

# Improving Cultural Competence: Evaluation and Treatment Planning

Author: SAMHSA

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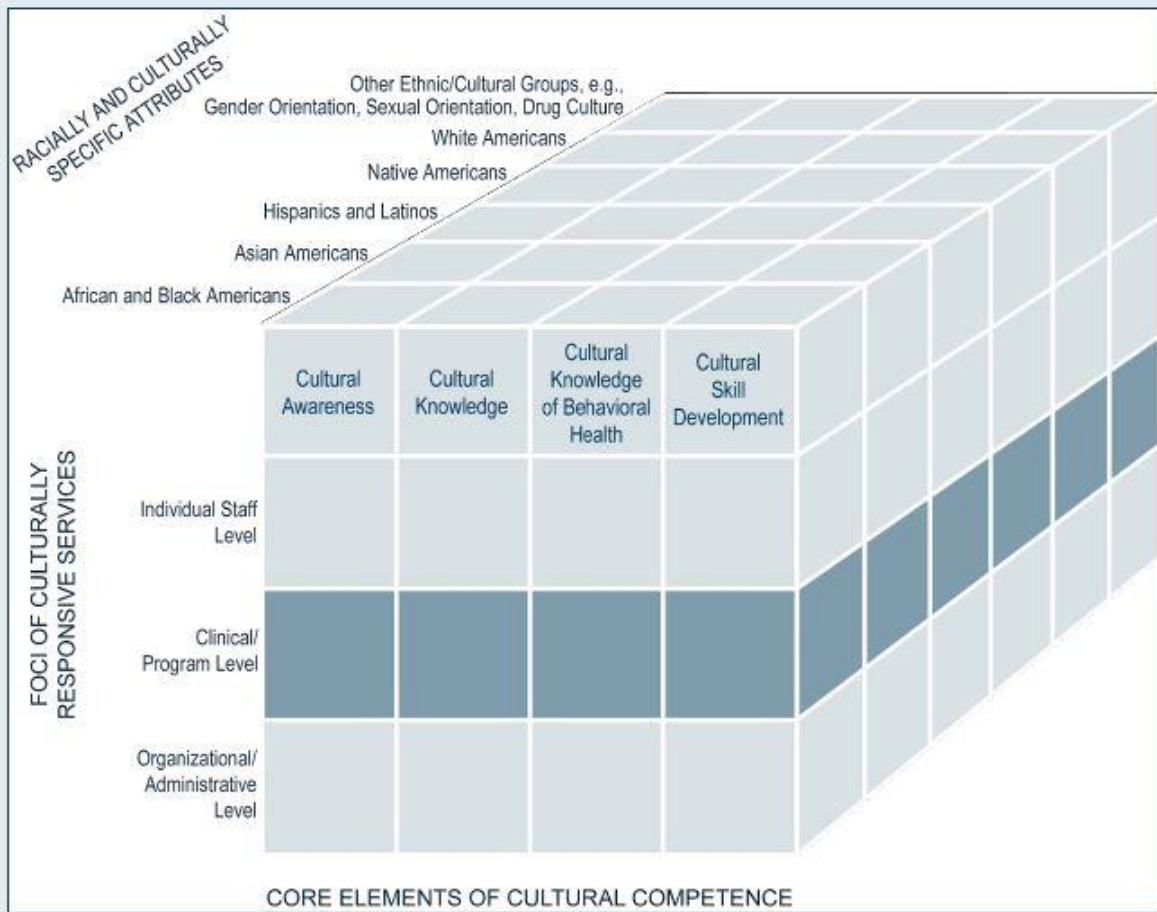
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Zhang Min, a 25-year-old first-generation Chinese woman, was referred to a counselor by her primary care physician because she reported having episodes of depression. The counselor who conducted the intake interview had received training in cultural competence and was mindful of cultural factors in evaluating Zhang Min. The referral noted that Zhang Min was born in Hong Kong, so the therapist expected her to be hesitant to discuss her problems, given the prejudices attached to mental illness and substance abuse in Chinese culture. During the evaluation, however, the therapist was surprised to find that Zhang Min was quite forthcoming. She mentioned missing important deadlines at work and calling in sick at least once a week, and she noted that her coworkers had expressed concern after finding a bottle of wine in her desk. She admitted that she had been drinking heavily, which she linked to work stress and recent discord with her Irish American spouse.

Further inquiry revealed that Zhang Min's parents, both Chinese, went to school in England and sent her to a British school in Hong Kong. She grew up close to the British expatriate community, and her mother was a nurse with the British Army. Zhang Min came to the United States at the age of 8 and grew up in an Irish American neighborhood. She stated that she knew more about Irish culture than about Chinese culture. She felt, with the exception of her physical features, that she was more Irish than Chinese—a view accepted by many of her Irish American friends. Most men she had dated were Irish Americans, and she socialized in groups in which alcohol consumption was not only accepted but expected.

Zhang Min first started to drink in high school with her friends. The counselor realized that what she had learned about Asian

## Multidimensional Model for Developing Cultural Competence: Clinical/Program Level



Americans was not necessarily applicable to Zhang Min and that knowledge of Zhang Min's entire history was necessary to appreciate the influence of culture in her life. The counselor thus developed treatment strategies more suitable to Zhang Min's background.

Zhang Min's case demonstrates why thorough evaluation, including assessment of the client's sociocultural background, is essential for treatment planning. To provide culturally responsive evaluation and treatment planning, counselors and programs must understand and incorporate relevant cultural factors into the process while avoiding a stereotypical or "one-size-fits-all" approach to treatment. Cultural responsiveness

in planning and evaluation entails being open minded, asking the right questions, selecting appropriate screening and assessment instruments, and choosing effective treatment providers and modalities for each client. Moreover, it involves identifying culturally relevant concerns and issues that should be addressed to improve the client's recovery process.

This chapter offers clinical staff guidance in providing and facilitating culturally responsive interviews, assessments, evaluations, and treatment planning. Using Sue's (2001) multidimensional model for developing cultural competence, this chapter focuses on clinical and programmatic decisions and skills that are

important in evaluation and treatment planning processes. The chapter is organized around nine steps to be incorporated by clinicians, supported in clinical supervision, and endorsed by administrators.

## Step 1: Engage Clients

Once clients are in contact with a treatment program, they stand on the far side of a yet-to-be-established therapeutic relationship. It is up to counselors and other staff members to bridge the gap. Handshakes, facial expressions, greetings, and small talk are simple gestures that establish a first impression and begin building the therapeutic relationship. Involving one's whole being in a greeting—thought, body, attitude, and spirit—is most engaging.

Fifty percent of racially and ethnically diverse clients end treatment or counseling after one visit with a mental health practitioner (Sue and Sue 2013*e*). At the outset of treatment, clients can feel scared, vulnerable, and uncertain about whether treatment will really help. The initial meeting is often the first encounter clients have with the treatment system, so it is vital that they leave feeling hopeful and understood. Paniagua (1998) describes how, if a counselor lacks sensitivity and jumps to premature conclusions, the first visit can become the last:

Pretend that you are a Puerto Rican taxi driver in New York City, and at 3:00 p.m. on a hot summer day you realize that you have your first appointment with the therapist...later, you learned that the therapist made a note that you were probably depressed or psychotic because you dressed carelessly and had dirty nails and hands...would you return for a second appointment? (p. 120)

To engage the client, the counselor should try to establish rapport before launching into a series of questions. Paniagua (1998) suggests that counselors should draw attention to the presenting problem “without giving the impression that too much information is needed

### Improving Cross-Cultural Communication

Health disparities have multiple causes. One specific influence is cross-cultural communication between the counselor and the client. Weiss (2007) recommends these six steps to improve communication with clients:

1. Slow down.
2. Use plain, nonpsychiatric language.
3. Show or draw pictures.
4. Limit the amount of information provided at one time.
5. Use the “teach-back” method. Ask the client, in a nonthreatening way, to explain or show what he or she has been told.
6. Create a shame-free environment that encourages questions and participation.

to understand the problem” (p. 18). It is also important that the client feel engaged with any interpreter used in the intake process. A common framework used in many healthcare training programs to highlight culturally responsive interview behaviors is the LEARN model (Berlin and Fowkes 1983). The how-to box on the next page presents this model.

## Step 2: Familiarize Clients and Their Families With Treatment and Evaluation Processes

Behavioral health treatment facilities maintain their own culture (i.e., the treatment milieu). Counselors, clinical supervisors, and agency administrators can easily become accustomed to this culture and assume that clients are used to it as well. However, clients are typically new to treatment language or jargon, program expectations and schedules, and the intake and treatment process. Unfortunately, clients from diverse racial and ethnic groups can feel more estranged and disconnected from treatment services when staff members fail to educate them and their families about treatment expectations or when the clients are not walked

## How To Use the LEARN Mnemonic for Intake Interviews

Listen to each client from his or her cultural perspective. Avoid interrupting or posing questions before the client finishes talking; instead, find creative ways to redirect dialog (or explain session limitations if time is short). Take time to learn the client's perception of his or her problems, concerns about presenting problems and treatment, and preferences for treatment and healing practices.

Explain the overall purpose of the interview and intake process. Walk through the general agenda for the initial session and discuss the reasons for asking about personal information. Remember that the client's needs come before the set agenda for the interview; don't cover every intake question at the expense of taking time (usually brief) to address questions and concerns expressed by the client.

Acknowledge client concerns and discuss the probable differences between you and your clients. Take time to understand each client's explanatory model of illness and health. Recognize, when appropriate, the client's healing beliefs and practices and explore ways to incorporate these into the treatment plan.

Recommend a course of action through collaboration with the client. The client must know the importance of his or her participation in the treatment planning process. With client assistance, client beliefs and traditions can serve as a framework for healing in treatment. However, not all clients have the same expectations of treatment involvement; some see the counselor as the expert, desire a directive approach, and have little desire to participate in developing the treatment plan themselves.

Negotiate a treatment plan that weaves the client's cultural norms and lifeways into treatment goals, objectives, and steps. Once the treatment plan and modality are established and implemented, encourage regular dialog to gain feedback and assess treatment satisfaction. Respecting the client's culture and encouraging communication throughout the process increases client willing to engage in treatment and to adhere to the treatment plan and continuing care recommendations.

*Sources: Berlin and Fowkes 1983; Dreachslin et al. 2013; Ring 2008.*

through the treatment process, starting with the goals of the initial intake and interview. By taking the time to acclimate clients and their families to the treatment process, counselors and other behavioral health staff members tackle one obstacle that could further impede treatment engagement and retention among racially and ethnically diverse clients.

### Step 3: Endorse Collaboration in Interviews, Assessments, and Treatment Planning

Most clients are unfamiliar with the evaluation and treatment planning process and how they can participate in it. Some clients may view the initial interview and evaluation as

intrusive if too much information is requested or if the content is a source of family dishonor or shame. Other clients may resist or distrust the process based on a long history of racism and oppression. Still others feel inhibited from actively participating because they view the counselor as the authority or sole expert.

The counselor can help decrease the influence of these issues in the interview process through a collaborative approach that allows time to discuss the expectations of both counselor and client; to explain interview, intake, and treatment planning processes; and to establish ways for the client to seek clarification of his or her assessment results (Mohatt et al. 2008a). The counselor can encourage collaboration by emphasizing the importance of clients' input and interpretations. Client feedback is integral in interpreting results and

can identify cultural issues that may affect intake and evaluation (Acevedo-Polakovich et al. 2007). Collaboration should extend to client preferences and desires regarding inclusion of family and community members in evaluation and treatment planning.

## Step 4: Integrate Culturally Relevant Information and Themes

By exploring culturally relevant themes, counselors can more fully understand their clients and identify their cultural strengths and challenges. For example, a Korean woman's family may serve as a source of support and provide a sense of identity. At the same time, however, her family could be ashamed of her co-occurring generalized anxiety and substance use disorders and respond to her treatment as a source of further shame because it encourages her to disclose personal matters to people outside the family. The following section provides a brief overview of suggested strength-based topics to incorporate into the intake and evaluation process.

### Immigration History

Immigration history can shed light on client support systems and identify possible isolation or alienation. Some immigrants who live in ethnic enclaves have many sources of social support and resources. By contrast, others may be isolated, living apart from family, friends, and the support systems extant in their countries of origin. Culturally competent evaluation should always include questions about the client's country of origin, immigration status, length of time in the United States, and connections to his or her country of origin. Ask American-born clients about their parents' country of origin, the language(s) spoken at home, and affiliation with their parents' culture(s). Questions like these give the counselor

### Advice to Counselors: Conducting Strength-Based Interviews

By nature, initial interviews and evaluations can overemphasize presenting problems and concerns while underplaying client strengths and supports. This list, although not exhaustive, reminds clinicians to acknowledge client strengths and supports from the outset.

