaps more than any other construct in the mental health field, spirituality is difficult to define. In fact, when we strive to define spirituality, we discover not its limits, but our own (Kurtz & Ketcham, 1992). Although spirituality, or the individual search for and encounter of that which is sacred, has been suggested as a universal human potential (Piedmont, 2007), the experience and expression of this potential are developmental, contextual, and highly personal (Young & Cashwell, 2011). Thus, it is difficult to construct a definition of *spirituality* that fully captures the full range of this universal human potential. Further

proving this point, the initial Summit on Spirituality, a gathering of counseling professionals with expertise in spirituality, was unable to define spirituality and instead chose to describe it (Young, Cashwell, Wiggins-Frame, & Belaire, 2002). Any attempt to define spirituality is, at best, the proverbial hand pointing to the moon, which should never be confused with the moon itself.

These caveats notwithstanding, the hand pointing to the moon is not without utility as it helps focus our vision on both the destination and the path to that destination. *Spirituality* has been defined as the "universal human capacity to experience self–transcendence and awareness of sacred immanence, with resulting increases in greater self-other compassion and love" (Young & Cashwell, 2011, p. 7). This definition is somewhat complex, and spirituality is perhaps best described by breaking down this definition into its components:

- Spirituality, in its diverse forms of experience and expression, is available to everyone (*universal human capacity*).
- Spiritual journeys involve transcending the ego and increasingly recognizing higher purposes beyond the ego self (*self-transcendence*).
- Whatever one believes about what the future holds (i.e., what happens after death), we are *here and now* for a purpose beyond ourselves (*sacred immanence*).
- True spiritual development always leads us to be more compassionate, both with ourselves and others. This self/other compassion is the seat of love.

Religion, by contrast, is far less difficult to define yet remains a complex social phenomenon. Religion involves a human-created social context for the experience and expression of spirituality. As such, religion typically is denominational, external, ritualistic, and public (Richards & Bergin, 1997), in contrast to the more private, personal, and internal experience of spirituality. The relationship between religion and spirituality is unique to each individual, though several overarching themes are evident. Consider the following examples:

- Jeff, a 45-year-old man, attends temple services every week; he also reads from the Jewish prayer book and studies the Torah daily. He is engaged in a local activist group that addresses homelessness, hunger, and poverty in his local community. Jeff is both religious and spiritual, with a clear social justice view of life.
- Jamie, a 30-year-old, attended church with her family as a child but now describes her early religious experiences as unhealthy. She sees and respects the value of organized religion for others but is not interested in participating in a religious community herself. Jamie practices mindfulness, breathwork, and yoga daily and volunteers for a local group that addresses environmental issues in her state. Jamie is spiritual but not religious; her social justice perspective on the world is evidenced by her concern for the environment.
- Sally is 52 years old and grew up attending conservative religious services a few times a week. As an adult, she describes these experiences as "kooky" and her parents as "religious nuts." She views all religion as an unhealthy "crutch" and harshly judges those who participate in religious communities. She has adopted an "every person for himself or herself" approach to life; she focuses on advancing her own career and life. Sally can be described as religiously hostile (Kelly, 1995) and living without a social justice orientation to life.
- Trevon is a 55-year-old man who grew up in a religious family that taught him that one must "go to church to go to heaven." He has maintained his participation in

organized religion throughout his life. He has no spiritual practices outside of his religious attendance, however, and is not engaged in any form of social service. Trevon is very outspoken about many social issues, speaking with great certainty that homosexuality is a sin, that abortion is murder, and that interracial dating goes against biblical principles. Trevon has gone through the motions of religious participation (i.e., is religious) but has not accessed his spirituality and, perhaps as a result, does not live with a social justice orientation.

- Leah is 28 years old and grew up in a family that emphasized science and believing only that which is observable. As a young adult, Leah began to feel a yearning for more and began to study vipassana meditation, a form of Buddhist meditation that cultivates insight, particularly on the impermanent nature of all things. As a result of her meditation practice, she became aware of a deep longing to help women who experience violence. She went to graduate school in counseling and developed a counseling practice that specialized in working with survivors of domestic and sexual violence. Leah is spiritual but not religious, and her meditation practice increased her compassion for others in a clear direction.
- Imani is a 55-year-old woman who is very active in her church. She spends extensive time serving others, particularly older adults in her church. She visits shut-ins, conducts a weekday Bible study for older adults at a local retirement community, and organizes meal delivery to families when a death occurs in a church member's family. For Imani, her religion and spirituality are inextricably intertwined, and she lives with a clear social justice and servant orientation to life.

