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Diversity, Complexity, and Intersectionality

Khaled,[1] a 38-year-old Muslim man, came to the therapist's office with his wife, Saida; their 11-year-old son, Ahmed; and their 6-month-old baby. Khaled reported that Ahmed was having difficulty swallowing, he had lost 10 pounds during the past 3 months, and their physician had ruled out any medical problem. Saida said the teacher told her that Ahmed cried a lot, was easily distracted, and did not play with the other children during recess. During the assessment, Khaled appeared frustrated, while Saida focused on keeping the baby quiet, and Ahmed gave only short answers to questions. When asked for family information, Khaled said he was an engineer before immigrating but was now working as a desk clerk at a hotel scheduled to close in 2 months. He acknowledged that the work situation was stressful, then emphasized that they were there for help with fixing Ahmed's swallowing problem.

On the intake form, Mrs. González identified herself as Catholic and "Spanish" from New Mexico. With her 17-year-old grandson, Roberto, present, she told the therapist that she had been raising her two grandchildren by herself for the past 5 years, after their father (her son) died in a motorcycle accident and their mother left. Mrs. González said she was worried about Roberto after "catching him" engaging in some sexual behavior with another boy. She began crying and added that Roberto had never had a girlfriend, he was drinking and

[1]All cases are composites or fictional and do not represent any one person. I have given people names (all pseudonyms) because recognizing culturally common names is a part of multicultural learning.

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Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach, Fourth Edition, by P. A. Hays

smoking cigarettes, and his grades were declining. "He disrespects me," she said, adding, "I don't know what to do with him." With a frown, Roberto said his grandma worried about everything, and he was fine.

Danilo was a 32-year-old bicultural (Filipino/Native Hawaiian) former soldier with serious injuries due to an improvised explosive device (IED) explosion 1 year before coming to see a counselor. He had recovered his cognitive abilities with the exception of some mild concentration difficulties but was blind in one eye and had mildly slurred speech and right-sided weakness. He tearfully reported feeling useless to his wife and two children, and he worried about their inadequate finances. He said he wanted to work again, then added, "But I'm so sick and tired of people's stares. When I'm not in uniform, people assume I'm drunk or mental. I know no one would give me a job like this. I hate the way I am."

In each of the cases given here, the clients' presenting concerns originated in and/or were heavily influenced by societal-level problems. For Khaled and his family, this included the enormous stressors involved with immigration (learning a new language, customs, and social norms), economic hardship and a decline in social status, loss of support from family and friends, different forms of health care, and anti-immigrant attitudes and actions in their new country. In Mrs. González's situation, drug abuse and a lack of treatment facilities contributed to her son's accident and the departure of her grandsons' mother, with societal and internalized homophobic attitudes complicating family relationships. Danilo's suffering was due to injuries caused by war and magnified by physical obstacles and dismissive attitudes toward disabled people and people of color.

These societal-level problems emanate out of structural inequalities that privilege a relatively small group of the world's population while oppressing the vast majority. This majority includes people who have been displaced within and across national borders due to war, poverty, and violence. Environmental degradation and extreme climate changes have magnified the impact of natural disasters, especially on economically marginalized communities. Economic globalization, technology, and the internet have contributed to a pace of change that leaves increasing numbers of people behind.

With these changes, the world's awareness of and approach to diversity has shifted in significant ways. A growing number of people now marry across cultural groups and have children who identify as multiracial. Dominant cultural attitudes have moved in a positive direction (albeit with a long way to go) toward sexual and gender minorities and people with disabilities. The value of Indigenous traditions is being acknowledged more widely, and calls for social justice include major movements in the form of #MeToo and Black Lives Matter. Unfortunately, the world has also seen a parallel rise in hate crimes against Muslims, Jews, and people of color, including overt violence by White supremacy groups. And the COVID-19 pandemic has magnified disparities in health care related to race, class, and disability (Andrews et al., 2021; Gruber et al., 2021).

These shifts are reflected in the helping professions (psychology, psychiatry, counseling, social work) and the broader field of public health, where researchers and providers recognize the profound impact of "social determinants." Shim and Compton (2018) noted the groundbreaking nature of the World Health Organization's (WHO) report *Closing the Gap in a Generation* in its emphasis on social determinants that create inequities and implicate "political structures and political power as drivers of these determinants" (p. 844).