Strengths and supports:

- Pride and participation in one's culture
- Social skills, traditions, knowledge, and practical skills specific to the client's culture
- Bilingual or multilingual skills
- Traditional, religious, or spiritual practices, beliefs, and faith
- Generational wisdom
- Extended families and nonblood kinships
- Ability to maintain cultural heritage and practices
- Perseverance in coping with racism and oppression
- Culturally specific ways of coping
- Community involvement and support

Source: Hays 2008.

important clues about the client's degree of acculturation in early life and at present, cultural identity, ties to culture of origin, potential cultural conflicts, and resources. Specific questions should elicit information about:

- Length of time in the United States, noting when immigration occurred or the number of generations who have resided in the United States.
- Frequency of returns and psychological and personal ties to the country of origin.
- Primary language and level of English proficiency in speaking and writing.
- Psychological reactions to immigration and adjustments made in the process.
- Changes in social status and other areas as a result of coming to this country.
- Major differences in attitudes toward alcohol and drug use from the time of immigration to now.

## Cultural Identity and Acculturation

As shown in Zhang Min's case at the beginning of this chapter, cultural identity is a unique feature of each client. Counselors should guard against making assumptions about client identity based on general ethnic and racial identification by evaluating the degree to which an individual identifies with his or her culture(s) of origin. As Castro and colleagues (1999b) explain, "for each group, the level of within-group variability can be assessed using a core dimension that ranges from high cultural involvement and acceptance of the traditional culture's values to low or no cultural involvement" (p. 515). For African Americans, for example, this dimension is called "Afrocentricity." Scales for Afrocentricity have been developed in an attempt to provide an indicator of an individual's level of involvement within the traditional or core African-oriented culture (Baldwin and Bell 1985; Cokley and Williams 2005; Klonoff and Landrine 2000). Many other instruments based on models of identity evaluate acculturation and identity. A detailed discussion of the theory behind such models is beyond the scope of this Treatment Improvement Protocol (TIP); however, counselors should have a general understanding of what is being measured when administering such instruments. The "Asking About Culture and Acculturation" advice box at right addresses exploration of culture and acculturation with clients. For more information on instruments that measure acculturation and/or identity, see Appendix B.

Other areas to explore include the cross-cutting factors outlined in Chapter 1, such as socioeconomic status (SES), occupation, education, gender, and other variables that can distinguish an individual from others who share his or her cultural identity. For example, a biracial client could identify with African

### Advice to Counselors: Asking About Culture and Acculturation

A thoughtful exploration of cultural and ethnic identity issues will provide clues for determining cultural, racial, and ethnic identity. There are numerous clues that you may derive from your clients' answers, and they cannot all be covered in this TIP; this is only one set of sample questions (Fontes 2008). Ask these questions tactfully so they do not sound like an interrogation. Try to integrate them naturally into a conversation rather than asking one after another. Not all questions are relevant in all settings. Counselors can adapt wording to suit clients' cultural contexts and styles of communication, because the questions listed here and throughout this chapter are only examples:

- Where were you born?
- Whom do you consider family?
- What was the first language you learned?
- Which other language(s) do you speak?
- What language or languages are spoken in your home?
- What is your religion? How observant are you in practicing that religion?
- What activities do you enjoy when you are not working?
- How do you identify yourself culturally?
- What aspects of being \_\_\_\_\_ are most important to you? (Use the same term for the identified culture as the client.)
- How would you describe your home and neighborhood?
- Whom do you usually turn to for help when facing a problem?
- What are your goals for this interview?

American culture, White American culture, or both. When a client has two or more racial/ethnic identities, counselors should assess how the client self-identifies and how he or she negotiates the different worlds.

### Membership in a Subculture

Clients often identify initially with broader racial, ethnic, and cultural groups. However, each person has a unique history that warrants an understanding of how culture is practiced and has evolved for the person and his or her

family; accordingly, counselors should avoid generalizations or assumptions. Clients are often part of a culture within a culture. There is not just one Latino, African American, or Native American culture; many variables influence culture and cultural identity (see the “What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture” section in Chapter 1). For example, an African American client from East Carroll Parish, LA, might describe his or her culture quite differently than an African American from downtown Hartford, CT.

## Beliefs About Health, Healing, Help-Seeking, and Substance Use

Just as culture shapes an individual’s sense of identity, it also shapes attitudes surrounding health practices and substance use. Cultural acceptance of a behavior, for instance, can mask a problem or deter a person from seeking treatment. Counselors should be aware of how the client’s culture conceptualizes issues related to health, healing and treatment practices, and the use of substances. For example, in cases where alcohol use is discouraged or frowned upon in the community, the client can experience tremendous shame about drinking. Chapter 5 reviews health-related beliefs and practices that can affect help-seeking behavior across diverse populations.

## Trauma and Loss

Some immigrant subcultures have experienced violent upheavals and have a higher incidence of trauma than others. The theme of trauma and loss should therefore be incorporated into general intake questions. Specific issues under this general theme might include:

- Migration, relocation, and emigration history—which considers separation from homeland, family, and friends—and the stressors and loss of social support that can accompany these transitions.

### Advice to Counselors: Eliciting Client Views on Presenting Problems

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word the following questions using the clients’ terminology rather than using the word “problem.” These questions help explore how clients view their behavioral health concerns:

- I know that clients and counselors sometimes have different ideas about illness and diseases, so can you tell me more about your idea of your problem?
- Do you consider your use of alcohol and/or drugs a problem?
- How do you label your problem? Do you think it is a serious problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What is going on in your body as a result of this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and its treatment?
- How is your problem viewed in your family? Is it acceptable?
- How is your problem viewed in your community? Is it acceptable? Is it considered a disease?
- Do you know others who have had this problem? How did they treat the problem?
- How does your problem affect your stature in the community?
- What kinds of treatment do you think will help or heal you?
- How have you treated your drug and/or alcohol problem or emotional distress?
- What has been your experience with treatment programs?

Sources: Lynch and Hanson 2011; Tang and Bigby 1996; Taylor 2002.

- Clients’ personal or familial experiences with American Indian boarding schools.
- Experiences with genocide, persecution, torture, war, and starvation.

## How To Use a Multicultural Intake Checklist

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word questions about the following topics using the client's terminology, rather than using the word "problem." Asking questions about the following topics can help you explore how a client may view his or her behavioral health concerns:

- Immigration history
- Relocations (current migration patterns)
- Losses associated with immigration and relocation history
- English language fluency
- Bilingual or multilingual fluency
- Individualistic/collectivistic orientation
- Racial, ethnic, and cultural identities
- Tribal affiliation, if appropriate
- Geographic location
- Family and extended family concerns (including nonblood kinships)
- Acculturation level (e.g., traditional, bicultural)
- Acculturation stress
- History of discrimination/racism
- Trauma history
- Historical trauma
- Intergenerational family history and concerns
- Gender roles and expectations
- Birth order roles and expectations
- Relationship and dating concerns
- Sexual and gender orientation
- Health concerns
- Traditional healing practices
- Help-seeking patterns
- Beliefs about wellness
- Beliefs about mental illness and mental health treatment
- Beliefs about substance use, abuse, and dependence
- Beliefs about substance abuse treatment
- Family views on substance use and substance abuse treatment
- Treatment concerns related to cultural differences
- Cultural approaches to healing or treatment of substance use and mental disorders
- Education history and concerns
- Work history and concerns
- SES and financial concerns
- Cultural group affiliation
- Current network of support
- Community concerns
- Review of confidentiality parameters and concerns
- Cultural concepts of distress (DSM-5\*)
- DSM-5 culturally related V-codes

\**Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association [APA] 2013).

Sources: Comas-Diaz 2012; Constantine and Sue 2005; Sussman 2004.

## Step 5: Gather Culturally Relevant Collateral Information

A client who needs behavioral health treatment services may be unwilling or unable to provide a full personal history from his or her

own perspective and may not recall certain events or be aware of how his or her behavior affects his or her well-being and that of others. Collateral information—supplemental information obtained with the client's permission from sources other than the client—can be derived from family members, medical and court records, probation and parole officers,



community members, and others. Collateral information should include culturally relevant information obtained from the family, such as the organizational memberships, beliefs, and practices that shape the client's cultural identity and understanding of the world.

As families can be a vital source of information, counselors are likely to attain more support by engaging families earlier in the treatment process. Although counselor interactions with family members are often limited to a few formal sessions, the families of racially and ethnically diverse clients tend to play a more significant and influential role in clients' participation in treatment. Consequently, special sensitivity to the cultural background of family members providing collateral information is essential. Families, like clients, cannot be easily defined in terms of a generic cultural identity (Congress 2004; Taylor et al. 2012). Even families from the same racial background or ethnic heritage can be quite dissimilar, thus requiring a multidimensional approach in understanding the role of culture in the lives of clients and their families. Using the culturagram tool on the next page in preparation for counseling, treatment planning, or clinical supervision, clinicians can learn about the unique attributes and histories that influence clients' lives in a cultural context.

## **Step 6: Select Culturally Appropriate Screening and Assessment Tools**

Discussions of the complexities of psychological testing, the interpretation of assessment measures, and the appropriateness of screening procedures are outside the scope of this TIP. However, counselors and other clinical service providers should be able to use assessment and screening information in culturally competent ways. This section discusses several

instruments and their appropriateness for specific cultural groups. Counselors should continue to explore the availability of mental health and substance abuse screening and assessment tools that have been translated into or adapted for other languages.

### **Culturally Appropriate Screening Devices**

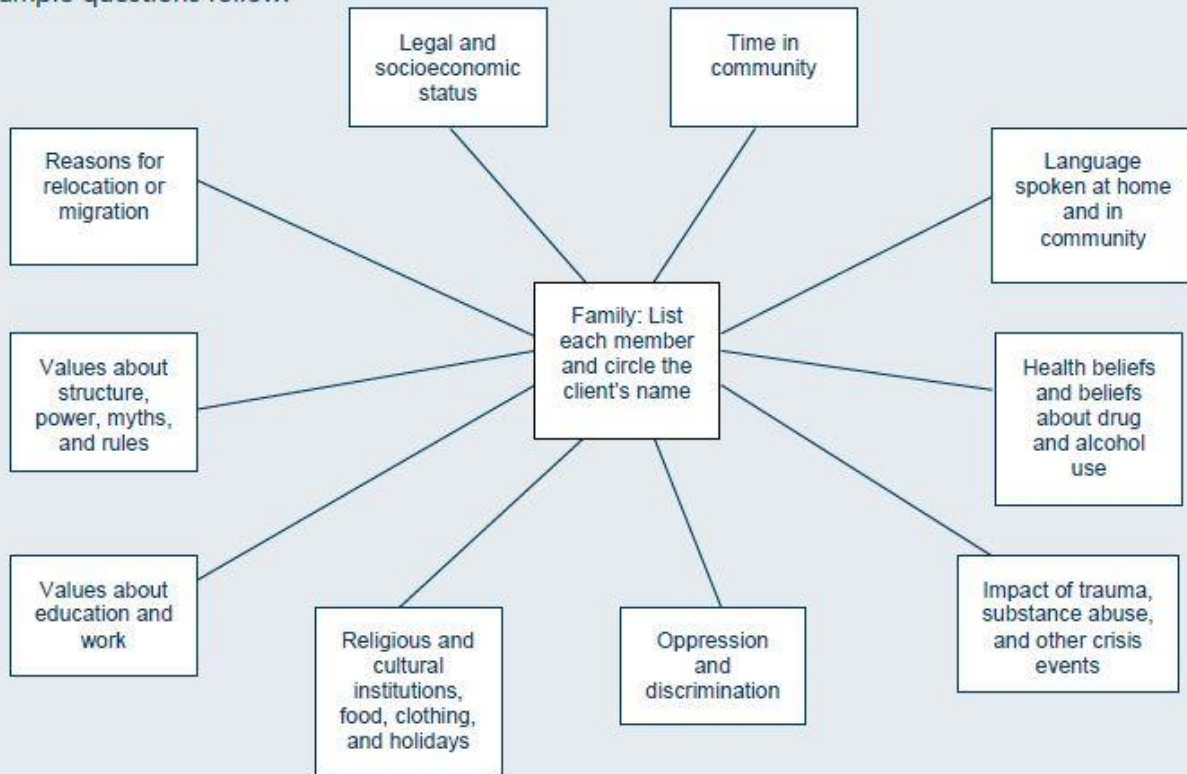
The consensus panel does not recommend any specific instruments for screening or assessing mental or substance use disorders. Rather, when selecting instruments, practitioners should consider their cultural applicability to the client being served (AACE 2012; Jome and Moody 2002). For example, a screening instrument that asks the respondent about his or her guilt about drinking could be ineffective for members of cultural, ethnic, or religious groups that prohibit any consumption of alcohol. Al-Ansari and Negrete's (1990) research supports this point. They found that the Short Michigan Alcoholism Screening Test was highly sensitive with people who use alcohol in a traditional Arab Muslim society; however, one question—"Do you ever feel guilty about your drinking?"—failed to distinguish between people with alcohol dependency disorders in treatment and people who drank in the community. Questions designed to measure conflict that results from the use of alcohol can skew test results for participants from cultures that expect complete abstinence from alcohol and/or drugs. Appendix D summarizes instruments tested on specific populations (e.g., availability of normative data for the population being served).