These are just a few brief examples of the many ways that people come to experience and express their spirituality, some of which result in a social justice orientation to life and others whose experiences leave them indifferent to the plights of others or, in some cases, oppressive of others. How is it that someone can carry a label, such as "Christian," with behaviors that range from the oppressive work of Westboro Baptist Church (http://www.godhatesfags.com/) to the compassionate and gracious life of Mother Teresa? One key to understanding this is to understand the concept of engaged spirituality.

Engaged Spirituality

As individuals and societies move into higher stages of religious and spiritual development (which is discussed more fully in subsequent sections of this chapter), they tend to adopt more inclusive, unifying worldviews. In essence, rather than viewing the world from dichotomous, dualistic frameworks (me vs. you, us vs. them, good vs. evil, etc.), people begin to envision the world as highly interconnected.

Wilber (2000) discussed this at length in describing duality versus nonduality. He stated that as people move into higher states of religious and spiritual development, they cease to recognize objects as separate entities. As an example, he used the experience of being in the presence of a mountain. In a dual state, a person experiences a mountain as a separate entity. However, from a nondual perspective, that person *is* the mountain. Thus, people begin to identify with the world as it exists around and inside themselves. Extending this further, just as it would be painful to sever a finger, it begins to hurt to see another person or the environment suffer. In the same way that humans instinctively protect themselves from harm, they begin to feel an innate desire to protect others and the environment from harm. This concept readily lends itself to social justice and, more specifically, to engaged spirituality.

According to Stanczak (2006), engaged spirituality is "the social juncture between the transcendent, active and ongoing, multidimensional, unlimited, emotional, and pragmatic aspects of spirituality that motivate actions for social change" (p. 20). This definition also emphasizes the transformative power of spirituality in and of itself to motivate one toward social activism. Stanczak (2006) asserted that transformative spiritual experiences muddle the division between the personal and the collective. Furthermore, engaged spirituality, as a practice, allows people the freedom to extend and offer their version of the sacred (perhaps religion based) to others beyond the secular boundaries that may discourage one from doing so.

As an example, consider the division between church and state in the United States. If a teenager were to attend a Christian Evangelical retreat and feel moved to share his experiences with others, he would most likely be dissuaded from doing so on public school premises. Through the practice of engaged spirituality, however, he might embody the message in his service toward others. Instead of telling others about the generosity and love of Jesus Christ, he might act with more generosity and love toward his peers. This could work with multiple examples across religious and spiritual traditions. Perhaps a Buddhist engages with others from a place of loving kindness or a Muslim translates the gratitude of Ṣalāh (prayer) to general gratitude toward others. Taken together, the emergence of engaged spirituality may stem from a developmental shift where one begins to see the world more universally, or it could stem from a transformational spiritual experience that intrinsically motivates one to share this with others.

With the understanding of engaged spirituality, we can begin to explore social justice and its connection to religion and spirituality a little more closely. According to the University of California Berkeley's School of Social Welfare (2013), *social justice* can be defined as

> [a] process, not an outcome, which (1) seeks fair (re)distribution of resources, opportunities, and responsibilities; (2) challenges the roots of oppression and injustice; (3) empowers all people to exercise self-determination and realize their full potential; (4) and builds social solidarity and community capacity for collaborative action. (para. 3)

In this definition, words such as *fairness*, *empowerment*, *solidarity*, *community*, and *collaboration* underscore some of the foundational tenets of religious and spiritual developmental models at the higher stages. Examining the connections between social justice and spirituality/religion a little more closely, one begins to see how they are linked and further inform the concept of engaged spirituality. To better understand how religion and spirituality evolve into engaged spirituality, it is necessary to understand spiritual development theory, the subject of the next section.

Individual Spiritual Development

An exhaustive review of models of spiritual development is beyond the scope of this chapter. Readers interested in knowing more are encouraged to read Foster and Holden (2011) for a concise overview of spiritual development models. Here we simply note that spiritual development is part of the trajectory of normal human development (Oser, Scarlett, & Bucher, 2006). In fact, Jung (1968) considered spiritual development a vital mechanism through which an individual integrates the conscious and unconscious aspects of the psyche. A number of developmental models have been established in the professional literature; the following models are among the most noted:

