

## **Chapter Summaries (300 words each) for Pamela A. Hays, Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach, Fourth Edition**

### **I: BECOMING A CULTURALLY RESPONSIVE THERAPIST**

#### **Chapter 1: Diversity, Complexity, and Intersectionality**

This chapter postulates that 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). 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.

The author introduces the ADDRESSING acronym which 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 identity*. 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. 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.

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.

It’s important to note that *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.

Another important distinction the chapter elucidates is that 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.

The definition of a culture as a *minority* group is contextual; that is, it depends on the context and the dominant culture(s) and 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. Multicultural learning is or should be in nearly every facet of learning.

## Chapter 2: Essential Knowledge and Qualities

This chapter presents the idea of bias and the fact that it's best thought of as a tendency to think, act, or feel in a particular way, sometimes pointing toward more accurate hypotheses, but sometimes not. When bias is reinforced by powerful groups and social and societal structures, the results are systems of privilege and oppression (e.g., racism, sexism, classism, heterosexism, ableism, ageism, colonialism).

Minority members in these systems are socialized to be acutely aware of the rules and lines separating them from those who hold privilege, because the outcomes of their lives are more dependent on those who hold power. Privileged members are socialized to not perceive and even to ignore the rules, lines, and laws separating them from those who do not hold such privilege.

Members of dominant groups often find it painful to acknowledge the existence of privilege systems because the idea goes against fundamental American beliefs in meritocracy and individualism.

Privilege separates dominant-culture therapists from information and experiences that facilitate a deeper understanding of clients who hold minority identities. Humility, compassion, critical thinking, and courage facilitate therapists' work across lines of privilege and oppression.

The obstacles of fear, ignorance, aversion to pain, and attachment contribute to defensive feelings and actions. Although defensive *feelings* can be helpful as cues that something needs attention, defensive *behaviors* are a problem because they often lead to a disconnection between people.

It's important to consider steps to minimize defensive behaviors, which include mindful awareness of the physical sensations that accompany defensive emotions, focusing on one's breath in the moment, and questioning the need for a client to see things in the same way you do.

## Chapter 3: Your Cultural Self-Assessment

This chapter opens with the idea that recognizing the ADDRESSING influences on our lives is a first step toward understanding the influence of cultural heritage on our beliefs and worldview.

The author goes on to say that unrecognized privilege is dangerous for therapists, because privilege cuts therapists off from information and experiences that help us understand clients. Privilege is contextual: A privileged identity in one cultural context may not be privileged in another. The areas in which we hold privilege are usually those in which we hold the least awareness and defensiveness tends to block recognition of one's own privilege.

Individually oriented work (e.g., introspection, self-questioning, reading, some forms of research) is necessary but not sufficient for a multicultural orientation.

The views and experiences of minority members are routinely excluded from mainstream media. What turns mainstream sources of information into learning opportunities is how we think about them and the questions we ask, which is in essence, critical thinking.

Engagement with people of diverse identities is important because if the people around us hold similar identities and privileges, belief in the “universal nature” of our beliefs and worldview will be reinforced. This is key.

Peer-level relationships offer the best opportunities for multicultural learning because both parties hold enough power to honestly and safely share their feelings and thoughts.

## **II: MAKING MEANINGFUL CONNECTIONS**

### **Chapter 4: That’s Not What I Meant – Finding the Right Words**

This chapter opens by presenting the term “microaggression” which refers to intentional and unintentional verbal, behavioral, and environmental insults that minority group members experience from the dominant culture.

Talking about race and other culturally related differences is difficult because it violates the *politeness protocol*, the *academic protocol*, and the *color-blind protocol*. The concept of color-blindness is offensive because it ignores the ways in which race profoundly affects the lives of people of color.

It’s important to note that researchers generally agree that race is a socially constructed concept and there are no pure gene pools, as human beings of dominant and minority cultures are genetically quite mixed. Also, it’s worth noting that although race is a socially constructed concept, its consequences are real, and therapists need to be aware of these consequences and the varied meanings race holds for members of minority and dominant cultural groups.

Ethnicity is commonly conceptualized as a discrete categorical variable, when, a person may identify as bi- or multicultural/racial, or the salience of their ethnic identity may vary over time, in different situations, and with developmental changes.

The term “minority” has traditionally been used in reference to groups whose access to power is limited by the dominant culture.

It is preferable to note a disabling environment (e.g., “There was no curb cut”) than to describe a person by their limitations (e.g., “physically challenged”).

“Gender” refers to a person’s internal sense of being male, female, or some- thing else, whereas “sexual orientation” refers to a person’s physical, romantic, and/or emotional attraction to another person.

“Transgender” is used by a broad range of people whose gender identity differs from that assigned at birth, including people who identify as gender- queer, gender nonconforming, and nonbinary.

## **Chapter 5: Intersectionality – The Complexities of Identity**

Chapter 5 posits that identity is a complex phenomenon that can vary over time and with changes in the person’s social context, experiences, and age. Despite the growth in multicultural research regarding identity development and diverse minority groups, there continues to be a gap regarding social class, classism, and psychotherapy with people in poverty.

Clients of minority identities may be reluctant to talk about identity-related differences because they assume that the therapist holds the same biases as the dominant culture.

Straightforward questions about a client’s identity may be inappropriate when clients perceive the concept of identity to be an abstraction unrelated to their presenting concerns.

Even if it feels intrusive or inappropriate to ask identity-related questions, therapists will still need to consider such questions because not doing so risks missing information that is key to understanding the person and their life. It’s important to include and face these questions head-on.