### **Culturally Valid Clinical Scales**

As the literature consistently demonstrates, co-occurring mental disorders are common in people who have substance use disorders. Although an assessment of psychological problems helps match clients to appropriate

## How To Use a Culturagram for Mapping the Role of Culture

The culturagram is an assessment tool that helps clinicians understand culturally diverse clients and their families (Congress 1994, 2004; Congress and Kung 2005). It examines 10 areas of inquiry, which should include not only questions specific to clients' life experiences, but also questions specific to their family histories. This diagram can guide an interview, counseling, or clinical supervision session to elicit culturally relevant multigenerational information unique to the client and the client's family. Give a copy of the diagram to the client or family for use as an interactive tool in the session. Throughout the interview, the client, family members, and/or the counselor can write brief responses in each box to highlight the unique attributes of the client's history in the family context. This diagram has been adapted for clients with co-occurring mental and substance use disorders; sample questions follow.



### Values about family structure, power, myths, and rules:

- Are there specific gender roles and expectations in your family?
- Who holds the power within the family?
- Are family needs more important than, or equally as important as, individual needs?
- Whom do you consider family?

### Reasons for relocation or migration:

- Are you and your family able to return home?
- What were your reasons for coming to the United States?
- How do you now view the initial reasons for relocation?
- What feelings do you have about relocation or migration?
- Do you move back and forth from one location to another?
- How often do you and your family return to your homeland?
- Are you living apart from your family?

### Legal status and SES:

- Has your SES improved or worsened since coming to this country?
- Has there been a change in socioeconomic status across generations?

*(Continued on the next page.)*

## How To Use a Culturagram for Mapping the Role of Culture (continued)

- What is the family history of documentation? (Note: Clients often need to develop trust before discussing legal status; they may come from a place where confidentiality is unfamiliar.)

### Time in the community:

- How long have you and your family members been in the country? Community?
- Are you and your family actively involved in a culturally based community?

### Languages spoken in and outside the home:

- What languages are spoken at home and in the community?
- What is your and your family's level of proficiency in each language?
- How dependent are parents and grandparents on their children for negotiating activities surrounding the use of English? Have children become the family interpreters?

### Health beliefs and beliefs about help-seeking:

- What are the family beliefs about drug and alcohol use? Mental illness? Treatment?
- Do you and your family uphold traditional healing practices?
- How do help-seeking behaviors differ across generations and genders in your family?
- How do you and your family define illness and wellness?
- Are there any objections to the use of Western medicine?

### Impact of trauma and other crisis events:

- How has trauma affected your family across generations?
- How have traumas or other crises affected you and/or your family?
- Has there been a specific family crisis?
- Did the family experience traumatic events prior to migration—war, other forms of violence, displacement including refugee camps, or similar experiences?

### Oppression and discrimination:

- Is there a history of oppression and discrimination in your homeland?
- How have you and your family experienced discrimination since immigration?

### Religious and cultural institutions, food, clothing, and holidays:

- Are there specific religious holidays that your family observes?
- What holidays do you celebrate?
- Are there specific foods that are important to you?
- Does clothing play a significant cultural or religious role for you?
- Do you belong to a cultural or social club or organization?

### Values about education and work:

- How much importance do you place on work, family, and education?
- What are the educational expectations for children within the family?
- Has your work status changed (e.g., level of responsibility, prestige, and power) since migration?
- Do you or does anyone in your family work several jobs?

Sources: Comas-Diaz 2012; Congress 1994, 2004; Singer 2007.

treatment, clinicians are cautioned to proceed carefully. People who are abusing substances or experiencing withdrawal from substances can exhibit behaviors and thinking patterns consistent with mental illness. After a period of abstinence, symptoms that mimic mental illness can disappear. Moreover, clinical instruments are imperfect measurements of

equally imperfect psychological constructs that were created to organize and understand clinical patterns and thus better treat them; they do not provide absolute answers. As research and science evolve, so does our understanding of mental illness (Benuto 2012).

Assessment tools are generally developed for particular populations and can be inapplicable

to diverse populations (Blume et al. 2005; Suzuki and Ponterotto 2008). Appendix D summarizes research on the clinical utility of instruments for screening and assessing co-occurring disorders in various cultural groups.

## Diagnosis

Counselors should consider clients' cultural backgrounds when evaluating and assessing mental and substance use disorders (Bhugra and Gupta 2010). Concerns surrounding diagnoses of mental and substance use disorders (and the cross-cultural applicability of those diagnoses) include the appropriateness of specific test items or questions, diagnostic criteria, and psychologically oriented concepts (Alarcon 2009; Room 2006). Research into specific techniques that address cultural differences in evaluative and diagnostic processes so far remains limited and underrepresentative of diverse populations (Guindon and Sobhany 2001; Martinez 2009).

Does the DSM-5 accurately diagnose mental and substance use disorders among immigrants and other ethnic groups? Caetano and

Shafer (1996) found that diagnostic criteria seemed to identify alcohol dependency consistently across race and ethnicity, but their sample was limited to African Americans, Latinos, and Whites. Other research has shown mixed results.

In 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses, including substance use disorders. WHO and NIH identified factors that appeared to be universal aspects of mental and substance use disorders and then developed instruments to measure them. These instruments, the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), include some DSM and International Statistical Classification of Diseases and Related Health Problems criteria. Studies report that both the CIDI and SCAN were generally accurate, but the investigators urge caution in translation and interview procedures (Room et al. 2003).

### **Advice to Counselors and Clinical Supervisors: Culturally Responsive Screening and Assessment**

- Assess the client's primary language and language proficiency prior to the administration of any evaluation or use of testing instruments.
- Determine whether the assessment materials were translated using specific terms, including idioms that correspond to the client's literacy level, culture, and language. Do not assume that translation into a stated language exactly matches the specific language of the client. Specifically, the client may not understand the translated language if it does not match his or her ways of thinking or speaking
- Educate the client on the purpose of the assessment and its application to the development of the treatment plan. Remember that testing can generate many emotional reactions.
- Know how the test was developed. Is normative data available for the population being served? Test results can be inflated, underestimated, or inaccurate due to differences within the client's population.
- Consider the role of acculturation in testing, including the influence of the client's worldview in responses. Unfamiliarity with mainstream United States culture can affect interpretation of questions, the client-evaluator relationship, and behavior, including participation level during evaluation and verbal and behavioral responses.

Sources: Association for Assessment in Counseling and Education (AACE) 2012; Saldaña 2001.

Overall, psychological concepts that are appropriate for and easily translated by some groups are inappropriate for others. In some Asian cultures, for example, feeling refers more to a physical than an emotive state; questions designed to infer emotional states are not easily translated. In most cases, these issues can be remedied by using culture-specific resources, measurements, and references while also adopting a cultural formulation in the interviewing process (see Appendix E for the APA's cultural formulation outline). The DSM-5 lists several cultural concepts of distress (see Appendix E), yet there is little empirical literature providing data or treatment guidance on using the APA's cultural formulation or addressing cultural concepts of distress (Martinez 2009; Mezzich et al. 2009).

## Step 7: Determine Readiness and Motivation for Change

Clients enter treatment programs at different levels of readiness for change. Even clients who present voluntarily could have been pushed into it by external pressures to accept treatment before reaching the action stage. These different readiness levels require different approaches. The strategies involved in motivational interviewing can help counselors prepare culturally diverse clients to change their behavior and keep them engaged in treatment. To understand motivational interviewing, it is first necessary to examine the process of change that is involved in recovery. See TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999b), for more information on this technique.

### Stages of Change

Prochaska and DiClemente's (1984) classic transtheoretical model of change is applicable

to culturally diverse populations. This model divides the change process into several stages:

- *Precontemplation.* The individual does not see a need to change. For example, a person at this stage who abuses substances does not see any need to alter use, denies that there is a problem, or blames the problem on other people or circumstances.
- *Contemplation.* The person becomes aware of a problem but is ambivalent about the course of action. For instance, a person struggling with depression recognizes that the depression has affected his or her life and thinks about getting help but remains ambivalent on how he/she may do this.
- *Preparation.* The individual has determined that the consequences of his or her behavior are too great and that change is necessary. Preparation includes small steps toward making specific changes, such as when a person who is overweight begins reading about wellness and weight management. The client still engages in poor health behaviors but may be altering some behaviors or planning to follow a diet.
- *Action.* The individual has a specific plan for change and begins to pursue it. In relation to substance abuse, the client may make an appointment for a drug and alcohol assessment prior to becoming abstinent from alcohol and drugs.
- *Maintenance.* The person continues to engage in behaviors that support his or her decision. For example, an individual with bipolar I disorder follows a daily relapse prevention plan that helps him or her assess warning signs of a manic episode and reminds him or her of the importance of engaging in help-seeking behaviors to minimize the severity of an episode.

Progress through the stages is nonlinear, with movement back and forth among the stages at different rates. It is important to recognize that change is not a one-time process, but

rather, a series of trials and errors that eventually translates to successful change. For example, people who are dependent on substances often attempt to abstain several times before they are able to acquire long-term abstinence.

## Motivational Interviewing

Motivational interventions assess a person's stage of change and use techniques likely to move the person forward in the sequence. Miller and Rollnick (2002) developed a therapeutic style called motivational interviewing, which is characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. The counselor's major tool is reflective listening and soliciting change talk (CSAT 1999c).

This nonconfrontational, client-centered approach to treatment differs significantly from traditional treatments in several ways, creating a more welcoming relationship. TIP 35 (CSAT 1999c) assesses Project MATCH and other clinical trials, concluding that the evidence strongly supports the use of motivational interviewing with a wide variety of cultural and ethnic groups (Miller and Rollnick 2013; Miller et al. 2008). TIP 35 is a good motivational interviewing resource. For specific application of motivational interviewing with Native Americans, see Venner and colleagues (2006). For improvement of treatment compliance among Latinos with depression through motivational interviewing, see Interian and colleagues (2010).

## Step 8: Provide Culturally Responsive Case Management

Clients from various racial, ethnic, and cultural populations seeking behavioral health services may face additional obstacles that can

interfere with or prevent access to treatment and ancillary services, compromise appropriate referrals, impede compliance with treatment recommendations, and produce poorer treatment outcomes. Obstacles may include immigration status, lower SES, language barriers, cultural differences, and lack of or poor coverage with health insurance.

Case management provides a single professional contact through which clients gain access to a range of services. The goal is to help assess the need for and coordinate social, health, and other essential services for each client. Case management can be an immense help during treatment and recovery for a person with limited English literacy and knowledge of the treatment system. Case management focuses on the needs of individual clients and their families and anticipates how those needs will be affected as treatment proceeds. The case manager advocates for the client (CSAT 1998a; Summers 2012), easing the way to effective treatment by assisting the client with critical aspects of life (e.g., food, childcare, employment, housing, legal problems). Like counselors, case managers should possess self-knowledge and basic knowledge of other cultures, traits conducive to working well with diverse groups, and the ability to apply cultural competence in practical ways.

Cultural competence begins with self-knowledge; counselors and case managers should be aware of and responsive to how their culture shapes attitudes and beliefs. This understanding will broaden as they gain knowledge and direct experience with the cultural groups of their client population, enabling them to better frame client issues and interact with clients in culturally specific and appropriate ways. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a), offers more information on effective case management.

Exhibit 3-1 discusses the cultural matching of counselors with clients. When counselors cannot provide culturally or linguistically competent services, they must know when and how to bring in an interpreter or to seek other assistance (CSAT 1998a). Case management includes finding an interpreter who communicates well in the client's language and dialect and who is familiar with the vocabulary required to communicate effectively about sensitive subject matter. The case manager works within the system to ensure that the interpreter, when needed, can be compensated. Case managers should also have a list of appropriate referrals to meet assorted needs. For example, an immigrant who does not speak English may need legal services in his or her language; an undocumented worker may need to know where to go for medical assistance. Culturally competent case managers build and maintain rich referral resources for their clients.

The Case Management Society of America's *Standards of Practice for Case Management* (2010) state that case management is central in meeting client needs throughout the course of treatment. The standards stress understanding relevant cultural information and communicating effectively by respecting and being responsive to clients and their cultural contexts. For standards that are also applicable to case management, refer to the National Association of Social Workers' *Standards on Cultural Competence in Social Work Practice* (2001).