- Fowler's (1981) stages of faith, which is based on extensive qualitative interviews with a diverse sample of people. Fowler found seven stages of faith, which he defined as a "loyalty to a transcendent center of value and power" (p. 14), which is not necessarily connected to organized religion.
- Washburn's (1995) model of transpersonal development focused on three sequential positions (preegoic, egoic, and transegoic), which can only be fully understood in relationship to one another. If development progresses, Washburn argued, a differentiated ego begins to emerge during the latency period of childhood. Furthermore, Washburn believed that most people stay in this "separate ego" stage for the remainder of their lives but that some experience spiritual awakenings, often during midlife, that leads evolution into the transegoic stage in which the individual feels emotionally and spiritually connected to something beyond the self and lives in services to this transcendent connection.
- Oser's religious judgment (Oser & Gmünder, 1991) model suggests that people experience a series of contingency situations that lead them to develop coping strategies to deal with these contingencies. For example, the death of a young family member or friend cannot be resolved within a purely logical framework. Grounded in the results of qualitative interviews, Oser and Gmünder found that people typically develop from a belief in an external omnipotent force in the universe from which they are separated to a sense of full entwinement with this Divine force, although many people do not reach the latter stages of development.
- Genia's (1995) developmental model is based on an integration of moral, cognitive, and psychosocial development models. Genia conceptualized as unhealthy those levels of development in which one's faith is egocentric and involves splitting of any external deity into "all good" or "all bad" frameworks or those who engage in a dogmatic faith in which external sources are needed for the rules and laws of behavior and relationships. More healthy stages of development involve an increased sense of flexibility, increased likelihood to apply universal moral principles, and openness to novel spiritual experiences.

Developmental models are crucial to our understanding of spirituality and religion and provide an essential framework for understanding engaged spirituality. Without such developmental frameworks, it is easy to judge those who are different from us. This is particularly ironic when people are being highly judgmental and critical of others for being judgmental and critical of others. Understanding such phenomena developmentally not only helps us cultivate more compassion for those whose religious and spiritual beliefs differ markedly from our own, but it also gives us a framework to help clients developmentally. Several key markers are common across spiritual development models.

Dualistic to More Complex Thinking

At earlier stages of spiritual development, people commonly think in dualistic "either–or" thinking. Within religious communities, this might manifest in any number of ways:

- religious wars;
- rigid thinking about what is right and wrong, along with harsh condemnation of those who are "wrong";
- certainty that belief systems different from your own are flawed and inaccurate; and
- many iterations of "us versus them" thinking.

In contrast, people in later stages of spiritual development tend to embrace more of the mystery of spirituality and both understand and accept that there is much that they do not understand or know for certain, though faith may leave them with clear beliefs nonetheless. This increased acceptance of "not knowing" typically leaves them with more tolerance, acceptance, and open-mindedness.

"Separate From" Versus "Connected With"

At earlier stages of spiritual development, people tend to focus on what distinguishes them from others. Because of this, they are more inclined to create barriers between themselves and those who are different from them. For example, organized religion has been used as a foundational institution to support both slavery and the oppression of women, within a framework that viewed African American people and women as "separate from" and "less than." In contrast, however, people functioning in later developmental stages tend to develop a "we" mentality. Rather than seeing the world through an "us vs. them" lens, they recognize the bonds that draw all of humanity together. Such people recognize connections and often have a "connected with" experience of life. This increased experience of connectedness inevitably results in greater compassion (literally "suffering with") for others that leads to social action.

External to Internal

The spiritual developmental continuum also involves movement back and forth between an external and an internal focus. People who function in the earlier stages almost always focus more on the external, such as external authority and external truths. For example, people who are drawn to follow a charismatic cult leader are almost always functioning at these earlier stages of development. At this developmental level, service to others is usually dictated by external authority, done in service to the individual's ego needs, or done out of fear of negative consequences by a punitive deity or universal force. This is discussed more fully in the section Servant Leadership: The Pre-Trans Fallacy.

If people continue to develop spiritually, however, there comes a point where there is a shift and the focus becomes more internal. People begin to view and review their belief systems. In some instances, these beliefs evolve into something that is more personalized. In other cases, the belief systems stay the same or, at the least, remain very similar. Having been consciously examined, however, these beliefs become more internalized as the individual "owns" them. At this stage, people begin to review external authority (both written and spoken) through the lens of their inner experience to discern if this is "true" for them as an individual. For many, this developmental period is marked by a sense of struggle and an internal focus. In some regards, this is comparable to the development of identity in adolescence as the person struggles with the following questions:

- Who am I?
- Why am I here?
- What do I believe?
- Is it okay to hold beliefs different from those in which I was raised?

It is interesting that this important developmental period may result in a decrease in external focus (i.e., service to others) as the individual spends a great deal of time and energy focused on the above questions.

Later stages of spiritual development are marked by a fluid movement between the internal and external, to the extent that the two are no longer separate. At these stages, a person experiences heartful compassion for those who struggle and are oppressed, and the logical extension of this contemplative awareness is action. Thus, at later stages of development, contemplation and action are, in fact, highly integrated and, in essence, two sides of the same coin.

Translative Versus Transformative

Religion (and, by extension, spirituality) serves two very distinct functions in people's lives. Wilber (1998) characterized these functions as translative and transformative. At earlier developmental stages, people are most interested in a translative (meaning-making) religion or spirituality. As an individual attempts to understand himself or herself within the context of a complicated world, individual belief systems emerge. The translative function "offers myths and stories and narratives and rituals and revivals that, taken together, help the separate self make sense of, and endure, the slings and arrows of outrageous fortune" (Wilber, 1998, p. 140). By definition, though, this strengthening of the self may preclude radical transformation, a hallmark of people in later spiritual development stages.

