In her work at a community mental health center, a recently graduated, young European American woman named Sarah received a referral from the Office of Children’s Services (OCS) for a severely abused, biracial 4-year-old named Maya. Following removal from her biological parents, Maya was brought to the initial appointment by her new foster mom, Carmen, an assertive, self-described Latina/African American Jehovah’s Witness. Carmen agreed to meet with Sarah because OCS required it. During sessions that alternated between individual and family meetings, Carmen interacted defensively with Sarah but was warm and caring with Maya.

After 6 weeks, Maya appeared very comfortable with her foster mom, and many of her posttraumatic stress disorder symptoms had improved. However, in a subsequent meeting alone with Sarah, Maya asked her if she believed in Jesus. Sarah said that she wasn’t a Christian but that she believed in

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1All cases are composites with pseudonyms and do not represent a specific individual.

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God—a response that clearly distressed Maya, who brought up the topic again in their next individual session, adding that she was afraid Sarah would die and go to the “bad place.” Sarah began to worry that Carmen might be sharing religious beliefs that were reactivating Maya’s fears. She also wondered whether Carmen knew that Sarah was gay and, if so, whether this might be a factor, along with their cultural, age, and religious differences, in Carmen’s defensiveness toward her. Considering Carmen’s disinterest in Sarah’s help, Maya’s overall improvement while in Carmen’s care, and the severe shortage of caring foster homes, Sarah was unsure whether she should address her concerns with Carmen, with OCS, or with both or neither.

When I began teaching a multicultural counseling class at Antioch University in Seattle in 1989, the field of multicultural counseling was just beginning, and like most new fields, its focus was relatively narrow. Relevant textbooks focused primarily on the ethnicity and race of the client, with little attention to the therapist’s identity or to the interaction of ethnicity and race with the client’s (or therapist’s) religion, class, age, disability, gender, sexual orientation, or nationality. There were some population-specific fields regarding women, older adults, and people who identified as gay or as having a disability, but the available books and articles in these fields also conceptualized identity in unidimensional terms. Feminist therapy initially focused on women (presumably White, Christian or secular, nondisabled, and middle class); the lesbian, gay, and bisexual literature on lesbian, gay, and bisexual people (presumably White, Christian or secular, nondisabled, and middle class); geropsychology on older men (presumably White, Christian or secular, nondisabled, and middle class); and so on. A field known as transcultural psychiatry overlapped with one called cross-cultural psychology, both of which focused on work with populations outside North America and Europe but were conducted primarily by European and U.S. (White) researchers.

Since 1989, the world’s awareness of and approach to diversity have changed significantly. Increasing numbers of people have been displaced both within and across national borders because of war, poverty, and violence. Environmental degradation and extreme climate changes have magnified the impact of natural disasters on human communities. With economic globalization and technology accelerating the pace of change, social connections have increased dramatically across borders, with a wide range of effects including a growing number of people who marry across cultural groups and who identify as multiracial and multicultural and changing attitudes toward minority groups such as lesbian, gay, and transgender people and people who have disabilities. And around the world, as Indigenous people become increasingly empowered and unified, the value of Indigenous traditions is being increasingly acknowledged.
In the face of such changes, therapists are now expected to work effectively with people of diverse ages, ethnic cultures, religions, disabilities, gender identities, sexual orientations, nationalities, and classes. At the same time, the effects of violence, abuse, trauma, chemical dependency, disability, chronic physical and mental illness—that is, poverty-correlated problems—are now commonly encountered in clinical practice, even in many wealthier countries. Counselors and clinicians are expected to “fix” the mental health problems stemming from these persistent social causes even as economic pressures have resulted in higher caseloads, less supervision, and fewer mental health resources. Cases as complex as Maya’s are now commonplace.

Recognizing the need for clear guidance on what works, an American Psychological Association (APA) task force took on the project of determining what constitutes practical, research-based, and highly relevant psychotherapy practice. The result was their definition of evidence-based practice in psychology (EBPP) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on EBPP, 2006). This definition does not prioritize any one theoretical orientation but rather tends to support a more integrative approach. In addition, by emphasizing “best available research,” the definition acknowledges the reality that for many minority groups, controlled studies of psychotherapy effectiveness do not exist. The definition also gives equal weight to clinical expertise, with an emphasis on using one’s expertise to adapt therapy to the particular individual and their cultural context.