## Step 9: Incorporate Cultural Factors Into Treatment Planning

The cultural adaptation of treatment practices is a burgeoning area of interest, yet research is limited regarding the process and outcome of culturally responsive treatment planning in behavioral health treatment services for

### Exhibit 3-1: Client–Counselor Matching

The literature is inconclusive about the value of client–counselor matching based on race, ethnicity, or culture (Imel et al. 2011; Larrison et al. 2011; Suarez-Morales et al. 2010). Sue et al. (1991) found that for people whose primary language was not English, counselor–client matching for ethnicity and language predicted longer time in treatment (more sessions) with better outcomes for all ethnic groups studied: Asian Americans, African Americans, Mexican Americans, and White Americans.

Ethnic matches may work better for Latinos in treatment; gender congruence seems more important than race or ethnicity in client–counselor matching, particularly for female clients (Sue and Sue 2013a). For Asian Americans and Pacific Islanders, the many different ethnic subgroups make a cultural match more difficult. In multicultural communities, racial and ethnic matching may help develop a working alliance between the therapist and the consumer (Chao et al. 2012). Other relevant variables of both the client and therapist are age, marital status, training, language, and parental status. The extent to which a cultural match is necessary in therapy depends on client preferences, characteristics, presenting problems, and treatment needs. For example, gender matching could be more important than race/ethnicity matching to female sexual abuse survivors, who may have difficulty discussing their trauma with male counselors.

Most clients want to know that their counselors understand their worldviews, even if they do not share them. Counselors' understanding of their clients' cultures improves treatment outcomes (Suarez-Morales et al. 2010). Fiorentine and Hillhouse (1999) found that empathy, regardless of race or ethnicity of counselor and client, was the most important predictor of favorable treatment outcomes. Sue et al. (1991) found that clients using outpatient mental health services more readily attended treatment and stayed longer if services were culturally responsive. In the treatment planning process, matching clients with providers according to cultural (and subcultural, when warranted) backgrounds can help provide treatment that is responsive to the personal, cultural, and clinical needs of clients (Fontes 2008).

diverse populations. How do counselors and organizations respond culturally to the diverse needs of clients in the treatment planning process? How effective are culturally adaptive treatment goals? (For a review, see Bernal and Domenech Rodriguez 2012.) Typically, programs that provide culturally responsive services approach treatment goals holistically, including objectives to improve physical health and spiritual strength (Howard 2003). Newer approaches stress implementation of strength-based strategies that fortify cultural heritage, identity, and resiliency.

Treatment planning is a dynamic process that evolves along with an understanding of the clients' histories and treatment needs. Foremost, counselors should be mindful of each client's linguistic requirements and the availability of interpreters (for more detail on interpreters, see Chapter 4). Counselors should be flexible in designing treatment plans to meet client needs and, when appropriate, should draw upon the institutions and resources of clients' cultural communities. Culturally responsive treatment planning is achieved through active listening and should consider client values, beliefs, and expectations. Client health beliefs and treatment preferences (e.g., purification ceremonies for Native American clients) should be incorporated in addressing specific presenting problems. Some people seek help for psychological concerns and substance abuse from alternative sources (e.g., clergy, elders, social supports). Others prefer treatment programs that use principles and approaches specific to their cultures. Counselors can suggest appropriate traditional treatment resources to supplement clinical treatment activities.

In sum, clinicians need to incorporate culture-based goals and objectives into treatment plans and establish and support open client–counselor dialog to get feedback on the proposed plan's relevance. Doing so can improve client engagement in treatment services, compliance with treatment planning and recommendations, and treatment outcomes.

### Group Clinical Supervision Case Study

Beverly is a 34-year-old White American who feels responsible for the tension and dissension in her family. Beverly works in the lab of an obstetrics and gynecology practice. Since early childhood, her younger brother has had problems that have been diagnosed differently by various medical and mental health professionals. He takes several medications, including one for attention deficit disorder. Beverly's father has been out of work for several months. He is seeing a psychiatrist for depression and is on an antidepressant medication. Beverly's mother feels burdened by family problems and ineffective in dealing with them. Beverly has always helped her parents with their problems, but she now feels bad that she cannot improve their situation. She believes that if she were to work harder and be more astute, she could lessen her family's distress. She has had trouble sleeping. In the past, she secretly drank in the evenings to relieve her tension and anxiety.

Most counselors agree that Beverly is too submissive and think assertiveness training will help her put her needs first and move out of the family home. However, a female Asian American counselor sees Beverly's priorities differently, saying that "a morally responsible daughter is duty-bound to care for her parents." She thinks that the family needs Beverly's help, so it would be selfish to leave them.

#### Discuss:

- How does the counselor's worldview affect prioritizing the client's presenting problems?
- How does the counselor's individualistic or collectivistic culture affect treatment planning?
- How might a counselor approach the initial interview and evaluation to minimize the influence of his or her worldview in the evaluation and treatment planning process?

Sources: *The Office of Nursing Practice and Professional Services, Centre for Addiction and Mental Health & Faculty of Social Work, University of Toronto 2008; Zhang 1994.*



## Improving Cultural Competence, Part 2 – Core Competencies

### IN THIS CHAPTER

- Core Counselor Competencies
- Self-Assessment for Individual Cultural Competence

Gil, a 40-year-old Mexican American man, lives in an upper middle class neighborhood. He has been married for more than 15 years to his high school sweetheart, a White American woman, and they have two children. Gil owns a fleet of street-sweeping trucks—a business started by his father-in-law that Gil has expanded considerably. Of late, Gil has been spending more time at work. He has also been drinking more than usual and dabbling in illicit drugs. As his drinking has increased, tensions between Gil and his wife have escalated. From Gil’s perspective and that of some family members and friends, Gil is just a hard-working guy who deserves to have a beer as a reward for a hard day’s work. Many people in his Mexican American community do not consider Gil’s low-level daily drinking a problem, especially because he drinks primarily at home.

Recently, Gil had an accident while working on one of his trucks. The treating physician identified alcohol abuse as one of several health problems and referred him to a substance abuse treatment center. Gil attended, but argued all the while that he was not a *borracho* (drunkard) and did not need treatment. He distrusted the counselors, stating that seeking help from professionals for a mental disorder was something that only *gabachos* (Whites) did. Gil was proud of his capacity to “hold his liquor” and felt anger and hostility toward those who encouraged him to reduce his drinking. Gil’s feelings and attitudes were valid; they stemmed from and were influenced by the Mexican American culture and community in which he had been raised from infancy. Gil dropped out of treatment. When his wife threatened to divorce him if he did not take immediate action to deal with his drinking problem, he reluctantly

enrolled in an outpatient treatment program. Gil, like all people, is a product of his environment—an environment that has provided him with a rich cultural and spiritual background, a strong male identity, a deep attachment to family and community, a strong work ethic, and a sense of pride in being able to support his family. In many Mexican American cultural groups, illness disrupts family life, work, and the ability to earn a living. Illness has psychological costs as well, including threats to a man's self-identity and sense of manhood (Sobralnske 2006). Given this background, Gil would understandably be reluctant to enter treatment, to accept the fact that his drinking was a problem or an illness, and to jeopardize his ability to care for his family and his company. A culturally competent counselor would recognize, legitimize, and validate Gil's reluctance to enter and continue in treatment. In an ideal situation, the treatment counselor would have experience working with people with similar backgrounds and beliefs, and the treatment program would be structured to change Gil's behavior and attitudes in a manner that was in keeping with his culture and community. His initial treatment might have succeeded if the counselor had been culturally competent and the treatment program had been culturally responsive.

Like Gil, all clients enter treatment carrying beliefs, attitudes, conflicts, and problems shaped by their cultural roots as well as their present-day realities. As with Gil, many clients enter treatment with some reluctance and denial. Research shows that if clients such as Gil are greeted by a culturally competent counselor, they are more likely to respond positively to treatment (Damashek et al. 2012; Griner and Smith 2006; Kopelowicz et al. 2012; Whaley and Davis 2007). The presence of counselors of any race or gender who are culturally competent in responding to the needs and issues of their clients can greatly

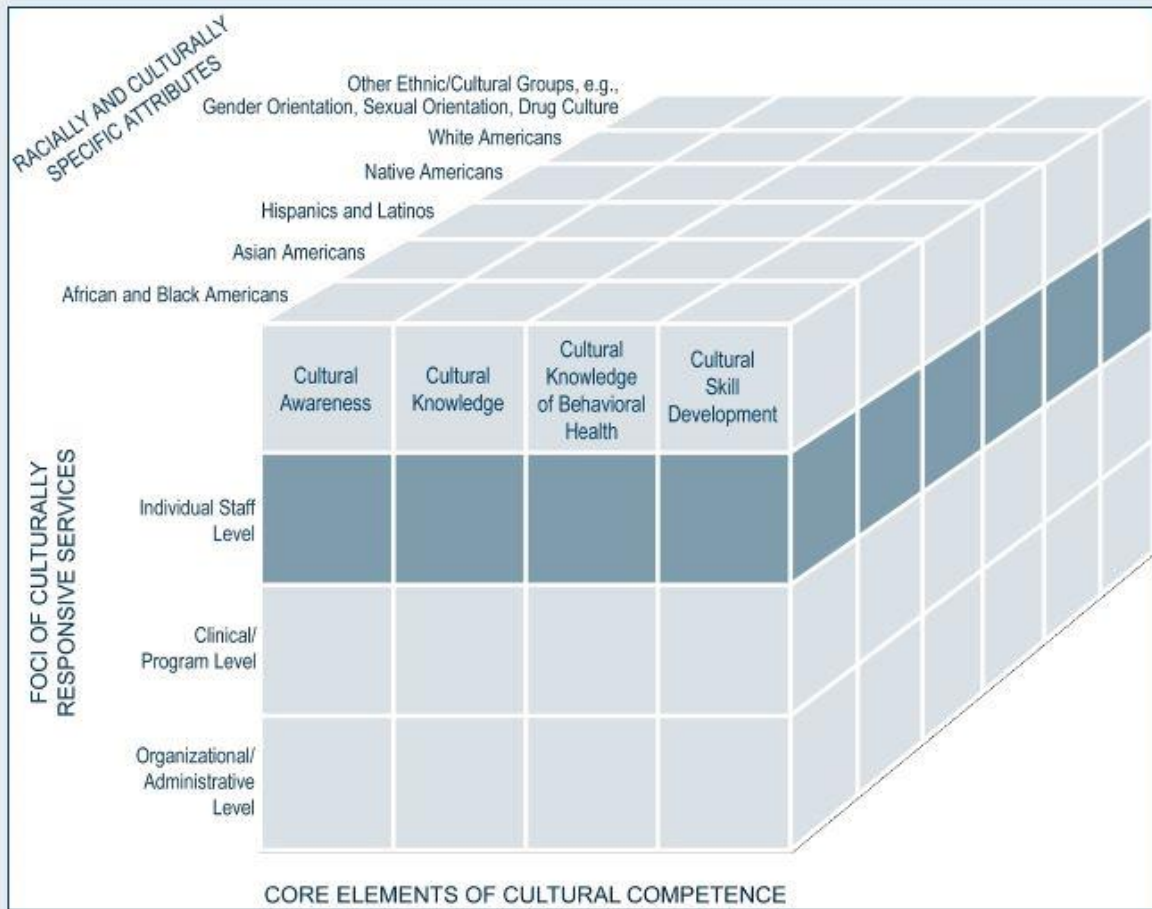
assist client recovery. Gaining regard, respect, and trust from clients is crucial for successful counseling outcomes (Ackerman and Hilsenroth 2003; Sue and Sue 2003a).

Effective therapy is an ongoing process of building relational bridges that engender trust and confidence. Sensitivity to the client's cultural and personal perspectives, genuine empathy, warmth, humility, respect, and acceptance are the tenets of all sound therapy. This chapter expands on these concepts and provides a general overview of the core competencies needed so that counselors may provide effective treatment to diverse racial and ethnic groups. Using Sue's (2001) multidimensional model for developing cultural competence, the content focuses on the counselor's need to engage in and develop cultural awareness; cultural knowledge in general; and culturally specific skills and knowledge of wellness, mental illness, substance use, treatments, and skill development.

## Core Counselor Competencies

Since Sue et al. introduced the phrase "multicultural counseling competencies" in 1992, researchers and academics have elaborated on the core skill sets that enable counselors to work with diverse populations (American Psychological Association [APA] 2002; Council of National Psychological Associations for the Advancement of Ethnic Minority Interests 2009; Pack-Brown and Williams 2003; Tseng and Streltzer 2004). Cultural competence has evolved into more than a discrete skill set or knowledge base; it also requires ongoing self-evaluation on the part of the practitioner. Culturally competent counselors are aware of their own cultural groups and of their values, assumptions, and biases regarding other cultural groups. Moreover, culturally competent counselors strive to

## Multidimensional Model for Developing Cultural Competence: Individual Staff Level



understand how these factors affect their ability to provide culturally effective services to clients.