The field of social work has long recognized the impact of systemic oppression and focused on meeting the needs of oppressed groups. In psychiatry, emphasis is increasing regarding the importance of "structural competency," defined as the knowledge of harmful structural/systemic influences on health such as income inequality, unemployment, adverse childhood experiences, food insecurity, and lack of clean water (Metzl & Hansen, 2018). In psychology, the focus is on multicultural competence that includes knowledge, awareness, and skills regarding diverse minority groups.

Along these lines, the American Psychological Association (APA) has created and updated guidelines for working with minority populations. These include *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017; i.e., *Multicultural Guidelines*), *Guidelines on Race and Ethnicity in Psychology* (APA, 2019c), *Guidelines for Psychological Practice for People With Low-Income and Economic Marginalization* (APA, 2019b), *Guidelines for Assessment of and Interventions With Persons With Disabilities* (APA, 2019a), *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (APA, 2015), *Guidelines for Psychological Practice With Sexual Minority Persons* (APA, 2021), *Guidelines for Psychological Practice With Girls and Women* (APA, 2018a), *Guidelines for Psychological Practice With Men and Boys* (APA, 2018b), and *Guidelines for Psychological Practice With Older Adults* (APA, 2014).

In addition, the definition of evidence-based practice in psychology (EBPP) has been clarified to account for the growing body of research regarding minority cultures. Contrary to the common belief that only quantitative studies with control groups of randomized participants qualify as EBPP, the APA Task Force on EBPP (2006) recognized that such a narrow definition would rule out most of the multicultural psychology research. The resulting definition of evidence-based practice is that EBPP consists of "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, p. 273).

By emphasizing "best available research," this definition recognizes the value of experimental control but also acknowledges that for many minority groups, controlled studies of psychotherapy effectiveness do not exist. The definition gives equal importance to case studies, qualitative reports, community participant research, and the advice of providers who are themselves minority group members. It does not prioritize any one theoretical orientation but rather supports a more integrative approach. And it emphasizes that therapy must be adapted to each client's cultural context and personal preferences.

> *Evidence-based practice in psychology (EBPP) is defined as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.*
>
> —APA TASK FORCE ON EBPP (2006, P. 273)

DEVELOPING A MULTICULTURAL ORIENTATION

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, with only one person of color. She stressed that they had 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. 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. It includes faculty who have first-hand knowledge of their students' cultures and their students' clients, who speak and read in more than one language, and who are connected to minority groups whom they consult in their development of educational materials and 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, psychiatry, counseling, and social work, professional organizations have committed to increasing the multicultural expertise of their members (see American Psychiatric Association, 2020; Clauss-Ehlers et al., 2019; National Association of Social Workers [NASW], 2015; and Ratts et al., 2015). This commitment is evident in the pipeline of psychology graduate students and new providers. People of color make up 38% of the U.S. population, and approximately 38% of psychology graduate students and 34% of early career psychologists are people of color (Andoh, 2021; Lin et al., 2018). 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 students' training, including practicum and internship (Magyar-Moe et al., 2005). And postgraduation continu-

ing education requirements reinforce the message that learning is a lifelong process.

At the same time, educators and researchers have grappled with the difficulties of defining multicultural competence (MCC). D. E. Davis and colleagues (2018) described these challenges, beginning with the limited amount of research supporting a direct connection between MCC and therapy outcomes. This may be because competence implies an end goal that can be definitively measured and met, whereas in reality, measuring such a construct is quite difficult, due in large part to the complexity of identity. How does one assess MCC given the enormous range of cultural influences and identities? What if, for example, a Latina student is highly aware and skilled with heterosexual people of color but has no personal experience or training with gay or nonbinary people? What about the White student with a disability whose therapeutic skills are specific to White people, including people with disabilities? Would these individuals' MCC level be considered partial, population-specific, fully competent, or incompetent?

In response to these challenges, D. E. Davis and colleagues (2018) suggested the alternative framework of a multicultural *orientation.* Such a focus allows for a more process-oriented approach that fits better with how psychotherapy is typically performed and taught. Using this framework, these researchers have found three concepts linked to positive outcomes. The first is *cultural humility*, including recognition of what one does not know, as well as what one knows. Cultural humility motivates therapists to look for and take advantage of the second correlate, *cultural opportunities*, defined as those points at which a client's beliefs, values, and other identity-related topics arise in therapy. The third construct, *cultural comfort*, refers to the therapist's ability to engage with diverse people and cultural topics with openness, ease, and acceptance that discomfort may at times be part of the learning process. Cultural humility, opportunities, and comfort have been linked to therapy outcomes including perceived improvement, racial and ethnic disparities in termination, and the therapeutic alliance (see D. E. Davis et al., 2018, for a summary of the Cultural Humility Scale, the Cultural Comfort Scale, and the Cultural Opportunities Scale).