Genuine transformation and liberation are hallmarks of people who function at later spiritual developmental levels.

> This function of religion does not fortify the separate self, but utterly shatters it—not consolation but devastation, not entrenchment but emptiness, not complacency but explosion, not comfort but revolution—in short, not a conventional bolstering of consciousness but a radical transmutation and transformation at the deepest seat of consciousness itself. (Wilber, 1998, p. 140)

It is important to highlight that both translation and transformation are equally important. For most people, translation without transformation ultimately feels insufficient. People then tend to either experience transformation, strengthen their beliefs (and, sometimes, rigidly so), or abandon their beliefs of origin in favor of a different translative system. In converse, transformation without translation (i.e., the ability to integrate and "understand" transformative experiences) often results in neuroses and, at times, psychoses. Wilber (1998) referred to this as a breakdown rather than a breakthrough. Although full spiritual development involves both the translative and transformative aspects, relatively few attain the transformative aspect.

A True Spirituality

Working from the definition of spirituality offered at the outset of this chapter, it is clear that not all spiritual and religious communities support development consistent with that definition. Whereas holistic spiritual development and a social justice orientation may be supported within healthy spiritual and religious communities, other communities stifle development and social justice perspectives. What distinguishes a healthy community from one that is toxic? Healthy spiritual and religious communities focus on the following concepts:

- *Conduits.* All living things are interconnected, and it is important to build bridges between people.
- *Trust.* As demonstrated in the work of Erikson (1968), healthy communities work to serve a benevolent universe or Higher Power through acts of social justice.

- *Forgiveness.* Healthy spiritual or religious communities teach principles of compassion and forgiveness, both for self and others, rather than promoting a culture of "not good enough" through messages of guilt and shame.
- *Positive sense of self.* Healthy spiritual and religious communities promote a positive sense of self even as they promote servant leadership and acts of social justice. That is, acts of service to others are not a function of a negative sense of self where the act is an effort to feel self-adequate or assuage guilt or shame.

Servant Leadership: The Pre-Trans Fallacy

Servant leadership, a phrase coined by Robert Greenleaf in the 1970s, describes a style of leadership that is grounded in many of the great ancient wisdom traditions. Teachers such as Lao-Tzu and Jesus spoke of serving rather than being served in an orientation toward helping others develop and function as well as possible (Greenleaf, 2002). It is the leadership approach most commonly espoused within communities that practice engaged spirituality.

Serving others is certainly an admirable quality and a hallmark of engaged spirituality. It comes, however, with caveats. One way to consider service to others is the pre-trans fallacy described by Wilber (1993). Within Wilber's framework, the personal level of development is the establishment of ego or separate self, and it is a necessary aspect of development. Within human development, then, we see an evolution of individuals from prepersonal to personal to transpersonal (literally, "beyond the ego"). The pre-trans fallacy, according to Wilber, occurs both when prepersonal acts are elevated to transpersonal status and transpersonal acts are reduced to prepersonal status. Consider, for example, a woman with very poor self-esteem who begins to get a lot of attention for serving others in her faith community. Are these acts genuinely in service to a higher purpose (transpersonal), or do they fortify a shaky sense of self (prepersonal)? Some might argue that it hardly matters because others are being served. To truly meet the criteria for engaged spirituality and servant leadership, however, the separate self cannot be the primary focus, as it is in prepersonal acts of service. Genuine engaged spirituality has a transpersonal focus that results from a clear and healthy sense of self. Put another way, you cannot transcend an ego that does not fully exist. Efforts to do so result in spiritual bypass (Welwood, 2000; Whitfield, 2003) or the avoidance of the difficult psychological and emotional work of personal growth by focusing solely on the spiritual dimension of life.

When service to others emerges from a transpersonal framework, the work of religious organizations resembles (and, in many ways, is) social activism. Similarly, the leadership initiatives of human rights leaders often are fueled by religion or spirituality. In an in-depth study on 10 human rights leaders including Mahatma Gandhi, Paulo Freire, Mother Teresa, and Viktor Frankl, Parameshwar (2005) emphasized the power of spirituality and ego-transcendence in their leadership efforts. Through phenomenological analysis, Parameshwar uncovered ego-transcendent themes associated with their leadership approaches. Taken together, the themes highlight the link between higher stages of spiritual/religious development and one's motivation to engage in social justice efforts. More specifically, the leaders transcended the ego and acted on behalf of the collective society.