Given the complex definition of culture and the fact that racially and ethnically diverse clients represent a growing portion of the client population, the need to update and expand guidelines for cultural competence is increasing. The consensus panel thus adapted existing guidelines from the Association of Multicultural Counseling for culturally responsive behavioral health services; some of their key suggestions for counselors and other clinical staff are outlined in this chapter.

### Self-Knowledge

Counselors with a strong belief in evidence-based treatment methods can find it hard to relate to clients who prefer traditional healing methods. Conversely, counselors with strong trust in traditional healers and culturally accepted methods can fail to understand clients who seek scientific explanations of, and solutions to, their substance abuse and mental health problems. To become culturally competent, counselors should begin by exploring their own cultural heritage and identifying how it shapes their perceptions of normality, abnormality, and the counseling process.

Counselors who understand themselves and their own cultural groups and perceptions are better equipped to respect clients with diverse belief systems. In gaining an awareness of their cultures, attitudes, beliefs, and assumptions through self-examination, training, and clinical supervision, counselors should consider the factors described in the following sections.

### **Cultural awareness**

Counselors who are aware of their own cultural backgrounds are more likely to acknowledge and explore how culture affects their client–counselor relationships. Without cultural awareness, counselors may provide counseling that ignores or does not address obvious issues that specifically relate to race, ethnic heritage, and culture. Lack of awareness can discount the importance of how counselors’ cultural backgrounds—including beliefs, values, and attitudes—influence their initial and diagnostic impressions of clients. Without cultural awareness, counselors can unwittingly use their own cultural experiences as a template to prejudge and assess client experiences and clinical presentations. They may struggle to see the cultural uniqueness of each client, assuming that they understand the client’s life experiences and background better than they really do. With cultural awareness, counselors examine how their own beliefs, experiences, and biases affect their definitions of normal and abnormal behavior. By valuing this awareness, counselors are more likely to take the time to understand the client’s cultural groups and their role in the therapeutic process, the client’s relationships, and his or her substance-related and other presenting clinical problems. Cultural awareness is the first step toward becoming a culturally competent counselor.

### **Racial, ethnic, and cultural identities**

A key step in attaining cultural competence is for counselors to become aware of their own racial, ethnic, and cultural identities. Although

### **Models of Racial Identity**

Models of racial identity, often structured in stages, highlight the process that individuals undertake in becoming aware of their sense of self in relation to race and ethnicity within the context of their families, communities, societies, and cultural histories. Influenced by the Civil Rights Movement, earlier racial identity models in the United States focused on White and Black racial identity development (Cross 1995; Helms 1990; Helms and Carter 1991). Since then, models have been created to incorporate other races, ethnicities, and cultures.

Although this chapter highlights two formative racial identity models (see next page), additional resources highlight racial identity models that incorporate other diverse groups, including those individuals who identify as multiracial (e.g., see Wijeyesinghe and Jackson 2012).

the constructs of these identities are complex and difficult to define briefly, what follows is an overview. Racial identity “refers to a sense of group or collective identity based on one’s perception that he or she shares a common heritage with a particular racial group” (Helms 1990, p. 3). Ethnic and cultural identity is “often the frame in which individuals identify consciously or unconsciously with those with whom they feel a common bond because of similar traditions, behaviors, values, and beliefs” (Chavez and Guido-DiBrito 1999, p. 41). Culture includes, but is not limited to, spirituality and religion, rituals and rites of passage, language, dietary habits (e.g., attitudes toward food/food preparation, symbolism of food, religious taboos of food), and leisure activities (Bhugra and Becker 2005).

Aspects of racial, ethnic, and cultural identities are not always apparent and do not always factor into conscious processes for the counselor or client, but these factors still play a role in the therapeutic relationship. Identity development and formation help people make sense of themselves and the world around them. If

positive racial, ethnic, and cultural messages are not available or supported in behavioral health services, counselors and clients can lack affirmative views of their own identities and may internalize negative messages or feel disconnected from their racial and cultural heritages. Counselors from mainstream society are less likely to be actively aware of their own ethnic and cultural identities; in particular, White Americans are not naturally drawn into examining their cultural identities, as they typically experience no dissonance when engaging in cultural activities.

In working to attain cultural competence, counselors must explore their own racial and cultural heritages and identities to gain a deeper understanding of personal development. Many models and theories of racial, ethnic, and cultural development are available; two common processes are presented below. Exhibit 2-1 highlights the racial/cultural identity development (R/CID) model (Sue and Sue 1999b) and the White racial identity development (WRID) model (Sue 2001). Although earlier work focused on a linear developmental process using stages, current thought centers on a more flexible process whereby identification status can loop back to an earlier process or move to a later phase.

Using either model, counselors can explore relational and clinical challenges associated with a given phase. Without an understanding of the cultural identity development process, counselors—regardless of race or ethnicity—can unwittingly minimize the importance of racial and ethnic experiences. They may fail to identify cultural needs and secure appropriate treatment services, unconsciously operate from a superior perspective (e.g., judging a specific behavior as ineffectual, a sign of resistance, or a symptom of pathology), internalize a client's reaction (e.g., an African American counselor feeling betrayed or inadequate when a client of

the same race requests a White American counselor for therapy during an initial interview), or view a client's behavior through a veil of societal biases or stereotypes. By acknowledging and endorsing the active process of racial and cultural identity development, counselors from diverse groups can normalize their own development processes and increase their awareness of clients' parallel processes of identity development. In counseling, racial, ethnic, and cultural identities can be pivotal to the treatment process in the relationships not only between the counselor and client, but among everyone involved in the delivery of the client's behavioral health and primary care services (e.g., referral sources, family members, medical personnel, administrators). The case study on page 41 uses stages from the two models in Exhibit 2-1 to show the interactive process of racial and cultural identity development in the treatment context.

Cultural and racial identities are not static factors that simply mediate individual identity; they are dynamic, interactive developmental processes that influence one's willingness to acknowledge the effects of race, ethnicity, and culture and to act against racism and disparity across relationships, situations, and environments (for a review of racial and cultural identity development, see Sue and Sue 2013c). For counselors and clinical supervisors, it is essential to understand the dynamic nature of cultural identity in all exchanges. Starting with a personal appraisal, clinical staff members can begin to reflect—without judgment—on how their own racial and cultural identities influence their decisions, treatment planning, case presentation, supervision, and interactions with other staff members. Clinicians can map the interactive influences of cultural identity development among clients, the clients' families, staff members, the organization, other agencies, and any other entities involved in the client's treatment. Using mapping (see the

## Exhibit 2-1: Stages of Racial and Cultural Identity Development

R/CID Model	WRID Model
<p><b>Conformity:</b> Has a positive attitude toward and preference for dominant cultural values; places considerable value on characteristics that represent dominant cultural groups; may devalue or hold negative views of own race or other racial/ethnic groups.</p> <p><b>Dissonance and Appreciating:</b> Begins to question identity; recognizes conflicting messages and observations that challenge beliefs/stereotypes of own cultural groups and value of mainstream cultural groups; develops growing sense of one's own cultural heritage and the existence of racism; moves away from seeing dominant cultural groups as all good.</p> <p><b>Resistance and Immersion:</b> Embraces and holds a positive attitude toward and preference for his or her own race and cultural heritage; rejects dominant values of society and culture; focuses on eliminating oppression within own racial/cultural group; likely to possess considerable feelings—including distrust and anger—toward dominant cultural groups and anything that may represent them; places considerable value on characteristics that represent one's own cultural groups without question; develops a growing appreciation for others from racially and culturally diverse groups.</p> <p><b>Introspection:</b> Begins to question the psychological cost of projecting strong feelings toward dominant cultural groups; desires to refocus more energy on personal identity while respecting own cultural groups; realigns perspective to note that not all aspects of dominant cultural groups—one's own racial/cultural group or other diverse groups—are good or bad; may struggle with and experience conflicts of loyalty as perspective broadens.</p> <p><b>Integrative Awareness:</b> Has developed a secure, confident sense of racial/cultural identity; becomes multicultural; maintains pride in racial identity and cultural heritage; commits to supporting and appreciating all oppressed and diverse groups; tends to recognize racism as a societal illness by which all can be victimized.</p>	<p><b>Naiveté:</b> Had an early childhood developmental phase of curiosity or minimal awareness of race; may or may not receive overt or covert messages about other racial/cultural groups; possesses an ethnocentric view of culture.</p> <p><b>Conformity:</b> Has minimal awareness of self as a racial person; believes strongly in the universality of values and norms; perceives White American cultural groups as more highly developed; may justify disparity of treatment; may be unaware of beliefs that reflect this.</p> <p><b>Dissonance:</b> Experiences an opportunity to examine own prejudices and biases; moves toward the realization that dominant society oppresses racially and culturally diverse groups; may feel shame, anger, and depression about the perpetuation of racism by White American cultural groups; and may begin to question previously held beliefs or reformatify prior views.</p> <p><b>Resistance and Immersion:</b> Increases awareness of one's own racism and how racism is projected in society (e.g., media and language); likely feels angry about messages concerning other racial and cultural groups and guilty for being part of an oppressive system; may counteract feelings by assuming a paternalistic role (knowing what is best for clients without their involvement) or overidentifying with another racial/cultural group.</p> <p><b>Introspection:</b> Begins to redefine what it means to be a White American and to be a racial and cultural being; recognizes the inability to fully understand the experience of others from diverse racial and cultural backgrounds; may feel disconnected from the White American group.</p> <p><b>Integrative Awareness:</b> Appreciates racial, ethnic, and cultural diversity; is aware of and understands self as a racial and cultural being; is aware of sociopolitical influences of racism; internalizes a nonracist identity.</p> <p><b>Commitment to Antiracist Action:</b> Commits to social action to eliminate oppression and disparity (e.g., voicing objection to racist jokes, taking steps to eradicate racism in institutions and public policies); likely to be pressured to suppress efforts and conform rather than build alliances with people of color.</p>

Sources: Sue 2001; Sue and Sue 1999b.

### **Case Study for Counselors: Racial and Cultural Identity**

The client is a 20-year-old Latino man. His father immigrated to the United States from Mexico as a child, and his mother (of Latino/Middle Eastern descent) grew up near Albuquerque, New Mexico. Throughout the initial phase of mental health treatment, the client presented feelings, attitudes, and behavior consistent with the resistance and immersion stage of the R/CID model. During group counseling in a partial hospitalization program, the client said that he did not think treatment was going to work. He believed that no one in treatment, except other Latino men, really understood him or his life experiences. He thought that his low mood was due, in part, to his recent job loss.

The client's current concerns, symptoms, and diagnosis (bipolar I) were presented and discussed during the treatment team meeting. The client's counselor (a White American man in the dissonance stage of the WRID model) was concerned that the client might leave treatment against medical advice and also stated that this would not be the first time a Latino client had done so. The team recognized that a Latino counselor would likely be useful in this situation (depending on the counselor's cultural competence). However, no Latino counselor was available, so the team decided that the client's current counselor should try to gain support from the client's parents to encourage the client to stay in treatment.

Because the client had signed an appropriate release of information, his counselor was able to contact the parents and arrange a family session. During the family session, the counselor brought up the client's need for a Latino counselor. His parents disagreed, expressing their belief that it was important for their son to learn to relate to the counselor. They said that this was just an excuse their son was using to leave treatment, which had happened before. The parents' reaction exemplified a conformity response, although other information would need to have been gathered to determine their current stage more accurately.

The counselor, client, parents, and organization were operating from different stages of racial and cultural identity development. Considering the lack of a proactive plan to provide appropriate resources—including the hiring of Latino staff or the development of other culturally appropriate resources (e.g., a peer counselor program)—the organization was most likely in the conformity phase of the WRID model. The counselor had some awareness of the client's racial and cultural needs and of the organization's failure to meet them, but he alienated the client despite his good intentions and reinforced mistrust by engaging the client's parents before working directly with the client. Had the counselor taken the time to understand the client's concerns and needs, he would likely have created an opportunity to challenge his own beliefs, learn more about the client's racial and cultural experiences and values, advocate for more appropriate resources for the client within the organization, be more flexible with treatment solutions, and enable the client to have an experience that exceeded his expectations of the treatment provider.

“How To Map Racial and Cultural Identity Development” box on the next page) as preparation for counseling, treatment planning, or clinical supervision, clinicians can gain awareness of the many forces that influence culturally responsive treatment.