UNDERSTANDING INTERSECTIONALITY

When I teach multicultural awareness workshops, I start by asking participants to take a minute to "Share with a partner everything you feel comfortable sharing about who you are culturally, including your identity and past and current cultural influences on you." If you are reading this by yourself, try doing this in the following box before reading further.

Once workshop participants finish sharing, I ask how many individuals mentioned ethnicity or race in their self-description. The number of people who raise their hand depends on the makeup of the group. I then ask how many mentioned religion. Again some hands go up. I also ask about age and

TRY THIS

List all of the cultural influences that describe your identity or who you are. Here are some prompts to help you:

I am _____
I identify as/with _____
I belong to _____
I come from _____
In my family _____
I do/do not speak _____
When I was growing up _____
_____
_____

generational influences, disability, sexual orientation, social class, nationality, language, and gender. When I ask if there are additional influences, participants often add geographical region, growing up in the military, working in the business world, and others.

Because most individuals raise their hands more than once, this exercise illustrates the complex nature of identity, or as Kimberlé Crenshaw described it, *intersectionality*. In her 2016 TED talk "The Urgency of Intersectionality," Crenshaw explained the concept via the story of Emma DeGraffenreid. Along with several other African American women, DeGraffenreid filed a discrimination suit against a car manufacturing plant because the company refused to hire African American women in the factory. The plant countered that they did indeed hire African Americans, and they hired women. However, as DeGraffenreid argued, all the African American employees were men working in the factory, and all of the women worked in office positions and were White. The plant refused to hire African American women, because they did not fit the plant's racial and gender requirements for "men's jobs" and "women's jobs."

To explain intersectionality, Crenshaw used the analogy of a road intersection in which a "race road" intersects with a "gender road." Imagine, she noted, that each road is served by a different emergency service. If there is an accident on the race road, the race ambulance comes. If someone is injured on the gender road, the gender ambulance arrives. But if an accident occurs at the intersection, no one shows up. DeGraffenreid was positioned at the intersection of race and gender. At the time her suit took place, the court did not have a mental frame for understanding this idea. As a result, the judge dismissed the case, allowing the plant to continue their discriminatory practices.

An intersectional approach calls attention to diverse cultural influences while simultaneously recognizing the unique ways in which the mix of these influences affect individuals. Think of it this way: When we combine the colors yellow and blue, we do not think of the resulting color as "yellow-blue." Rather, we think of this new product as its own unique color: green (Roysircar & Lanza,

2021). Similarly, identities are not simply additive. Intersectionality reflects this more holistic understanding of people.

Today, many people identify with multiple minority and/or dominant cultural identities. When it comes to multicultural education, one challenge involves the question of who and what to focus on. For the purposes of psychological practice, I highlight nine key influences and related minority groups noted in the APA, ACA, and NASW guidelines cited earlier. These major helping organizations state clearly that their focus is on cultural influences and minority (sometimes called target) groups that have been systematically neglected in the helping professions and the dominant culture.

THE ADDRESSING INFLUENCES

To help with remembering the nine key influences and related minority cultures, I use an acronym that spells the word ADDRESSING. As you read through the list of ADDRESSING influences including minority and dominant groups, you will recognize that the groups listed as minority groups are only minorities 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 context, the dominant and minority groups will be specific to that region or country. Also, remember that the term "minority group" refers to status, not numbers; for example, women are a minority group but not a numerical minority in the United States.

As Table 1.1 summarizes, A stands for *Age and generational influences* that include 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, especially those that occur during a generation's childhood and early adulthood (i.e., formative years). For many older adults, these influences include the Great Depression, World War II, the institutionalization of people with disabilities, laws prohibiting gay relationships, and racial segregation. For Baby Boomers, important early influences were post-World War II economic prosperity, the civil rights and women's movements, Vietnam War protests, and the increased use of drugs and medications. Those known as Gen X (born between 1965 and 1980) experienced the impact of more mothers working outside the home and increased divorce rates of parents. For Gen Y millennials (born 1981–2000), cohort experiences include online technology since birth, intense levels of virtual connectedness through social media, the high cost of college, and climate change.