Societal Spiritual and Religious Development

Religious and spiritual developmental models can be applied not only to individuals, but also to whole societies. Two comprehensive conceptualizations of societal evolution are

Beck and Cowan's (1996) spiral dynamics (drawn from early work by Clare W. Graves) and a portion of Wilber's (2000) integral theory (the interior-collective quadrant). These are explained in this section to illuminate the ways in which beliefs (religious and otherwise) at any given point in time rest upon society's level of consciousness within that time period. This naturally leads into a discussion of how our current stage of functioning lends itself to engaged spirituality.

According to Beck and Cowan (1996), the theory of spiral dynamics helps explain societal shifts in human consciousness. It is based on the concept of vMEMES, or value memes. "A vMEME reflects a world view, a valuing system, a level of psychological existence, a belief structure, an organizing principle, a way of thinking, or a mode of adjustment" (Beck & Cowan, 1996, p. 4). These vMEMEs illuminate the developmental shifts in society, which, in spiral dynamics, are organized by colors and characterized by specific themes. Wilber's (2000) levels of consciousness (existing in the interior-collective quadrant of his All Quadrants All Levels [AQAL] model), roughly parallel those in spiral dynamics. (The following is a cursory review of these specific theories; for more information, see Beck & Cowan, 1996, and Wilber, 2000.)

Although the levels or stages in spiral dynamics and integral theory are not completely parallel, their general direction and associated themes are similar. In essence, both models begin with a rudimentary base focused on instinctual and survivalist perspectives (the "beige" level in spiral dynamics and "archaic" level in integral theory). Spiritual beliefs during this time period may have been more earth-based. From this early time period, the collective society moved into the magical and symbolic realm characterized by magical, symbolic, and superstitious thinking ("purple" era in spiral dynamics and "magical" era in integral theory). Such spiritual practices during this time period may have included voodoo, chanting, and animistic-type engagement. After this, society seemed to move into a more rule-bound era, reaching into the "red" and "blue" stages of spiral dynamics and the "mythic" stage of integral theory. Religious doctrine may have prevailed during this era as people sought to be obedient to their understanding of the Divine. From there, the evolution of society's consciousness moved toward a more rational worldview, governed by greater achievement, idealism, and introspection. As such, people began to engage in critical analysis of their beliefs and adopt more inclusive, worldcentric viewpoints. At this point, people may have adopted more relativistic perspectives of religion and spirituality. Both Wilber (2000) and Beck and Cowan (1996) considered that society exists in a stage that values holism. As such, people seek to synthesize and integrate information from a multitude of perspectives. From a spiritual framework, this stage touches upon the transpersonal realm. It is curious to note that as the consciousness of society develops, it becomes more and more inclusive and more transcendent (a key theme in Wilber's integral theory) or, in other words, more oriented to social justice and servant leadership.

At first glance, it may seem odd that evolutionary models of collective consciousness would be included in a chapter on spirituality and social justice. However, both Beck and Cowan (1996) and Wilber (2000) emphasized society's transitions toward greater integration and wholeness. Thus, as spiritual/religious development progresses both individually and collectively, it becomes more inclusive. Naturally, it would follow that as an individual or as a society is more inclusive, concern about others within the system increases. With more concern, people are likely more motivated to address the concern, which is directly linked to social justice.

One of the most visible signs of the connection between social justice and spirituality/religion is evident in the actual social justice actions undertaken in the name of religion.

(This further explicates the previous discussion about the power of transformative spiritual experiences to lead to social activism.) Hodge (2012) illuminated this connection by outlining such faith-based social justice organizations as the Buddhist Peace Fellowship, the Christian Community Development Association, BAPS Charities (Hinduism), and Jews for Social Justice, all of which demonstrate the entwinement of religion and social justice in an explicit, observable manner. Certainly, one could argue that people's dogmatic adherence to religion and spirituality may provoke factions and wars. However, as Wilber (2000) argued, social justice activists may suffer from a similar trap in falling prey to "intolerance in the name of tolerance" (p. 285). In such situations, it is important to once again consider developmental stages and the transition from duality to unity. From a place of unity, the person (or group) is moved to act in ways that benefit others, once again exemplifying the concept of engaged spirituality.

Across social justice organizations and leaders of many religious and spiritual traditions, there appears to be both an explicit and implicit social justice message. The message of the golden rule, or treating others as one would want to be treated, connects with the fairness, solidarity, and community aspects associated with the definition of social justice. It is interesting that the message of the golden rule is paramount across religions, as the following examples demonstrate (McKenna, 2000).