### **Worldview: The cultural lens of counseling**

The term “worldview” refers to a set of assumptions that guide how one sees, thinks

about, experiences, and interprets the world (Koltko-Rivera 2004). Starting in early childhood, worldview development is facilitated by significant relationships (particularly with parents and family members) and is shaped by the individual's environment and life experiences, influencing values, attitudes, beliefs, and behaviors. In more simplistic terms, each person's worldview is like a pair of glasses with colored lenses—the person takes in all of life's experiences through his or her own uniquely

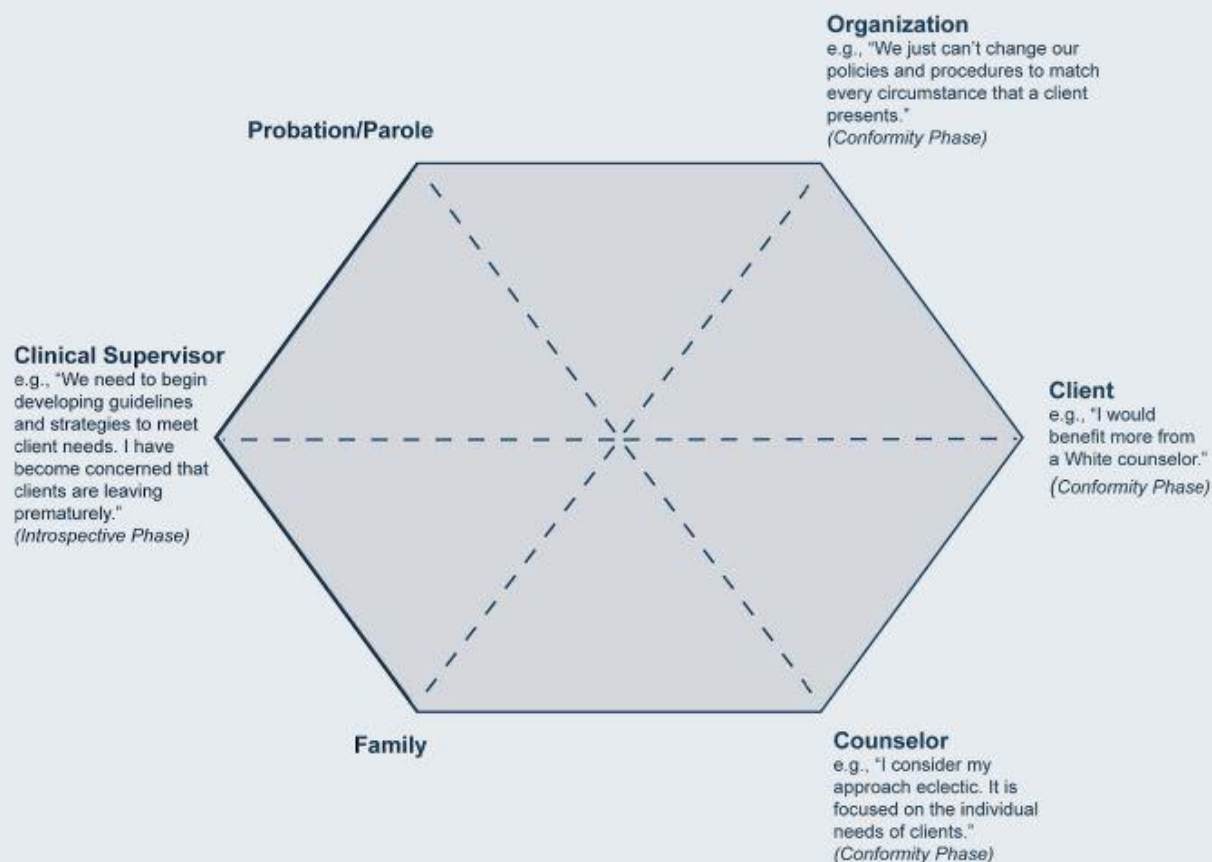
## How To Map Racial and Cultural Identity Development

Completing this diagram can give a clearer perspective on past and anticipated dialog among key stakeholders. The diagram can be used as a training tool to teach racial and cultural identity development, to help clinicians and organizations recognize their own development, to explore clinical issues and dialogs that occur when diverse parties are at similar or different developmental stages, and to develop tools and resources to address issues that arise from this developmental process. Using case studies, this diagram can serve as an interactive educational exercise to help counselors, clinical supervisors, and agencies gain awareness of the effects of race, ethnicity, and cultural groups.

**Materials needed:** Paper and pencils; handouts on the R/CID and WRID models.

### Instructions:

- Identify all relevant parties, including client, counselor, family, supervisor, referral source, other staff members, and staff from other agencies (e.g., probation/parole, medical center/office, child and youth services). Include yourself. Place the names at each intersection of the hexagon.
- List the common statements and behaviors (including lack of verbal responses) that you witness regarding the cultural needs of the client and/or the general statements made by each party regarding race, ethnicity, and culture. Write these as one-line abbreviated phrases that represent each person/agency's stance under the appropriate entry on the diagram.
- Using current information, choose the cultural identity development stage that best fits the statements or behaviors (knowing that you may be inaccurate); write it under each name.





spiritual beliefs; ideas about success; and soon (Exhibit 2-2).

However, counselors also contend with another worldview that is often invisible but still powerful—the clinical worldview (Bhugra and Gupta 2010; Tilburdt and Geller 2007; Tseng and Streltzer 2004). Influenced by education, clinical training, and work experiences, counselors are introduced into a culture that reflects specific counseling theories, techniques, treatment modalities, and general office practices. This worldview, coupled with their personal cultural worldview, significantly shapes the counselor’s beliefs pertaining to the nature of wellness, illness, and healing; interviewing skills and behavior; diagnostic impressions; and prognosis. Moreover, it influences the definition of normal versus abnormal or disordered behavior, the determination of treatment priorities, the means of intervention, and the definitions of successful outcomes and treatment failures.

Foremost, counselors need to remember that worldviews are often unspoken and inconspicuous; therefore, considerable reflection and self-exploration are needed to identify how their own cultural worldviews influence their interactions both inside and outside of counseling. Clinical staff members need to question how their perspectives are perpetuated in and shape client–counselor interactions, treatment decisions, planning, and selected counseling

approaches. In sum, culturally responsive practice involves an understanding of multiple perspectives and how these worldviews interact throughout the treatment process—including the views of the counselor, client, family, other clients and staff members, treatment program, organization, and other agencies, as well as the community.

### ***Stereotypes, prejudices, and history***

Cultural competence involves counselors’ willingness to explore their own histories of prejudice, cultural stereotyping, and discrimination. Counselors need to be aware of how their own perceptions of self and others have evolved through early childhood influences and other life experiences. For example, how were stereotypes of their own races and ethnic heritages perpetuated in their upbringing? What myths and stereotypes were projected onto other groups? What historical events shaped experiences, opportunities, and perceptions of self and others?

Regardless of their race, cultural group, or ethnic heritage, counselors need to examine how they have directly or indirectly been affected by individual, organizational, and societal stereotypes, prejudice, and discrimination. How have certain attitudes, beliefs, and behaviors functioned as deterrents to obtaining equitable opportunities? In what ways have discrimination and societal biases provided benefits to them as individuals and as counselors? Even though these questions can be uncomfortable, difficult, or painful to explore, awareness is essential regarding how these issues affect one’s role as a counselor, status in the organization, and comfort level in exploring clients’ life experiences and perceptions during the treatment process. If counselors avoid or minimize the relevance of bias and discrimination in self-exploration, they will likely do the same in the assessment and counseling process.

**Exhibit 2-2: Counselor Worldview**



All counselors should examine their stereotypes, prejudices, and emotional reactions toward others, including individuals from their own races or cultural backgrounds and individuals from other groups. They should examine how these attitudes and biases may be detrimental to clients in treatment for substance-related and mental disorders.

Clients can have behavioral health issues and healthcare concerns associated with discrimination. If counselors are blind to these issues, they can miss vital information that influences client responses to treatment and willingness to follow through with continuing care and ancillary services. For example, a counselor may refer a client to a treatment program without noting the client's history or perceptions of the recommended program or type of program. The client may initially agree to attend the program but not follow through because of past negative experiences and/or the perception within his or her racial/ethnic community that the service does not provide adequate treatment for clients of color.

### ***Trust and power***

Counselors need to understand the impact of their role and status within the client–counselor relationship. Client perceptions of counselors' influence, power, and control vary in diverse cultural contexts. In some contexts, counselors can be seen as all-knowing professionals, but in others, they can be viewed as representatives of an unjust system. Counselors need to explore how these dynamics affect the counseling process with clients from diverse backgrounds. Do client perceptions inhibit or facilitate the process? How do they affect the level of trust in the client–counselor relationship? These issues should be identified and addressed early in the counseling process. Clients should have opportunities to talk about and process their perceptions, past experiences, and current needs.

### ***Practicing within limits***

A key element of ethical care is practicing within the limits of one's competence. Counselors must engage in self-exploration, critical thinking, and clinical supervision to understand their clinical abilities and limitations

### ***Advice to Counselors and Clinical Supervisors: Using the RESPECT Mnemonic To Reinforce Culturally Responsive Attitudes and Behaviors***

- **Respect**—Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communications.
- **Explanatory model**—Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective?
- **Sociocultural context**—Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.
- **Power**—Acknowledge the power differential between clients and counselors.
- **Empathy**—Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.
- **Concerns and fears**—Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.
- **Therapeutic alliance/Trust**—Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors.

*Sources: Bigby and American College of Physicians 2003; Campinha-Bacote et al. 2005.*

regarding the services that they are able to provide, the populations that they can serve, and the treatment issues that they have sufficient training to address. Cultural competence requires an ability to assess accurately one's clinical and cultural limitations, skills, and expertise. Counselors risk providing services beyond their expertise if they lack awareness and knowledge of the influence of cultural groups on client–counselor relationships, clinical presentation, and the treatment process or if they minimize, ignore, or avoid viewing treatment in a cultural context.

Some counselors may assume that they have cultural competence based on having similar experiences as clients, being from the same race as clients, identifying as a member of the same ethnic heritage or cultural group as clients, or attending training on cultural competence. Other counselors may assume competence based on their current or prior relationships with others from the same race or cultural background as their clients. These experiences can be helpful and filled with many potential learning opportunities, but they do not make an individual eligible or competent to provide multicultural counseling. Likewise, the assumption that a person from the same cultural group, race, or ethnic heritage will intrinsically understand a client from a similar background is operating out of two common myths: the “myth of sameness” (i.e., that people from the same cultural group, race, or ethnicity are alike) and the myth that “familiarity equals competence” (Srivastava 2007). The Association for Multicultural Counseling and Development adopted a set of counselor competencies that was endorsed by the American Counseling Association (ACA) for counselors who work with a multicultural clientele (Exhibit 2-3). Competencies address the attitudes, beliefs, knowledge, and skills associated with the counselor's need for self-knowledge.

## Knowledge of Other Cultural Groups

In addition to an understanding of themselves and how their cultural groups and values can affect the therapeutic process, culturally competent counselors work to acquire cultural knowledge and understanding of clients and staff with whom they work. From the outset, counselors need general knowledge and awareness when working with other cultural groups in counseling. For example, they should acknowledge that culture influences communication patterns, values, gender roles and socialization, clinical presentations of distress, counseling expectations, and behavioral norms and expectations in and outside the counseling session (e.g., touching, greetings, gift-giving, accompaniment in sessions, level of formality between counselor and client). Counselors should filter and interpret client presentation from a broad cultural perspective instead of using only their own cultural groups or previous client experiences as reference points.

Counselors also need to invest the time to know clients and their cultures. Culturally responsive practice involves a commitment to obtaining specific cultural knowledge, not only through ongoing client interactions, but also through the use of outside resources, cultural training seminars and programs, cultural events, professional consultations,

“Become familiar with the community in which the client lives and the general cultural norms of the individual client. This can be accomplished by visiting with people who know the community well, attending important community celebrations and other events, asking open-ended questions about community concerns and quality of life, and identifying community capacities that affect wellness in the community.”

(Perez and Luquis 2008, p. 177)

## Exhibit 2-3: ACA Counselor Competencies: Counselors' Awareness of Their Own Cultural Values and Biases

### Attitudes and beliefs:

- Culturally skilled counselors have moved from being culturally unaware to being aware and sensitive to their own cultural heritages 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.
- Culturally skilled counselors recognize the limits of their multicultural competence and expertise.
- Culturally skilled counselors are comfortable with differences that exist between themselves and their clients in terms of race, ethnicity, culture, and beliefs.

### Knowledge:

- Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions of normality, abnormality, and the process of counseling.
- Culturally skilled counselors possess knowledge and understanding of how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White American counselors, it can mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism.
- Culturally skilled counselors possess knowledge about their social impact on others. They are knowledgeable about communication style differences and how their style may clash with or foster the counseling process with minority clients. They anticipate the impact their style may have on others.