Obviously, age and generational influences vary across cultural groups, just as how one defines dominant and minority groups varies in different countries and contexts. In North America, the minority groups associated with age and

TABLE 1.1. *ADDRESSING* Cultural Influences

Cultural influence	Dominant group	Nondominant/minority
Age and generational influences	Young/middle-aged adults	Children and older adults
Developmental disability or other Disability	Nondisabled people	People with cognitive, intellectual, sensory, physical, and/or psychiatric disability
Religion and spirituality	Christian and secular	Muslims, Jews, Hindus, Buddhists, and other religions
Ethnic and racial identity	White people/ European Americans	Asian, South Asian, Latinx, Pacific Islander, Arab, Black, African American, Middle Eastern/North African, and multiracial people
SES/social class	Upper- and middle-class	People of lower status by occupation, education, income, or inner city/ rural habitat
Sexual orientation	Heterosexual people	Gay, lesbian, and bisexual people
Indigenous heritage	European Americans	American Indians, Iñuit, Alaska Native people, Métis, Native Hawaiians, New Zealand Māori, and Aboriginal Australians
National origin	U.S.-born Americans	Immigrants, refugees, and international students
Gender	Cisgender men	Women, transgender, and nonbinary people

Note. SES = socioeconomic status.

generational influences are children and older adults, because elders and children do not have the privileges that young and middle-aged adults have. But because privilege is context-specific, in some countries, elder status carries both privilege and power. I talk more about the contextual specifics of these definitions in later chapters.

The next set of letters, DD, stands for *Developmental disability or other Disability*. This category includes disability that occurs at any time during a person's lifetime, for example, due to illness, accident, or stroke, as well as disability that occurs from birth or early in a child's development (e.g., from Down syndrome or fetal alcohol spectrum disorder). Regarding the latter, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) uses the specific term "neurodevelopmental disorder" to describe disorders that are typically evident early on and characterized by impairments in personal, social, academic, or occupational functioning, as in autism spectrum disorder or attention-deficit/hyperactivity disorder.

It is important to recognize that "disorder" and "disability" are not synonymous. "Disorder" is a medical term. In contrast, disability occurs in the interaction of an individual with the dominant nondisabled world. Many individuals who identify as members of Deaf culture (signified by the capital D) do not identify as disabled because they have no impairments when in Deaf culture; it is the hearing world's inability to sign that is the problem. Some individuals with disability identify as members of Disability culture. However, many disabled individuals do not consider themselves members of a culture, as in the case of an older woman whose cognitive functioning is impaired following a stroke.

The distinction between people who grow up with a disability and individuals 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 nondisabled 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 disability.

The next letter R stands for *Religion and spirituality*. In North America, the largest religious minority groups are Muslim, Jewish, Hindu, and Buddhist, along with many smaller groups (e.g., Bahai, Shinto, Confucian, Zorastrian). Although some members of some Christian religions (e.g., Latter Day Saints, Seventh Day Adventists, Jehovah's Witnesses, and Fundamentalist Christians) think of themselves as minority groups, they are still Christian and benefit from the 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 secular American culture, which has Christian roots.

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, Latinx, Middle Eastern/North African (MENA), Black, and African Americans. This includes people who identify as biracial or multiracial. Within each of these large cultural groupings, there are many specific cultures. 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 because what constitutes a minority culture depends on the country and its dominant culture.

S stands for *Socioeconomic status* (SES) and the closely related concept of social class. SES is commonly measured by income, occupation, and education, whereas class refers to a person's ranking with respect to social status and power. Within a community or culture, social status and power may be related to leadership roles, fame, or family reputation, in addition to income, wealth, or education (APA, 2019b). Minority groups include low-income and

economically marginalized people and those who experience lower status or less power because of SES or class.

The second S stands for *Sexual orientation*, and minority groups include lesbian, gay, and bisexual people. In the United States, sexual minority groups often use an acronym that includes additional groups related to gender identity. The more common ones are LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual) and SGM (sexual and gender minorities). To call attention to the unique aspects of sexual orientation and gender, the ADDRESSING acronym lists sexual orientation and gender separately.