- *Baha'i Faith:* Lay not on any soul a load that you would not wish to be laid upon you, and desire not for anyone the things you would not desire for yourself. (Baha'u'llah, Gleanings)
- *Buddhism:* Treat not others in ways that you yourself would find hurtful. (The Buddha, Udanavarga 5.18)
- *Christianity:* In everything, do to others as you would have them do to you; for this is the law and the prophets. (Jesus, Matthew 7:12)
- *Hinduism:* This is the sum of duty: do not do to others what would cause pain if done to you. (Mahabharata 5:1517)
- *Islam:* Not one of you truly believes until you wish for others what you wish for yourself. (The Prophet Muhammad, Hadith)
- *Judaism:* What is hateful to you, do not do to your neighbour. This is the whole Torah; all the rest is commentary. Go and learn it. (Hillel, Talmud, Shabbath 31a)
- *Sikhism:* I am a stranger to no one; and no one is a stranger to me. Indeed, I am a friend to all. (Guru Granth Sahib, p. 1299)
- *Taoism:* Regard your neighbour's gain as your own gain and your neighbour's loss as your own loss. (Lao Tzu, T'ai Shang Kan Ying P'ien 213–218)

Thus far, we have defined religion and spirituality, outlined individual and collective developmental models of religion and spirituality, and discussed the ways in which spiritual and religious development naturally leads to social justice endeavors and engaged spirituality. Now we apply these concepts to plausible situations.

Personal Voices
The Story of Jane

The following case study shows an example of the integration of spirituality within a social justice counseling framework. Jane, a 26-year-old White female, sought counseling with one of us (Craig S. Cashwell). Her initial presenting issue revolved around problems

with her faith life. In her first session, Jane talked in very broad and vague terms about the fact that she was questioning some of the beliefs of her religion of origin. When invited to speak in more detail, she resisted and continued to speak only in very broad terms. Sensing that to challenge her to say more in the first session might be too threatening, the counselor used a person-centered approach in the initial session and acknowledged and validated how difficult this topic seemed to be for Jane to talk about.

At the outset of the second session, Jane began with, "Okay, I've decided I just need to say this to you. It's tough to talk about because I am afraid of how you will react. I have never told anyone close to me this, but I am a lesbian. My church says that's not okay and I don't know what to do about it." The counselor resisted his initial impulse, which was to reassure her that her sexual orientation was acceptable and that the problem was with the constricting message from her religious community. Instead, he helped Jane fully "unpack" this struggle to integrate two parts of her identity. More specifically, as she continued to attend the religious services in which she was raised, the associated messages within that religious community repeatedly condemned homosexuality as a "sin and abomination." This left Jane with internalized homophobia, increasing the dissonance between the lesbian part of her identity and the religious part of her identity.

Jane conceptualized her problem as "two worlds colliding" and said she felt like she would have to "let go" of one of these worlds—either foregoing church or repressing her attraction to women. After clarifying what she meant, the counselor asked her if she could see any other possible outcomes to this situation. Jane replied that she did not. The counselor asked Jane if she would like to keep both "parts" of herself and not give up either one. Jane replied, "Yeah, that would be great, but I don't see how it can be that way." The counselor was familiar with two different religious communities (of the same denomination as Jane's) in the local area that not only had openly gay, lesbian, and bisexual members, but also actively affirmed the GLBTQ community. The counselor asked Jane if she knew there were such churches in her community and, almost in shock, she stated that she did not. He iterated that he did not know if these churches would be good fits for her theologically but that it might be worth visiting to see if that could be a possibility. He knew the minister of one of the two churches, a vocal advocate in the local community for GLBTQ rights, so he gave Jane the minister's name and phone number. Jane contacted the minister later that day, met with him the next day, and attended her first service the following Sunday. She tearfully recounted what it was like to walk in the door of the church and immediately see two women holding hands. Although Jane required counseling to deal with her internalized homophobia and what it meant to keep the truth of her sexual orientation from her highly religious parents, the Sunday service marked a turning point for her as she began to accept herself both spiritually and sexually.

Individual Counseling: Applications at the Microlevel

On a microlevel, there are many ways that issues of religious and spiritual development present in counseling. As illustrated in the case study, individuals might have experienced only low levels of spiritual and religious development in their communities and, accordingly, might have a constricted perspective of spirituality and religion. For example, a client may present with a negative sense of self that has largely been created and/or supported within a religious community. It is critical to remember that many religious communities, particularly more conservative communities, see "secular" counseling and therapy as anathematic to their religious beliefs and assume that counselors judge them for their religious

beliefs. As Wilber (2000) noted, it is possible to get caught up in a social justice perspective to the point that one is intolerant of others' intolerance. For example, consider a client who has lived with the belief that acceptance of Jesus Christ is the only way one can avoid hell and whose belief is causing internal strife. Two clinical mistakes could emerge from this scenario. First, a counselor could wholly agree with this belief and discourage the client from exploring the internal strife related to this belief. Second, a counselor might strongly disagree with this belief and, from a place of intolerance, confront this belief. Remembering that this is a deeply held lifelong belief, however, the counselor's counter will have little impact on client beliefs but almost certainly will damage the ever-important therapeutic relationship. Yet we have seen counselors quickly confront such core beliefs and then stand back incredulously when the client "resisted" this notion. Counselors who behave this way with clients cannot simply conclude that clients who do not appear for sessions are not ready to do the work when in fact the counselors triggered the resistance. These therapeutic mistakes occur when counselors allow their own predilections to influence the interpersonal process of counseling rather than focusing fully on the client's experience.