### Skills:

- Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally diverse populations. Being able to recognize the limits of their competencies, they seek consultation, seek further training or education, refer out to more qualified individuals or resources, or engage in a combination of these.
- Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

Source: American Counseling Association Web site ([http://www.counseling.org/docs/competencies/cross-cultural\\_competencies\\_and\\_objectives.pdf](http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf)). Adapted with permission.

cultural guides, and clinical supervision. Counselors need to be mindful that they will not know everything about a specific population or initially comprehend how an individual client endorses or engages in specific cultural practices, beliefs, and values. For instance, some clients may not identify with the same cultural beliefs, practices, or experiences as other clients from the same cultural groups. Nevertheless, counselors need to be as knowledgeable as possible and attend to these cultural attributes—beginning with the intake and assessment process and continuing

throughout the counseling and treatment relationship. For a review of content areas essential in knowing other cultural groups, refer to the "What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture" section in Chapter 1. These cultural knowledge content areas include:

- Language and communication.
- Geographic location.
- Worldview, values, and traditions.
- Family and kinship.
- Gender roles.
- Socioeconomic status and education.

- Immigration, migration, and acculturation stress.
- Acculturation and cultural identification.
- Heritage and history.
- Sexuality.
- Religion and spirituality.
- Health, illness, and healing.

Counselors should not make assumptions about clients' race, ethnic heritage, or culture based on appearance, accents, behavior, or language. Instead, counselors need to explore with clients their cultural identity, which can involve multiple identities (Lynch and Hanson 2011). Counselors should discuss what cultural identity means to clients and how it influences

treatment. For example, a young adult two-spirited (gay) American Indian man may be more concerned with having access to traditional healing practices than to specialized services for gay men. Counselors and clients should collaboratively examine presenting treatment issues and obstacles to engaging in behavioral health treatment and maintaining recovery, and they should discuss how cultural groups and cultural identities can serve as guideposts in treatment planning.

Exhibit 2-4 lists ACA-endorsed counselor competencies for knowledge of the worldviews of clients from diverse cultural groups.

#### Exhibit 2-4: ACA Counselor Competencies: Awareness of Clients' Worldviews

##### Attitudes and beliefs:

- Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups and recognize that these reactions may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of clients from diverse cultures in a nonjudgmental fashion.
- Culturally skilled counselors are aware of the stereotypes and preconceived notions they may hold toward other racial and ethnic minority groups.

##### Knowledge:

- Culturally skilled counselors possess specific knowledge and information about the particular group(s) with whom they are working. They are aware of the life experiences, cultural heritages, and historical backgrounds of clients from cultures other than their own. This competence is strongly linked to the minority identity development models available in the literature.
- Culturally skilled counselors understand how race, cultural group, ethnicity, and other factors can affect personality formation, vocational choices, manifestation of mental disorders, help-seeking behavior, and the appropriateness or inappropriateness of various counseling approaches.
- Culturally skilled counselors understand and have knowledge of sociopolitical influences upon the lives of racial and ethnic minorities. They understand that factors such as immigration issues, poverty, racism, stereotyping, and powerlessness can affect self-esteem and self-concept in the counseling process.

##### Skills:

- Culturally skilled counselors familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.
- Culturally skilled counselors are actively involved with minority individuals outside of the counseling setting (community events, social and political functions, celebrations, friendships, neighborhood groups, etc.); their perspective of minorities is more than an academic/helping exercise.

Source: American Counseling Association Web site ([http://www.counseling.org/docs/competencies/cross-cultural\\_competencies\\_and\\_objectives.pdf](http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf)). Adapted with permission.

## Cultural Knowledge of Behavioral Health

Counselors should learn how culture interacts with health beliefs, substance use, and other behavioral health issues. They can access literature and training that address cultural contexts and meanings of substance use, behavioral and emotional reactions, help-seeking behavior, and treatment. Chapter 5 gives information on culturally responsive behavioral health services for major ethnic and racial groups. The how-to box below lists ways to improve one's cultural knowledge of health issues by acquiring knowledge in key areas to work successfully with diverse clients:

- Patterns of substance use and treatment-seeking behavior specific to people of

- diverse racial and cultural backgrounds.
- Beliefs and traditions surrounding substance use, including cultural norms concerning the use of alcohol and drugs.
- Beliefs about treatment, including expectations and attitudes toward health care and counseling.
- Community perceptions of behavioral health treatment.
- Obstacles encountered by specific populations that make it difficult to access treatment, such as geographic distance from treatment services.
- Patterns of co-occurring disorders and conditions specific to people from diverse racial and cultural backgrounds (e.g., culturally specific syndromes, earlier onset of

### How To Improve Cultural Knowledge of Health, Illness, and Healing

To promote culturally responsive services, counselors need to acquire cultural knowledge regarding concepts of health, illness, and healing. The following questions highlight many of the culturally related issues that are prevalent in and pertinent to assessment, treatment planning, and case management. This list of considerations can help facilitate discussions in counseling and clinical supervision contexts:

- Does the cultural group in question consider psychological, physical, and spiritual health or well-being as separate entities or as unified aspects of the whole person?
- How are illnesses and healing practices defined and conceptualized?
- What are acceptable behaviors for managing stress?
- How do people who belong to the culture in question typically express emotions and emotional distress?
- What behaviors, practices, or customs do members of this culture consider to be preventive?
- What words do people from this cultural group use to describe a particular problem?
- How do members of the group explain the origins or causes of a particular condition?
- Are there culturally specific conditions or cultural concepts of distress?
- Are there specific biological and physiological variations among members of this population?
- What are the common symptoms that lead to misdiagnosis within this population?
- Where do people from this cultural group typically seek help?
- What traditional healing practices and treatments are endorsed by members of this group?
- Are there biomedical treatments or procedures that would typically be unacceptable?
- Are there specific counseling approaches more congruent with the beliefs of most members?
- What are common health inequities, including social determinants of health, for this population?
- What are acceptable caregiving practices?
- Do members of this group attach honor to caring for family members with specific diseases?
- Are individuals with specific conditions shunned from the community?
- What are the roles of family members in providing health care and in making decisions?
- Is discussing consequences of and prognosis for behaviors, conditions, or diseases acceptable?
- Is it customary for family members to withhold prognosis from the client?

- diabetes, higher prevalence of depression and substance dependence).
- Assessment and diagnosis, including culturally appropriate screening and assessment and awareness of common diagnostic biases associated with symptom presentation.
- Individual, family, and group therapy approaches that hold promise in addressing mental and substance-related disorders specific to the racial and cultural backgrounds of diverse clients.
- Culturally appropriate peer support, mutual-help, and other support groups (e.g., the Wellbriety movement, a culturally appropriate 12-Step program for Native American people).
- Traditional healing and complementary methods (e.g., use of spiritual leaders, herbs, and rituals).
- Continuing care and relapse prevention, including attention to clients' cultural environments, treatment needs, and accessibility of care within their communities.
- Treatment engagement/retention patterns.

### Skill Development

Becoming culturally competent is an ongoing process—one that requires introspection, awareness, knowledge, and skill development. Counselors need to develop a positive attitude toward learning about multiple cultural

groups; in essence, counselors should commit to cultural competence and the process of growth. This commitment is evidenced via investment in ongoing learning and the pursuit of culturally congruent skills. Counselors can demonstrate commitment to cultural competence through the attitudes and corresponding behaviors indicated in Exhibit 2-5.

Beyond the commitment to and development of these fundamental attitudes and behaviors, counselors need to work toward intervention strategies that integrate the skills discussed in the following sections.

### Frame issues in culturally relevant ways

Counselors should frame clinical issues with culturally appropriate references. For example, in cultural groups that value the community or family as much as the individual, it is helpful to address substance abuse in light of its consequences to family or the community. The counselor might ask, “How are your family and community affected by your use? How do family and community members feel when they see you high?” For clients who place more value on their independence, it can be more effective to point out how substance dependence undermines their ability to manage their own lives through questions like “How might your use affect your ability to reach your goals?”

**Exhibit 2-5: Attitudes and Behaviors of Culturally Competent Counselors**

Attitude	Behavior
Respect	<ul style="list-style-type: none"> <li>• Exploring, acknowledging, and validating the client’s worldview</li> <li>• Approaching treatment as a collaborative process</li> <li>• Investing time to understand the client’s expectations of treatment</li> <li>• Using consultation, literature, and training to understand culturally specific behaviors that demonstrate respect for the client</li> <li>• Communicating in the client’s preferred language</li> </ul>
Acceptance	<ul style="list-style-type: none"> <li>• Maintaining a nonjudgmental attitude toward the client</li> <li>• Considering what is important to the client</li> </ul>

*(Continued on the next page.)*

**Exhibit 2-5: Attitudes and Behaviors of Culturally Competent Counselors (continued)**

Attitude	Behavior
Sensitivity	<ul style="list-style-type: none"> <li>• Understanding the client’s experiences of racism, stereotyping, and discrimination</li> <li>• Exploring the client’s cultural identity and what it means to her/him</li> <li>• Actively involving oneself with individuals from diverse backgrounds outside the counseling setting to foster a perspective that is more than academic or work related</li> <li>• Adopting a broader view of family and, when appropriate, including other family or community members in the treatment process</li> <li>• Tailoring treatment to meet the cultural needs of the client (e.g., providing outside resources for traditional healing)</li> </ul>
Commitment to equality	<ul style="list-style-type: none"> <li>• Proactively addressing racism or bias as it occurs in treatment (e.g., processing derogatory comments made by another client in a group counseling session)</li> <li>• Identifying the specific barriers to treatment engagement and retention among the populations being served</li> <li>• Recognizing that equality of treatment does not translate to equity—that equity is defined as equality in opportunity, access, and outcome (Srivastava 2007)</li> <li>• Endorsing counseling strategies and treatment approaches that match the unmet needs of diverse populations to ensure treatment engagement, retention, and positive outcomes</li> </ul>
Openness	<ul style="list-style-type: none"> <li>• Recognizing the value of traditional healing and help-seeking practices</li> <li>• Developing alliances and relationships with traditional practitioners</li> <li>• Seeking consultation with traditional healers and religious and spiritual leaders when appropriate</li> <li>• Understanding and accepting that persons from diverse cultural groups can use different cognitive styles (e.g., placing more attention on reflecting and processing than on content; being task oriented)</li> </ul>
Humility	<ul style="list-style-type: none"> <li>• Recognizing that the client’s trust is earned through consistent and competent behavior rather than the potential status and power that is ascribed to the role of counselor</li> <li>• Acknowledging the limits of one’s competencies and expertise and referring clients to a more appropriate counselor or service when necessary</li> <li>• Seeking consultation, clinical supervision, and training to expand cultural knowledge and cultural competence in counseling skills</li> <li>• Seeking to understand oneself as influenced by ethnicity and cultural groups and actively seeking a nonracist identity</li> <li>• Being sensitive to the power differential between client and counselor</li> </ul>
Flexibility	<ul style="list-style-type: none"> <li>• Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client</li> <li>• Accommodating different learning styles in treatment approaches (e.g., the use of role-plays or experiential activities to demonstrate coping skills or alcohol and drug refusal skills)</li> <li>• Using cultural, socioeconomic, environmental, and political contextual factors in conducting evaluations</li> <li>• Integrating cultural practices as treatment strategies (e.g., Alaska Native traditional practices, such as tundra walking and sustenance activities)</li> </ul>



### ***Allow for complexity of issues based on cultural context***

Counselors must take care with suggesting simple solutions to complex problems. It is often better to acknowledge the intricacies of the client's cultural context and circumstances. For instance, a Native American single mother who upholds traditional values could balk at a suggestion to stop spending time with family members who drink heavily. Here, the counselor might encourage the woman to broaden support within her community by connecting with an elder who supports recovery or by engaging in a women's talking circle. Likewise, a referral for a psychiatric evaluation for major depression may not be an appropriate initial recommendation for a Chinese client who relies on cultural remedies and healing traditions. An alternative approach would be to explore the client's beliefs in healing, develop steps that respect and incorporate the client's help-seeking practices, and coordinate services to secure a culturally responsive intervention (Cardemil et al. 2011; Gallardo et al. 2012; Lynch and Hanson 2011).