The I stands for *Indigenous heritage* and includes people of Indigenous, Aboriginal, and Native heritage. These terms are similar in meaning but used differently in different countries and contexts (more on this in Chapter 4). Within the larger culture of Indigenous people, there are many smaller and specific cultures. For example, in my home community of Kenai, Alaska, the local Indigenous culture is the Kenaitze Tribe. Kenaitze people belong to the larger culture of the Dena'ina, who belong to the larger Athabascan culture, which is one of many Alaska Native cultures. I have listed Indigenous heritage separately from ethnic and racial identity because Indigenous people have distinct and unique concerns. These include land, water, and fishing rights related to subsistence and cultural traditions, and status as sovereign nations.

The N stands for *National origin*, with minority groups including immigrants, refugees, and international students. Because being born in the United States automatically confers citizenship, those born in the United States are the dominant group. Language is often a strong cultural influence related to national origin, although it is also connected to the ADDRESSING domains of ethnic and racial identity, Indigenous heritage, and disability (i.e., the use of sign language in Deaf culture).

Finally, G stands for *Gender identity*. Minority groups include women and people of transgender, transsexual, intersex, nonbinary, and other gender nonconforming identities. I talk more about the complexities of gender identity in Chapter 4 on language and terminology.

When students and therapists first learn about the ADDRESSING acronym, questions often arise regarding the list of minority groups. "What about [fill in the blank] group?" people often ask. "Don't they fit the definition of a culture? Don't you think they experience oppression?"

Please note that I am not saying discrimination and oppression are limited to the minority groups mentioned here. But for educational purposes, I have chosen to focus on the influences and minority cultures highlighted by the APA, ACA, and NASW. The ADDRESSING acronym is a *heuristic*, a word that comes from Greek and is defined as a practical method for discovery that is not guaranteed to be perfect, but which raises questions and facilitates learning. In this vein, the ADDRESSING acronym calls attention to cultural influences on everyone, whether we are aware of these influences or not. It serves as a reminder of minority group identities that are often overlooked by dominant culture members. And it highlights the multidimensional nature of identity. It

is also the starting point for what I call the ADDRESSING *framework,* a more comprehensive approach to culturally responsive practice.

It is my hope that you will use the ADDRESSING acronym as a tool for raising questions about yourself and others, toward the goal of understanding and connecting with diverse people, especially those who have been systematically ignored and mistreated.

TRY THIS

See if you can memorize the list of ADDRESSING influences. Do not worry about memorizing all the groups at this point, just focus on the influences for now.

THE ADDRESSING FRAMEWORK

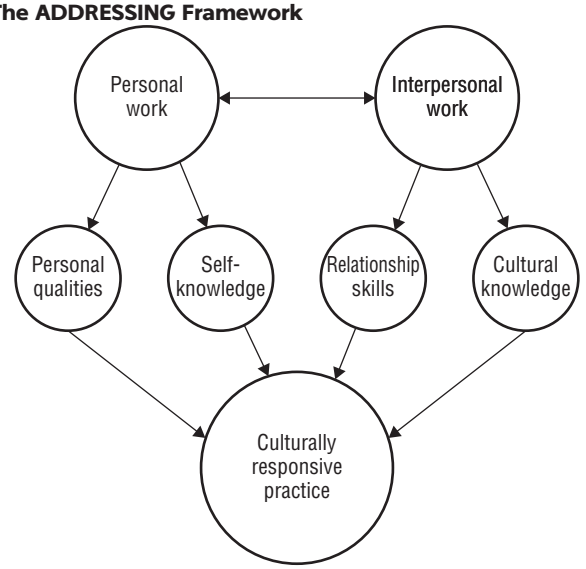
The ADDRESSING framework is an approach to therapy that conceptualizes multicultural work in two broad categories. The first category of *personal work* involves cultivation of key personal qualities and self-knowledge. This includes learning about and reflecting on who you are as a human being with your own cultural belief system and worldview. The second category of *interpersonal work* focuses on learning about diverse cultures through direct experience with members of diverse groups and the development of culture-specific relationship skills. Throughout the process of developing a multicultural orientation, the personal and interpersonal work overlap with and contribute to the development of culturally responsive practice.