Developing Multicultural Competence

At a national psychology conference in the United States several years ago, I started a conversation with a young European American psychologist who had recently joined the faculty of a prestigious university. In response to my questions about the diversity of the psychology department, she told me that it consisted of 36 full-time members, one of whom was a person of color. She stressed that they’d made significant progress in the hiring of women, but all of the women were White except the one person of color, and none were tenured. I asked her opinion about why this was the case, and she replied, “Well, I think the core faculty put their priority on developing a high-quality research program rather than on hiring for diversity.”

This psychologist’s statement reflects the commonly held belief that quality and diversity involve competing agendas. However, I would argue,
as many others have, that the exact opposite is true. A high-quality program by definition includes faculty of diverse perspectives who bring ideas that move a department beyond those of the mainstream. It consists of diverse teachers and supervisors who serve as role models for a culturally diverse student body and clinical faculty who have firsthand knowledge of the cultures of the clients being seen by their students. It includes faculty who speak more than one language, read the psychological literature of more than one culture, and are connected to minority groups whom they consider and consult in their development of research projects.

Given the relatively monocultural origins of the field, this is a tall order. However, significant strides have been made. Throughout the fields of psychology, counseling, mental health, and social work, professional organizations have made a clear commitment to increasing the multicultural competence of their members; in North America, this effort has included the APA (2000a, 2000b), the American Counseling Association (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003), and the National Association of Social Workers (2007). As researchers, teachers, supervisors, and practitioners in these professions become more diverse, they are experiencing and demonstrating the advantages of a diverse learning environment. And the idea that diversity can be addressed in one multicultural counseling course has been replaced by the view that cross-cultural information, experiences, and questions must be integrated throughout the training curriculum, including practica and internships (Magyar-Moe et al., 2005).

Addressing Both Diversity and Complexity

When I teach multicultural awareness workshops, I start by asking participants to do the following: “Take a minute to share with a partner everything you feel comfortable sharing about yourself that explains who you are and your identity, including past and current cultural influences on you.” If you’re reading this by yourself, try doing this in the box before reading further.

List all of the cultural influences you can think of that explain or describe your identity:

_____________________
_____________________
_____________________
_____________________

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Once people have finished sharing, I ask how many mentioned ethnicity or race in their self-description; depending on the makeup of the group, a varying number of people raise their hand. I then ask how many mentioned religion, and a different number raise their hand. I also ask about age and generational influences, disability, sexual orientation, social class, nationality, language, and gender. Then I ask if anyone thought of influences I did not mention, and participants often add being from a particular geographic region, growing up in the military, working in the business world, and others.

This exercise illustrates how, when we think of culture, so many different influences come into play. All of these influences shape who we are, but as I found when I began teaching, the dilemma is how, whom, and what to focus on. For the purposes of psychological practice, I have chosen to focus on the influences and related minority groups that the major helping professions target for special attention because these influences and groups have been neglected in the field and dominant culture. These influences can be organized in an easy-to-remember acronym that spells the word ADDRESSING (see Table 1.1).

As you read through the list of ADDRESSING influences and dominant and minority groups, you will recognize that for many of the influences, the groups listed as minority groups are minorities only in the United States (e.g., people of Asian heritage are not a minority in China or, for that matter, in the world). So think of this list as only an example: If you are practicing in a different region or country, the dominant and minority groups will be specific to that particular context.

**ADDRESSING Influences**

A stands for *Age and generational influences* and includes not just chronological age, but also generational roles that are important in a person’s culture. For example, the role of eldest son in many cultures carries specific responsibilities, just as being a parent, grandparent, or auntie brings with it culturally based meanings and purpose.

Age and generational influences also include experiences specific to age cohorts, particularly experiences that occurred during the cohort’s childhood and early adulthood (i.e., the formative years). For example, for many elders, the Great Depression, World War II, and racial segregation were generation-related influences that profoundly affected their lives. For baby boomers, important early influences were post-World War II economic prosperity, the civil rights movement, the women’s movement, Vietnam War protests, and the widespread use of drugs. For people in their 20s, economic pressures, college debt, technology and social media, and environmental degradation are common influences—
all of these also affect older people, but people in their 20s have never lived without them.