In the second example from the previous paragraph, consider how the knowledge that religiosity and spirituality are developmental might help the counselor accept and show compassion for the client. Is it possible that the counselor could more gently (and compassionately) shake the client's thinking to initiate a change process? This process can be likened to the way that an irritant within a mollusk can produce a pearl. Encouraging clients to dig deeper into their sacred texts to unearth new insights on a particular topic can be a useful process for some individuals. Furthermore, counselors can also take steps to intervene on a macrolevel (through advocacy) to address issues of religion and spirituality in counseling.

Advocacy Counseling: Applications at the Macrolevel

As it relates to religion and spirituality, advocacy counseling occurs when counselors confront issues of intolerance and oppression in the name of organized religion and spirituality. For example, those counselors who participate in religious and spiritual communities themselves can advocate for disenfranchised groups and educate members of their community about the deleterious psychological, emotional, and spiritual effects on those who are oppressed. Similarly, looking for opportunities to denounce historical and more current form of religious and spiritual intolerance, such as the Spanish Inquisition of the late 1400s, the Jewish Holocaust of the 1940s, the attacks on the World Trade Center in 2001, and the murder of six members of a Wisconsin Sikh gurdwara in 2012, serves to promote a culture of religious and spiritual diversity.

For example, in the scenario above, the counselor intervened at a microlevel to help Jane know there were religious communities that held a perspective on same-sex relationships that was diametrically opposed to the message she had received from the religious community in which she was raised. At the same time, her counselor might take this a step further by doing workshops and trainings, both within counseling communities and religious communities, about the deleterious effects of oppression to increase acceptance within religious communities.

Conclusion

Spirituality and religion are sources of great comfort for many people in many circumstances, and engaged spirituality serves as an intersection between one's spiritual life and his or her so-

cial justice endeavors. As such, the individual's spiritual beliefs, practices, and experiences fuel the passion for social justice. In other instances, however, spirituality and religion can serve as fuel for oppression and hatred. Spiritual developmental models may provide a framework within which this can be understood conceptually and worked with at both microlevels and macrolevels to encourage greater respect for diverse religious and spiritual traditions.

Resources

Articles, Chapters, and Books

Cashwell, C. S., & Young, J. S. (Eds.). (2011). *Integrating spirituality in counseling: A guide to competent practice* (2nd ed.). Alexandria, VA: American Counseling Association.

Crethar, H. C., & Winterowd, C. L. (2012). Values and social justice in counseling. *Counseling and Values, 57,* 3–9.

Fukuyama, M. A., & Sevig, T. D. (1999). *Integrating spirituality into multicultural counseling.* Thousand Oaks, CA: Sage Publications.

Palmer, M. D., & Burgess, S. M. (Eds.). (2012). *The Wiley-Blackwell companion to religion and social justice.* Hoboken, NJ: Wiley-Blackwell.

Wiggins, M. I. (2010). Religion and spirituality and the ACA advocacy competencies. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA advocacy competencies. A social justice framework for counselors* (pp. 75–83). Alexandria, VA: American Counseling Association.

Website

The Network of Spiritual Progressives
http://spiritualprogressives.org/newsite/

References

Beck, D. E., & Cowan, C. C. (1996). *Spiral dynamics: Mastering values, leadership, and change: Exploring the new science of memetrics.* Malden, MA: Blackwell Business.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York, NY: Norton.

Foster, R. D., & Holden, J. M. (2011). Human and spiritual development and transformation. In C. S. Cashwell & J. S. Young (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (2nd ed., pp. 97–118). Alexandria, VA: American Counseling Association.

Fowler, J. W. (1981). *Stages of faith: The psychology of human development and the quest for meaning.* San Francisco, CA: Harper and Row.

Genia, V. (1995). *Counseling and psychotherapy of religious clients.* Westport, CT: Praeger.

Greenleaf, R. K. (2002). *Servant leadership: A journey into the nature of legitimate power & greatness.* Mahway, NJ: Paulist Press.

Hodge, D. R. (2012). The conceptual and empirical relationship between spirituality and social justice: Exemplars from diverse faith traditions. *Journal of Religion & Spirituality in Social Work: Social Thought, 31*, 32–50. doi:10.1080/15426432.2012.647878

Jung, C. G. (1968). Concerning the archetypes, with special reference to the anima concept. In M. F. H. Read & G. Adler (Eds.), *The collected works of C. G. Jung* (2nd ed., Vol. 9, pp. 54–72). Princeton, NJ: Princeton University Press.