The Personal Work

The ADDRESSING framework begins with the cultivation of four key personal qualities: humility, compassion, veracity, and courage. Simultaneously, it involves exploration of the effects of diverse cultural influences on your beliefs, thinking, behavior, and worldview. These effects stem from age-related experiences, experience or inexperience with disability, religious or spiritual upbringing and orientation, ethnic and racial identity, and so on (i.e., the ADDRESSING influences). 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 (see Figure 1.1).

For example, a White, middle-class, lesbian therapist may hold an exceptional awareness of the sexist and heterosexist biases against lesbian, gay, bisexual, and transgender clients. However, this awareness does not automatically translate into greater awareness of the issues faced by people of color, people with disabilities, or people living in poverty. The privileges this therapist holds

FIGURE 1.1. The ADDRESSING Framework



in relation to her ethnicity, race, education, abilities, and professional status are likely to separate her from people who do not hold such privileges. If her friends and family are similar in ethnicity, religion, and social class, she will not have easy access to information that would help her understand, for example, a heterosexual, African American Muslim man. Because of the way privilege separates dominant-culture members from knowledge relevant to minority groups, this therapist would need to put extra effort into finding and learning the knowledge and skills to understand this client and work effectively with him.

The Interpersonal Work

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

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

- What are the *Age-related issues and generational influences* on this man, given his status as a second-generation immigrant? In his cultural context, does his older age give him more or less privilege than younger people? Has his generation been influenced by traumatic events in his current country of residence or his parents' country of origin?

- Might he have a *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 be a caregiver for a child or parent with a disability?
- Does he have a *Religious identity or spiritual practice*? Was he brought up in a particular religion? (Hindu, 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 South Asian people immigrated to African countries and were then forced to leave because of political persecution by the host country.)
- Does he identify himself *Ethnically or racially*? Is he often mistaken for another identity (e.g., Arab)? How does his physical appearance (e.g., skin color) relate to his experiences within his own ethnic group and in the dominant culture?
- What were his *Socioeconomic status* (SES) and social class growing up? What are they 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 or class in the dominant culture, such as his family name, geographical origins, or marital status?
- What is his *Sexual orientation*, not assuming heterosexuality simply because he is or has been married? How would a question about his sexual orientation be perceived?
- Might *Indigenous* heritage be part of his ethnic identity, for example, related to his family's premigration geographical or community origin?
- What is his *National origin*? What country were his parents from? Was he born in his country of residence? What is his national identity (the nation of his residence, both, or neither)? What is his primary language—Hindi, English, Bengali, or some other language?
- Considering his cultural heritage and identity as a whole, what have been the important *Gender-related influences* on him, for example, roles, expectations, and accepted types of relationships in his culture?

TRY THIS

Are there any other questions that come up for you when thinking about the ADDRESSING influences in relation to this man?

The ADDRESSING acronym does not provide the answers to these queries; 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 queries 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 person.

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 this idea 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 of their culture(s). The broader cultural information serves as a sort of template that helps in generating hypotheses and questions that are closer to the client's reality, increasing efficiency and decreasing the likelihood of offensive questions. I talk more about this use of the ADDRESSING acronym to facilitate culturally responsive assessment in later chapters.

WHAT'S NEW IN THIS EDITION

You may have noticed that this fourth edition has a slightly new title that emphasizes both counseling and clinical practice. Clinical programs typically prepare students for practice in medical and independent settings, with a research base focused on psychopathology, neuropsychology, pain management, and other medically related topics. The most common theoretical clinical orientations are cognitive behavioral and psychodynamic. In contrast, counseling programs are stronger in the area of multicultural mental health, with a greater focus on humanistic and person-centered orientations (Norcross et al., 2021). Over the years, both fields have moved more toward each other, fueled in part by the increasing number of master's-level therapists working in community mental health and private practice.

My own training includes an MA in counseling psychology and a PhD in clinical psychology, and I appreciate the strengths of both. In this book, I draw from both fields, along with psychiatry and social work. Specifically, this fourth edition includes the following:

- a new chapter on culturally adapted cognitive behavioral tools and techniques,
- updated information regarding gender identity with attention to clinically relevant research regarding transgender and nonbinary people,
- more on the largest minority group in the United States—people with disabilities,
- the latest terminology and language regarding diverse minority groups,

- a new chapter on trauma due to racism and other systemic forms of oppression, and
- a special section on social justice and its relationship to therapeutic practice.