Obviously, age and generational influences vary across ethnic and other cultural groups, just as dominant and minority groups vary in different countries and contexts. In North America, the minority groups associated with age and generational influences are children and older adults, because elders and children do not have the same privileges that young and middle-aged adults have. However, in some countries, elder status carries a great deal of privilege and power. I will provide examples of contextual specifics of these definitions in Chapter 2.

The next letters, DD, stand for Developmental or other Disability. The broad category of disability includes disability that may occur at any age and generational influences. The table below provides examples of different cultural influences and their associated groups:

<table>
<thead>
<tr>
<th>Cultural Influence</th>
<th>Dominant Group</th>
<th>Nondominant or Minority Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and generational influences</td>
<td>Young and middle-aged adults</td>
<td>Children, older adults</td>
</tr>
<tr>
<td>Developmental or other Disability</td>
<td>Nondisabled people</td>
<td>People with cognitive, intellectual, sensory, physical, and psychiatric disabilities</td>
</tr>
<tr>
<td>Religion and spiritual orientation</td>
<td>Christian and secular</td>
<td>Muslims, Jews, Hindus, Buddhists, and other religions</td>
</tr>
<tr>
<td>Ethnic and racial identity</td>
<td>European Americans</td>
<td>Asian, South Asian, Latino, Pacific Islander, African, Arab, African American, Middle Eastern, and multiracial people</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>Upper and middle class</td>
<td>People of lower status by occupation, education, income, or inner city or rural habitat</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Heterosexuals</td>
<td>People who identify as gay, lesbian, or bisexual</td>
</tr>
<tr>
<td>Indigenous heritage</td>
<td>European Americans</td>
<td>American Indians, Inuit, Alaska Natives, Métis, Native Hawaiians, New Zealand Māori, Aboriginal Australians</td>
</tr>
<tr>
<td>National origin</td>
<td>U.S.-born Americans</td>
<td>Immigrants, refugees, and international students</td>
</tr>
<tr>
<td>Gender</td>
<td>Men</td>
<td>Women and people who identify as transgender</td>
</tr>
</tbody>
</table>


With the increased use of the term intellectual disability, the term developmental disability is being used less often, particularly within the Disability community; however, it is included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) and the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD–10–CM; see Chapter 4).
The New Reality
time during a person’s lifetime, for example, as a result of illness, accident, or stroke. Developmental disabilities are specifically those that affect a person’s development from birth or childhood, such as fetal alcohol spectrum disorder or Down syndrome. (Note that the term intellectual disability has replaced the pejorative term mental retardation; more on this in Chapter 4.) Related minority groups include people who have cognitive, intellectual, sensory, physical, and psychiatric disabilities.

Some individuals with disabilities identify as members of a Disability culture (signified by a capital D). However, many individuals who have disabilities do not consider themselves members of a culture, particularly people who acquire a disability later in life (e.g., an older woman whose cognitive functioning is impaired following a stroke). Similarly, many people who identify as members of Deaf culture do not identify as disabled because they have no impairments when in the Deaf culture; it is the hearing world’s inability to sign that is the problem.

The distinction between people who grow up with a disability and those whose disability is acquired later in life has important implications for therapeutic work. Many people who grow up with a disability learn coping skills that enable them to function well in the dominant non-disabled world; when these individuals come to counseling, it is often for a problem that is unrelated to the disability. In contrast, individuals who become impaired later in life (e.g., following an accident or physical illness) often come to therapy for help with learning how to cope and live with the disability.

The next letter, R, stands for Religion and spiritual orientation. In North America, the largest religious minority groups are Muslim, Jewish, Hindu, and Buddhist, and there are many smaller groups (e.g., Baha’i, Shinto, Confucian, Zoroastrian). Although some members of particular Christian religions (e.g., Mormon, Seventh-Day Adventist, Jehovah’s Witness, and fundamentalist Christian) think of themselves as minority groups, they are still Christian groups and as such have privileges that non-Christian groups do not have. Similarly, some individuals with atheistic beliefs consider themselves part of a minority group; however, atheists still benefit from privileges related to the dominant secular culture.