Kelly, E. W., Jr. (1995). *Spirituality and religion in counseling and psychotherapy: Diversity in theory and practice.* Alexandria, VA: American Counseling Association.

Kurtz, E., & Ketcham, K. (1992). *The spirituality of imperfection: Storytelling and the search for meaning*. New York, NY: Bantam.

McKenna, P. (2000). *The golden rule across the world's religions: Thirteen sacred texts—English version*. Retrieved from http://www.scarboromissions.ca/Golden_rule/sacred_texts_en.php

Oser, F. K., & Gmünder, P. (1991). *Religious judgment: A developmental perspective.* Birmingham, AL: Religious Education.

Oser, F. K., Scarlett, W. G., & Bucher, A. (2006). Religious and spiritual development throughout the lifespan. In R. M. Lerner (Ed.), *Handbook of child psychology* (6th ed., pp. 942–998). Hoboken, NJ: Wiley.

Parameshwar, S. (2005). Spiritual leadership through ego-transcendence: Exceptional responses to challenging circumstances. *The Leadership Quarterly, 16*, 689–722. doi:10.1016/j.leaqua.2005.07.004

Piedmont, R. (2007). Cross-cultural generalizability of the Spiritual Transcendence Scale to the Phillippines: Spirituality as a human universal potential. *Mental Health, Religion, and Culture, 10,* 89–107.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy.* Washington, DC: American Psychological Association.

Stanczak, G. C. (2006). *Engaged spirituality: Social change and American religion.* Piscataway, NJ: University of Rutgers Press.

University of California Berkeley's School of Social Welfare. (2013). *Social justice symposium home*. Retrieved from http://socialwelfare.berkeley.edu/social-justice-symposium

Washburn, M. (1995). *The ego and the dynamic ground: A transpersonal theory of human development* (2nd ed.). Albany: State University of New York.

Welwood, J. (2000). *Toward a psychology of awakening: Buddhism, psychotherapy, and the path of personal and spiritual transformation.* Boston, MA: Shambala.

Whitfield, C. (2003). *My recovery: A personal plan for healing.* Deerfield Beach, FL: HCI.

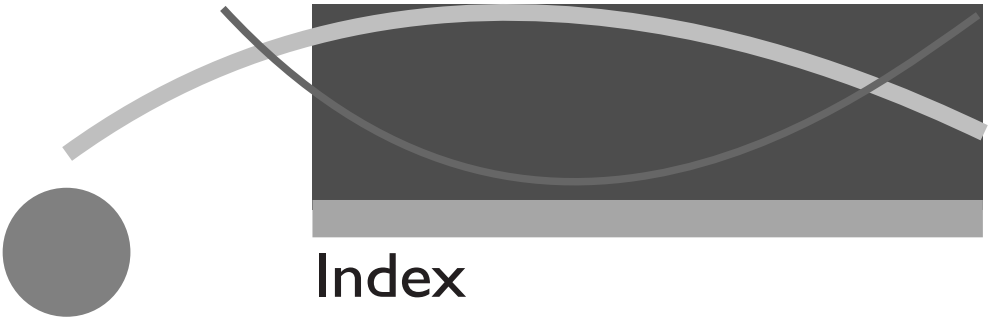
Wilber, K. (1993). The pre-trans fallacy. In R. Walsh & F. Vaughn (Eds.), *Paths beyond ego* (pp. 124–129). Los Angeles, CA: Tarcher.

Wilber, K. (1998). Translation versus transformation. In K. Wilber (Ed.), *The essential Ken Wilber: An introductory reader* (pp. 140–143). Boston, MA: Shambhala.

Wilber, K. (2000). *A brief history of everything.* Boston, MA: Shambhala.

Young, J. S., & Cashwell, C. S. (2011). Integrating spirituality and religion into counseling: An introduction. In C. S. Cashwell & J. S. Young (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (2nd ed., pp. 1–24). Alexandria, VA: American Counseling Association.

Young, J. S., Cashwell, C. S., Wiggins-Frame, M., & Belaire, C. (2002). Spiritual and religious competencies: A national survey of CACREP-accredited programs. *Counseling and Values, 47*, 22–33.



Index

Exhibits, figures, and tables are indicated by "exh", "f", and "t" following the page number.

A

B

C

D

E

F

G

H

I

J

K

L

M

(Continued)

N

O

P

(Continued)

T

For technical support with this product, please contact Wiley by phone (800-762-2974 USA or 317-572-3994 International) or through the Wiley website (http://support.wiley.com).

WILEY END USER LICENSE AGREEMENT

Go to www.wiley.com/go/eula to access Wiley's ebook EULA.