ORGANIZATION

With the intention of conveying cultural information in the way that it is typically experienced by therapists, 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. The book begins with suggestions for facilitating therapists' personal process of becoming more culturally aware and knowledgeable. Subsequent topics include building a positive alliance, conducting assessments, testing, making diagnoses, and providing individual and family psychotherapy. Throughout these sections, I use case examples of clients and therapists 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 SES. In addition, cases are included in which therapists have diverse and complex identities too.

Recognizing the heavy emphasis on U.S. racial and ethnic minorities within the multicultural counseling literature, information and case examples represent cultures not commonly found in U.S. texts (e.g., Indonesian, Arab, French Canadian, Mauritanian, Filipino, Haitian, South Asian, Costa Rican, Korean, and Greek cultures, among others). 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 with multicultural training involves the translation of academic knowledge and learning into actual therapeutic practice (Sehgal et al., 2011). To help with this process, practice exercises at the end of each chapter provide an opportunity to take your 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 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.

Part II, Making Meaningful Connections, is based on the premise that you are engaged in the ongoing process of self-assessment and learning and begins

with Chapter 4 on language, with a focus on terms that unintentionally convey bias and an explanation of respectful 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 offers suggestions for establishing a positive therapeutic alliance with an emphasis on the cultivation of respect.

In Part III, Sorting Things Out, Chapter 7 provides specific suggestions for conducting culturally responsive assessments. Chapter 8 focuses on the assessment of trauma, including trauma related to racism and other systemic forms of oppression. This chapter also contains guidelines for working with interpreters. Chapter 9 offers suggestions for making standardized testing as culturally responsive as possible, including tests of mental status, intellectual, neuropsychological, and personality functioning. Chapter 10 addresses cross-cultural issues in the diagnostic process using the *DSM-5*, along with information regarding the 10th edition of the *International Statistical Classification of Diseases and Related Health Problems, Clinical Modification* (*ICD-10-CM*; WHO, 2016) and 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (*ICD-11*; WHO, 2019).

Part IV, Beyond the Treatment Manuals, covers the use of diverse approaches to psychotherapy. Chapter 11 outlines an integrative approach to culturally responsive therapy with individuals, families, couples, and groups, while Chapter 12 describes culturally adapted cognitive behavioral tools and techniques. Chapter 13 provides examples of Indigenous, mindfulness, expressive arts, and other approaches to healing, along with a special section on social justice. Finally, Chapter 14 pulls together suggestions from the preceding chapters in the case example of an older African American Christian woman and family seeing a younger African American male psychologist.

YOUR JOURNEY

The year I began teaching multicultural psychology, Stephen R. López published a study with a group of graduate students that chronicled the students' development of awareness, knowledge, and skills during a multicultural training course (López et al., 1989). The subsequent analysis of their writings showed four stages to their learning. 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 stereotypic 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 cul-

tural information flexibly, adapting it to clients' needs and preferences. At this point, students 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, as an individual might have a high skill level with one group but very little with another and move in and out of different stages not necessarily in this order.

As you read this book, I hope you keep these stages in mind. If you find yourself thinking that you have no biases regarding a group with which you have minimal 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. The development of a multicultural orientation is a lifelong endeavor with unlimited domains for new learning. It is my hope that this book conveys to you how exciting, life enriching, and positive this journey can be.

PRACTICE: STARTING FROM WHERE YOU ARE

Reread the three case examples on the first page of this chapter, and write a paragraph describing your awareness, knowledge, and skills regarding therapeutic work in each case. Include your strengths and limitations and where you see yourself per the stages outlined by López and colleagues (1989). Save your writing, as you will be revisiting this exercise at the end of the book.

KEY IDEAS

1. Evidence-based practice in psychology (EBPP) is defined by the APA 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, p. 273).
2. The APA definition of EBPP supports an integrative approach to psychotherapy and acknowledges the reality that controlled studies of psychotherapy effectiveness with many minority groups do not exist.
3. The ADDRESSING acronym stands for *Age and generational influences*, *Developmental or other Disability*, *Religion and spirituality*, *Ethnic and racial identity*, *Socioeconomic status/social class*, *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 in two categories of work: (a) the personal work of introspection, self-exploration, and lifelong learning about the cultural influences on oneself and (b) the ongoing 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 culture as a *minority* group is contextual; that is, it depends on the context and the dominant culture(s).

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 cross-cultural information, experiences, and questions must be integrated throughout the training curriculum, including practicum and internship, and in postgraduation continuing education.