E stands for Ethnic and racial identity. In the United States, the largest groupings of ethnic and racial minority cultures are Asian, South Asian, Pacific Islander, Latino, and African American. Also included are people who identify as biracial or multiracial and people of Middle Eastern heritage who are experiencing racism and other oppressive attitudes and behaviors from the dominant culture. Within each of these large cultural groupings, there are many specific groups. For example, South Asian includes people whose heritage originates in Pakistan, India, Bangladesh, Afghanistan, Nepal, Sri Lanka, Bhutan, and the Maldives (and, depending on the definition, some additional countries such as Tibet). Here again, the definition of these cultures as minority groups is specific to
the United States; what constitutes a minority group depends on the
country and its dominant culture.

**S** stands for *Socioeconomic status*, which is usually defined by educa-
tion, occupation, and income. Related minority groups include people
who have lower status because of limited formal education and the
occupations and lower income that usually go along with less educa-
tion. The focus is on people who are living in poverty, often in rural and
inner-city areas.

The second **S** stands for *Sexual orientation*, and the related minority
groups include people who identify as lesbian, gay, and bisexual. In the
United States, sexual minority groups often use an acronym that includes
additional groups, such as LGBTQIA (lesbian, gay, bisexual, transgender,
queer, intersex, ally or asexual), but because some of these groups are
related more to gender, I group them under the influence of gender iden-
tity (see discussion of **G** that follows).

The **I** stands for *Indigenous heritage*, and related minority groups
are people of Indigenous, Aboriginal, and Native heritage. These terms
are similar in meaning but are used differently in different countries
and contexts (more on this in Chapter 4 on finding the right words).
Within the cultural grouping of Indigenous people, there are many
smaller and specific cultures. For example, I work with members of the
Kenaitze Tribe, which is the local Indigenous culture where I live in
Alaska. Members of the Kenaitze Tribe belong to the larger culture of
Dena’ina people, who belong to the larger Athabascan culture, which
is one of many Alaska Native cultures. The ADDRESSING acronym lists
Indigenous heritage as a separate influence from ethnic and racial iden-
tity because many Indigenous people identify as part of a worldwide
culture of Indigenous people who have concerns and issues separate
from those of ethnic and racial minority groups (e.g., land, water, and
fishing rights related to subsistence and cultural traditions) and who, in
some cases, constitute sovereign nations.

The **N** stands for *National origin*, and related minority groups includ-
ing immigrants, refugees, and international students. Language is often
a strong cultural influence related to national origin, but it may also
be related to the ADDRESSING domains of ethnic and racial identity,
Indigenous heritage, and disability (e.g., sign language).

Finally, **G** stands for *Gender identity*, and minority groups include
women and people of transgender, transsexual, intersex, gender ques-
tioning, androgyne, and other gender-nonconforming identities. I’ll talk
more about the complexities of gender identity in Chapter 4 on language
and terminology.

As mentioned earlier, the ADDRESSING acronym summarizes nine
key cultural influences that shape the beliefs and behaviors of domi-
nant and minority group members. It calls attention to the overlapping,
multidimensional nature of identity (also referred to as *intersectionality*; Ecklund, 2012). The acronym serves as a reminder of minority groups related to each of the nine influences, and it can be used to highlight the within-culture diversity of any given culture (whether minority or dominant). In addition, the ADDRESSING acronym is the foundation for what I call the ADDRESSING framework.

**The ADDRESSING Framework**

The ADDRESSING framework is a practitioner-oriented approach to therapy that conceptualizes multicultural work in two broad categories. The first category of *personal work* involves introspection, self-exploration, and understanding of cultural influences on one's own belief system and worldview. The second category of *interpersonal work* focuses on learning from and about other cultures, which usually involves interaction with people. The importance of both the personal and interpersonal aspects of learning has been emphasized throughout the multicultural literature (Arredondo & Perez, 2006).

**PERSONAL WORK**

The ADDRESSING approach begins with an emphasis on understanding the effects of diverse cultural influences on your own beliefs, thinking, behavior, and worldview. These effects stem from age-related generational experiences, experience or inexperience with disability, religious or spiritual upbringing, ethnic and racial identity, and so on (i.e., the ADDRESSING influences). In particular, recognizing the areas in which you are a member of a dominant group can help you become more aware of the ways in which such identities limit your knowledge and experience regarding minority members who differ from you.

For example, as a result of her membership in a sexual minority group, a middle-class European American lesbian therapist may hold an exceptional awareness of the sexist and heterosexist biases against lesbian, gay, bisexual, and transgender clients and the challenges these clients face. However, this awareness and expertise do not automatically translate into greater awareness of the issues faced by people of color, people who have disabilities, or people living in poverty.