### ***Make allowances for variations in the use of personal space***

Cultural groups have different expectations and norms of propriety concerning how close people can be while they communicate and how personal communications can be depending on the type of relationship (e.g., peers versus elders). The concept of personal space involves more than the physical distance between people. It also involves cultural expectations regarding posture or stance and the use of space within a given environment. These cultural expectations, although they are subtle, can have an impact on treatment. For example, an Alaska Native may feel more comfortable sitting beside a counselor, whereas a European may prefer to be separated from a counselor by a desk (Sue and Sue 2013a). The use of space can also be a nonverbal expression of power. Standing too close to someone can, for example, suggest power over them. Standing too far away or sitting behind a desk can indicate aloofness. Acceptable or expected degrees of closeness between people are culturally specific; counselors should be educated on the general

#### ***Advice to Counselors and Clinical Supervisors: Behaviors for Counselors To Avoid***

- Addressing clients informally; counselors should not assume familiarity until they grasp cultural expectations and client preferences.
- Failing to monitor and adjust to the client's verbal pacing (e.g., not allowing time for clients to respond to questions).
- Using counseling jargon and treatment language (e.g., "I am going to send you to our primary stabilization program to obtain a biopsychosocial and then, afterwards, to partial").
- Using statements based on stereotypes or other preconceived ideas generated from experiences with other clients from the same culture.
- Using gestures without understanding their meaning and appropriate context within the given culture.
- Ignoring the relevance of cultural identity in the client-counselor relationship.
- Neglecting the client's history (i.e., not understanding the client's individual and cultural background).
- Providing an explanation of how current difficulties can be resolved without including the client in the process to obtain his or her own explanations of the problems and how he or she thinks these problems should be addressed.
- Downplaying the importance of traditional practices and failing to coordinate these services as needed.

Sources: Fontes 2008; Lynch and Hanson 2011; Pack-Brown and Williams 2003; Srivastava 2007.

parameters and expectations of the given population. However, counselors should not predetermine the clients' expectations; instead, they should follow the clients' lead and inquire about their preferences.

### ***Display sensitivity to culturally specific meanings of touch***

Some treatment and many support groups have opening or closing traditions that include holding hands or giving hugs. This form of touching can be very uncomfortable to new clients regardless of cultural groups; cultural prescriptions, including religious beliefs, concerning appropriate touching can compound this effect (Comas-Diaz 2012). Many cultural groups use touch to acknowledge or greet someone, to show respect or convey status or power, or to display comfort. As counselors, it is essential to understand cultural norms about touch, which often are guided by gender and age, and the contexts surrounding "appropriate" touch for specific cultural groups (Srivastava 2007). Counselors need to devote time to understanding their clients' norms for and interpretations of touch, to assisting clients in negotiating and upholding their cultural norms, and to helping clients understand the context and cultural norms that are likely to prevail in support and treatment groups.

### ***Explore culturally based experiences of power and powerlessness***

Ideas about power and powerlessness are influenced by the client's culture and social class. What constitutes power and powerlessness varies from culture to culture according to the individual's gender, age, occupation, ancestry, religious affiliation, and a host of other factors. For example, power can be defined in terms of one's place within the family, with the oldest member being the most powerful and the youngest being the least powerful. Even the words "power" and "powerlessness" carry cultural meaning. These words can carry

negative connotations for clients with histories of discrimination and multiple experiences with racism, for some women, for indigenous peoples with histories of colonization, and for refugees or immigrants who have left oppressive regimes. In this regard, counselors should use these words carefully. For example, a Hmong refugee who experienced trauma in her country of origin could already feel helpless and powerless over the events that occurred; thus, the concept of powerlessness, often used in drug and alcohol treatment programs, can be contraindicated in addressing her substance-related disorder. However, a White American business executive who has authority over others and a history of financial influence may need help acknowledging that he cannot control his substance abuse.

### ***Adjust communication styles to the client's culture***

Cultural groups all have different communication styles. Norms for communicating vary in and between cultural groups based on class, gender, geographic origins, religion, subcultures, and other individual variations. Counselors should educate themselves as much as possible regarding the patterns of communicating in the client's cultural, racial, or ethnic population while also being aware of his/her own communication style. For a comprehensive guide in self-assessment and understanding of communication styles, refer to *Culture Matters: The Peace Corps Cross-Cultural Workbook* (Peace Corps Information Collection and Exchange 2012).

The following are general guidelines for ascertaining the client's communication style:

- Understand the client's verbal and nonverbal ways of communicating. Be aware of the possible need to move away from comprehending and interpreting client responses in conventional professional ways

## How To Assess Differences in Communication Styles

This exercise can be used by counselors and clinical supervisors as a self-assessment tool and a means of exploring differences in communication styles among counselors, clients, and supervisors. It can also serve as a group exercise to help clients discuss and understand cultural differences in communicating with others. This self-administered tool promotes self-understanding and cultural knowledge. It is not an empirically based instrument, nor is it meant to assess client communication styles or skills formally.

**Materials needed:** Colored pencils/pens and copies of the exercise.

### Instructions:

- First, place an X along the line for each item that best matches your style or pattern of communication overall. Communication patterns can change across situations and environments depending on expectations, stress level, and familiarity, (e.g., attending a staff meeting versus spending time with friends); try to assign the style that best reflects your patterns across situations.
- After reviewing your own patterns, compare differences between you and your client, clinical supervisor, or fellow staff member. For example, select a recent client you treated and place a second X (using a different color pen) on each line to mark your perceived view of this client's communication style. Then examine the differences between you and your client and generate a list of potential misunderstandings that could occur due to these differences. Use clinical supervision to discuss how your own patterns can hinder and/or promote the counseling process.

### NONVERBAL PATTERNS

#### Eye Contact

When talking:

Direct, sustained

Indirect or not sustained

When listening:

Direct, sustained

Indirect or not sustained

#### Vocal Pitch/Tone

High/loud

Low/soft

More expressive

Less expressive

#### Speech Rate

Fast

Slow

#### Pauses or Silence

Little use of silence in dialog

Pauses; uses silence in dialog

#### Facial Expressions

Frequent expression

Little expression

#### Use of Other Gestures

Frequent expression

Little expression

### VERBAL PATTERNS

#### Emotional Expression

Does express and identify feelings in speech

Does not express or identify feelings in speech

#### Self-Disclosure

Frequently

Rarely or little

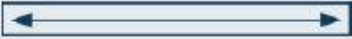

#### Formality

Informal

Formal in addressing others and showing respect

*(Continued on the next page.)*

## How To Assess Differences in Communication Styles (continued)

<p><b>Directness</b> Verbally explicit</p>		<p>Indirect; subtle; doesn't believe in saying everything</p>
<p><b>Context</b> Low context; relies more on words to convey meaning</p>		<p>High context: verbal and nonverbal cues convey much of the meaning</p>
<p><b>Orientation</b> Orientation to self; use of "I" statements</p>		<p>Orientation to others, use of plural and third-person pronouns (e.g., we, he)</p>

### Other Things To Consider in Exploring Communication Styles:

- Are there known differences in body language and expression within the given cultural group?
- What are the common, culturally appropriate parameters of touch across situations? For example, a handshake could be appropriate as a means of introduction for one cultural group but not for another.
- How is personal space used in and outside of the office? Are there known cultural patterns in the use of space and proximity of communication?
- What verbal and nonverbal counselor behaviors may affect trust in the counseling process?

Sources: Cormier et al. 2009; Fontes 2008; Srivastava 2007; Sue and Sue 2013a.

- (Bland and Kraft 1998). Always be curious about the client's cultural context and be willing to seek clarification and better understanding from the client. It is as important for counselors to access and engage in cultural consultation to acquire more specific knowledge and experience. Styles of communication and nonverbal methods of communication are important aspects of cultural groups. Issues such as the appropriate space to have between people; preferred ways of moving, sitting, and standing; the meaning of gestures; and the degree of eye contact expected are all culturally defined and situation specific (Hall 1976). As an example, high-context cultural groups place greater importance on nonverbal cues and message context, whereas low-context cultural groups rely largely on verbal message content. Most Asian Americans come from high-context cultural groups in which sensitive messages are encoded carefully to avoid offending others. A provider who listens only to the content could miss the message. What is

not said can possibly be more important than what is said.

- Listen to storytelling carefully, as it can be a way of communicating with the therapist. As in any good therapy, follow the associations and listen for possible metaphors to better understand relational meaning, cognition, and emotion within the context of the conversation.

### *Interpret emotional expressions in light of the client's culture*

Feelings are expressed differently across and within cultural groups and are influenced by the nature of a given event and the individuals involved in the situation. A certain level of emotional expression can be socially appropriate within one culture yet inappropriate in another. In some cultural groups, feelings may not be expressed directly, whereas in other cultural groups, some emotions are readily expressed and others suppressed. For example, expressions of sadness may at first be more readily shared by some clients in counseling settings, whereas others may find it more

comfortable to express anger as their initial response. Counselors must recognize that not all cultures place the same value on verbalizing feelings. In fact, clients from some cultures may not perceive that emotional expression is a worthy course of treatment and healing at all. Thus, counselors should not impose a prescribed approach that measures progress and equates healing with the ability to display emotions. Likewise, counselors should be careful not to attribute meaning based on their own cultural backgrounds or to project their own feelings onto clients' experiences. Instead, counselors need to assist their clients in identifying and labeling feelings within their own cultural contexts.

### **Expand roles and practices**

Counselors need to acquire a mindset that allows for more flexible roles and practices—while still maintaining appropriate professional boundaries—when working with clients. Some clients whose culture places considerable emphasis upon and orientation toward family could look to counselors for advice with unrelated issues pertaining to other family members. Other clients may expect a more prescribed and structured approach in which counselors give specific recommendations and advice in the session. For example, Asian American clients appear to expect and benefit from a more directive and highly structured approach (Fowler et al. 2011; Lee and Mock 2005a; Sue 2001; Uba 1994). Still others could expect that counselors be connected to their communities through participation in community events, in working with traditional healers, or in building collaborative relationships with other community agencies. As counselors, it is important to understand the cultural contexts of clients and how this translates to expectations in the client–counselor relationship. The appropriate role usually

Providing good care goes beyond counselors' general knowledge, clinical skills, and approaches; it involves understanding the multicultural context of clients and of themselves as counselors. Cultural competence is an ethical issue requiring counselors to be invested in developing the tools to provide culturally congruent care—care that matches the needs and context of the client. For a review of ethics and ethical dilemmas in a multicultural context, refer to Pack-Brown and Williams (2003).

Results from the counselor's understanding of and sensitivity to the values, cultures, and special needs of the individuals and groups being served (Sue and Sue 2013d). Counselors need to adopt an ongoing commitment to developing skills and endorsing practices that assist clients in receiving and experiencing the best possible care. Exhibit 2-6 lists counselor competencies endorsed by ACA for culturally appropriate intervention strategies.

## **Self-Assessment for Individual Cultural Competence**

Several instruments for evaluating an individual's cultural competence have been developed and are available online. One assessment tool that has been widely circulated is Goode's *Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families*. It can be adapted for counselors treating adult clients with behavioral health concerns. This tool and other additional resources are provided in Appendix C. For an interactive Web-based tool on cultural competence awareness, visit the American Speech-Language-Hearing Association Web site (<http://www.asha.org>).

## Exhibit 2-6: ACA Counselor Competencies: Culturally Appropriate Intervention Strategies

### Attitudes and beliefs:

- Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.
- Culturally skilled counselors respect traditional helping practices and intrinsic help-giving networks in minority communities.
- Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling.

### Knowledge:

- Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they could clash with the cultural values of various minority groups.
- Culturally skilled counselors are aware of institutional barriers that prevent minorities from using behavioral health services.
- Culturally skilled counselors know of the potential biases in assessment instruments and use procedures and interpret findings in keeping with the cultural and linguistic characteristics of clients.
- Culturally skilled counselors have knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about family and community characteristics and resources.
- Culturally skilled counselors are aware of relevant discriminatory practices at the social and community levels that could be affecting the psychological welfare of the populations being served.

### Skills:

- Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach, recognizing that helping styles and approaches can be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and ameliorate its negative impact.
- Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a problem stems from racism or bias in others (the concept of health paranoia) so that clients do not inappropriately personalize problems.
- Culturally skilled counselors are not averse to seeking consultation with traditional healers, religious and spiritual leaders, and practitioners in the treatment of culturally diverse clients when appropriate.
- Culturally skilled counselors take responsibility for interacting in the languages requested by their clients; if not feasible, they make appropriate referrals. A serious problem arises when the linguistic skills of a counselor do not match the language of the client. When language matching is not possible, counselors should seek a translator with cultural knowledge and appropriate professional background and/or refer to a knowledgeable and competent bilingual counselor.
- Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments, understand their technical aspects, and are aware of their cultural limitations. This allows counselors to use test instruments for the welfare of diverse clients.
- Culturally skilled counselors are aware of and work to eliminate biases, prejudices, and discriminatory practices. They are aware of sociopolitical contexts in conducting evaluation and providing interventions and are sensitive to issues of oppression, sexism, elitism, and racism.
- Culturally skilled counselors educate clients about the processes of psychological intervention, explaining such elements as goals, expectations, legal rights, and the counselor's theoretical orientation.

Source: American Counseling Association Web site ([http://www.counseling.org/docs/competencies/cross-cultural\\_competencies\\_and\\_objectives.pdf](http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf)). Adapted with permission.