The privileges this therapist holds in relation to her ethnicity, education, mental and physical abilities, and professional status are likely to separate her from people who do not hold such privileges. And if
her friends and family are similar with regard to ethnicity, religion, and social class, she will not have easy access to information that would help her understand, for example, a client of African American Muslim heritage. In contrast, an African American Muslim therapist working with the same client would be more likely to know relevant cultural information or would have easier access to it. Because of the way privilege separates dominant-culture members from knowledge about minority groups, this European American therapist would need to put extra effort into finding and learning the knowledge and skills to understand this client and work effectively with him.

INTERPERSONAL WORK

Although we human beings like to think of ourselves as complex, we often regard others as one dimensional, relying on their visible characteristics as the explanation for everything they say, believe, and do. The more we recognize the complexity of human experience and identity, the more able we are to understand and build a positive therapeutic alliance. And by calling attention to multiple identities and contexts, the ADDRESSING framework helps therapists avoid inaccurate generalizations on the basis of characteristics such as the person’s physical appearance, name, or language.

For example, by using the ADDRESSING acronym as a reminder of influences that may not be immediately apparent, a therapist attempting to understand an older man of East Indian heritage could begin to think about a more relevant and broader range of questions and hypotheses, such as the following:

- What are the issues related to Age and generational influences on this man, given his status as a second-generation immigrant?
- Might he have a Developmental or other Disability that is not apparent, for example, a learning disability, difficulty hearing, or chronic back pain? Could he have had experience with a temporary disability in the past, or might he be a caregiver for a child or parent with a disability?
- Does he have an identity related to his Religion or spirituality? Was he brought up in a particular religion? (Hindu, or possibly Muslim or Sikh, would be reasonable hypotheses, but at this point, one is simply hypothesizing.) Is he a member of a religious minority that was forcibly ejected from his country of birth or his parents’ residence? (Many Indian people immigrated to African countries but then were forced to leave because of political changes and racism in the host country.)
- Does he identify himself as having an Ethnic or racial identity? Is he often mistaken for another identity (e.g., Pakistani or Arab)? How does his physical appearance (e.g., skin color) relate to his
ethnic or racial identity and experiences within his own ethnic group and in the dominant culture? (For examples, see Inman, Tummala-Narra, Kaduvettoor-Davidson, Alvarez, & Yeh, 2015).

- What was his Socioeconomic status (SES) growing up, and what is it now—within his own ethnic community, and in relation to the dominant culture? How might his within-culture status be affected by factors not commonly associated with SES in the dominant culture—for example, his family name, geographic origins, or marital status?

- What is his Sexual orientation, not assuming heterosexuality simply because he is or has been married? How would he perceive a question about his sexual orientation?

- Might Indigenous heritage be part of his ethnic identity, for example, related to his premigration geographic, family, or community origin?

- What is his National origin? Was he born in his country of residence? What is his national identity (e.g., Indian, the nation of his residence, both, or neither)? What is his primary language—Hindi, English, Bengali, or some other language?

- Finally, considering his cultural heritage and identity as a whole, what important influences related to Gender has he experienced—for example, gender roles, expectations, and accepted types of relationships in his culture?

The ADDRESSING acronym does not provide the answers to these questions; rather, it is a tool for developing hypotheses and questions. In some cases, it may be appropriate to ask a question directly. However, in many cases such questions will be perceived as irrelevant or offensive, with a resulting diminishment of the therapist’s credibility. The way I use the acronym is to facilitate my consideration of questions and hypotheses that I might otherwise overlook. Once I know how a client identifies, I can then seek out the culture-specific information that will help me better understand the client.

Regarding this point about gathering cultural information, I have heard some therapists say that it is best to let the client educate you about their culture, but I think this point needs clarification. As a therapist, I believe it is my responsibility to learn as much as I can about the broad cultural influences related to the client’s identity. This broad cultural information can then help me understand the client’s individual experience within that culture. The broader cultural information serves as a sort of template that helps me generate hypotheses and questions that are closer to the client’s reality, increasing my efficiency and decreasing the likelihood of offensive questions. I will talk more about the use of the ADDRESSING acronym to facilitate hypothesis generation and culturally responsive assessment in Chapters 5 and 7.
What’s New in This Edition?

Since publication of the previous edition, a number of significant developments have occurred in clinical and counseling psychology, including the growing integration of behavioral health with medical practice. Along with society’s increasing diversity (ethnic minority cultures now make up over one-third of the U.S. population), the move toward integrated care has raised awareness of the need for evidence-based practices that work with a greater diversity of clients and patients. The American Psychiatric Association (2013) recently published the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), and the 10th edition of the International Classification of Diseases (ICD–10; World Health Organization, 1992) is being adopted in the United States as the 11th edition nears completion. The field of positive psychology has contributed to a new perspective on health aimed at building well-being (i.e., beyond simply eliminating symptoms). And broader social changes affecting professional practice include continuing poverty-related problems, increased social awareness of diversity, and changing expectations regarding therapists and psychological services.

To address these changes, in the third edition of this volume I have included

- a new chapter on continually changing multicultural terminology and language, including offensive terms and preferable alternatives;
- up-to-date information on the DSM–5, ICD–10, and upcoming ICD–11;
- new sections on poverty, children, transgender people, and trauma-informed care;
- new information on intellectual and neuropsychological assessment across cultures;
- a chapter on the integrative approach to psychotherapy, with a focus on culturally responsive cognitive–behavioral therapy;
- research from the new field of positive psychology, including mindfulness practices; and
- practice exercises at the end of each chapter that can be used individually or as class assignments.

Organization

With the intention of conveying cultural information in the way therapists typically experience it, this edition continues to be organized according to the flow of clinical work (rather than the one-chapter-per-
group organization of most multicultural texts). This more integrated approach allows for consideration of the specifics and complexities of psychotherapy practice.

The book begins with suggestions for facilitating therapists’ personal process of becoming more culturally aware and knowledgeable, followed by information on building a positive alliance, conducting assessments, testing, making diagnoses, and providing psychotherapy. Throughout these sections, I use case examples of people who hold complex identities. For example, the case of an older African American woman does not focus solely on her ethnic and racial identity; it also considers disability, gender, generational experiences, religion, and socioeconomic status. In addition, I include cases in which therapists have diverse identities, too.

Recognizing the heavy emphasis on U.S. ethnic minorities within the multicultural counseling literature, I include information on and case examples of cultures and minority groups not commonly found in U.S. texts (e.g., Indonesian, Tunisian Arab, French Canadian, Mauritanian, Filipino, Haitian, East Indian, Costa Rican, Korean, and Greek cultures). To increase awareness of U.S.-centric assumptions, some of these cases are set in Canada. Cases involving international identities are also included, although setting cases in a variety of national contexts proved difficult because what constitutes a minority culture in one country is often a dominant culture in another.

One of the biggest challenges in multicultural competence training is providing information that translates academic learning into actual therapeutic practice (Sehgal et al., 2011). To help with this process, I’ve included practice exercises at the end of each chapter that provide an opportunity to take this learning beyond book reading.

In Part I, Becoming a Culturally Responsive Therapist, Chapters 2 and 3 describe specific steps and exercises for facilitating your own cultural self-assessment. Chapter 2 focuses on the exploration of personal experiences, values, and biases. Strategies are described for developing compassion and critical thinking skills and for preventing defensive interactions with clients. Chapter 3 provides an extended case example of the self-assessment process with a particular therapist who discusses the complexity of his identity, including generational experiences, ethnicity, sexual orientation, and the other ADDRESSING influences. This chapter provides exercises for understanding your own cultural identity and the role of privilege in the context of your work.

Consistent with the premise that you are engaged in and committed to the self-assessment process, in Part II, Making Meaningful Connections, Chapter 4 addresses language, with a focus on terms that unintentionally convey bias along with an explanation of preferable alternatives. Chapter 5 explains how to use the ADDRESSING framework to facilitate greater understanding of clients’ identities through the formulation of
hypotheses and questions that are closer to clients’ experiences. Chapter 6 outlines considerations in establishing rapport and demonstrating respect with people of diverse identities.

In Part III, Sorting Things Out, Chapter 7 provides specific suggestions for conducting culturally responsive assessments, including guidelines for working with interpreters. Chapter 8 focuses on standardized testing in mental status, intellectual, neuropsychological, and personality assessments. Chapter 9 addresses cross-cultural issues in the diagnostic process using the new DSM–5, along with information regarding the ICD–10–CM (World Health Organization, 1992a) and the upcoming ICD–11.

Part IV, Beyond the Treatment Manuals, focuses on the use of diverse approaches to psychotherapy, with an integrative orientation to culturally responsive work. Chapter 10 illustrates the application of this orientation in the form of culturally responsive cognitive behavior therapy. Chapter 11 provides examples of Indigenous, traditional, and other approaches to healing, including expressive modalities (e.g., art and play therapies) and family, couple, and group approaches. Finally, Chapter 12 pulls together suggestions from the preceding chapters in the case example of an older African American woman and her family who see a young African American male psychologist.

Your Journey

The year I began teaching multicultural psychology, Stephen R. López (López et al., 1989) published a study with a group of graduate students that chronicled the students’ development of awareness, knowledge, and skills during a multicultural training course. The subsequent analysis of their writings showed four stages in the development of multicultural competence. In the first stage, the students had little awareness of cultural influences and believed themselves to be bias free. In the second stage, as they learned about the influence of culture, they began to see their own biases, but their attempts to understand clients were often characterized by stereotypical explanations. In the third stage, the students experienced mounting confusion, frustration, and defensiveness as they recognized their limited knowledge and skills and perceived the consideration of cultural influences to be more of a burden than a help. However, by the fourth stage, the students were able to use cultural information flexibly, adapting it to clients’ particular needs and preferences, and they were aware of their biases but also more accepting of their limitations and the need for lifelong learning. These stages did not always occur in linear fashion; an individual could have a high level of competence with members of one group and very little with another and move in and out of different stages not necessarily in this order.
As you read this book, possibly along with a related course or internship, and learn more about whatever cultures are new to you, I hope that you will keep these stages in mind. If you find yourself thinking that you have no biases regarding a group with which you have little experience, dig a little deeper, because as the next chapter explains, we all have biases. If you begin to feel frustrated or confused because of the complexity of applying your learning with real people, be gentle with yourself and remember that this is a normal part of the process. Keep in mind that the development of multicultural competence is a lifelong process with unlimited domains for new learning. It is my hope that this book conveys to you how exciting, life enriching, and positive this process can be.

**Practice: Starting From Where You Are**

Choose a minority or dominant cultural group that you belong to, and think about your multicultural competence with members of this group. Write a paragraph describing how your multicultural competence with this group fits or doesn’t fit one of the stages described by López et al. (1989). Then choose a minority group with which you have little or no experience, and write a paragraph describing how your multicultural competence with this group fits or doesn’t fit one of the stages. (Note: Save your writing, because at the end of this book I will ask you to look back at it.)

### KEY IDEAS

1. Evidence-based practice in psychology (EBPP) is defined by the American Psychological Association (APA) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.”

2. The APA definition of EBPP supports an integrative approach to psychotherapy, acknowledges the reality that controlled studies of psychotherapy effectiveness with many minority groups do not exist, and emphasizes the importance of clinical expertise in adapting therapy to the particular individual and his or her cultural context.

3. The ADDRESSING acronym stands for *Age and generational influences, Developmental or other Disability, Religion and spirituality, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender.*
4. The ADDRESSING acronym is a tool for developing hypotheses and questions about cultural influences that therapists may be inclined to overlook; some of these questions may be appropriate to ask clients directly, and some may not.

5. The ADDRESSING framework makes use of the ADDRESSING acronym through two categories of work: (a) the personal work of introspection, self-exploration, and understanding the cultural influences on one’s own belief system and worldview; and (b) the interpersonal work of learning from, about, and with diverse people.

6. Recognizing the areas in which you are a member of a dominant group can help you become more aware of the ways in which privilege limits your knowledge and experience regarding minority members who differ from you.

7. Age and generational influences include not just chronological age but also generational roles that are important in a person’s culture and experiences specific to age cohorts.

8. Many people who grow up with a disability learn coping skills that enable them to function well in the dominant nondisabled world, and when these individuals come to counseling, it is often for a problem that is unrelated to the disability.

9. The definition of a group as a minority group is contextual; that is, it depends on the context and its dominant cultures.

10. The idea that diversity can be addressed in one multicultural counseling course has been replaced by the view that multicultural learning is lifelong and that cross-cultural information, experiences, and questions must be integrated throughout the training curriculum, including practica and internships.