A key aspect of questions regarding gender, sexuality, and disability involves assessing the degree to which they play a role in the client’s presenting problem; in some cases, they may be the focus, whereas in others, they may have little to do with the problem.

Because SGM people of color may have no social environment completely free of prejudice and discrimination, the reluctance to disclose may be an adaptive, self-protective response. Referring to someone’s birth-assigned gender as their “real gender” is erroneous and offensive; for a transgender person, their real, true gender is what they are living or wish to live.

It’s important to note that although medical interventions are often seen by the dominant culture as the most significant and life-changing aspect of a person’s gender transition, many people do not want medical interventions, which confirms the strong mental aspect of gender transition.

The ADDRESSING framework can help therapists formulate hypotheses and well-informed questions that are closer to the client’s reality and increase the therapist’s credibility.

## **Chapter 6: Creating a Positive Therapeutic Alliance**

Chapter 6 states that in a summary of over a dozen meta-analyses, the APA’s Task Force on Evidence-Based Therapy Relationships (2006) concluded that the relationship between therapist and client significantly affects therapy outcomes whatever one’s theoretical model or treatment modality.

Information about specific cultures does not explain the behavior of all members of that culture, but it does open new hypotheses that increase the likelihood of establishing a positive alliance.

The concept of respect is central in Latinx, Black, African American, Asian, South Asian, Middle Eastern/North African, and many Indigenous cultures and involves both an internal orientation to others and specific behaviors.

Regarding cultural patterns of speech, changing the term “indirect” to “subtle and polite” highlights the importance given to harmonious relationships in Asian, American Indian, and Alaska Native cultures.

As surprising as this seems when people of different speech paces interact, pausers often interpret over-lappers as rude and self-centered, and over-lappers assume pausers are cognitively impaired or hard of hearing.

There’s an expectation that informal social interaction will precede a formal procedure such as an assessment (for example, the expectation of *personalismo* in Latinx cultures) which is common to many cultural and other minority groups.

The APA Ethics Code does not prohibit dual or multiple relationships if they do not present any harm to the client; these relationships may be positive for the client and add to the therapist’s clinical judgment, competency, and credibility.

A therapist’s self-disclosure is not completely within the therapist’s control and occurs in nonverbal as well as verbal forms, including one’s choice of words, behaviors, workspace, expectations, and community involvement.

Out of a desire to form an alliance with clients of color, European American therapists may minimize ethnic/racial differences, whereas therapists of color may overidentify with the client and minimize psychopathology when it is present.

A meta-analysis of racial/ethnic matching found that across 52 studies, clients of diverse identities reported moderately strong preference for a therapist of their own race or ethnicity, but racial/ethnic matching had almost no effect on treatment outcomes with one exception—when African American clients were matched with African American therapists, treatment outcomes were “mildly better.”

### **III: SORTING THINGS OUT**

#### **Chapter 7: Conducting a Culturally Responsive Assessment**

Chapter 7 recommends, during an initial assessment, for therapists to include time for obtaining informed consent to allow for a client’s limited language or comprehension abilities, fear about signing official documents, distrust of authorities, and/or financial concerns.

We should recognize cultural norms that may prevent the client from answering certain types of questions or questions posed in a particular way, for example, questions regarding spirituality or a family member's problems. Think systemically and, whenever possible, seek out multiple sources of information in multiple ways regarding multiple domains.

Also, therapists should use cultural history as a cognitive template into which individual and family information can be placed to increase understanding of the client and stay aware of changing conceptualizations and cultural differences regarding illness, health, and disability over time.

It's important to ask about the client's conceptualization of their problem, situation, and health including self-care practices and to convey respect for a person's religion and spirituality, ask about these during questions about strengths and supports.

Members of LIEM communities may use casual register in settings where middle-class people speak in formal register.

Do not depend on clients to tell you their strengths and supports; actively look for culturally related strengths at the individual, interpersonal, and environmental levels.

In distinguishing pathological from nonpathological behaviors and beliefs, remember that the latter are usually preceded and followed by good coping, lead to increased self-esteem, and receive the support of family and community.

## **Chapter 8: Understanding Trauma**

Research confirms the cumulative effects of trauma over a person's lifetime in interaction with racism, heterosexism, ableism, classism, and other systems of oppression. It's important to note that minority group membership increases one's exposure to traumatic events that impact individual as well as community health.

Whereas a microaggression by itself might not be traumatic, in combination with multiple microaggressions, knowledge of past atrocities, and current violence, trauma can result.

Moral injury is a term used to describe the distress that affects a person psychologically, behaviorally, socially, and spiritually in response to experiencing or witnessing events that go against one's values and moral beliefs.

A lifetime of trauma may contribute to internalized oppression that convinces an individual they are to blame for the discrimination and abuse they experience.

When assessing for trauma, consider historical and current traumatic events related to the client's culture and community. We should be cautious about making judgments as to what constitutes a traumatic experience until you fully understand the client's family, community, and cultural histories.

Facilitate use of the client's preferred language, if necessary, through referral to another therapist or the involvement of a well-qualified interpreter.

A professional interpreter can enhance the therapeutic alliance, facilitate patient access to care, build a shared understanding, activate advocacy resources, and increase the cultural compatibility of services.

This chapter reminds us that because trauma work puts therapists at heightened risk for burnout and secondary trauma, self-care is essential.

## **Chapter 9: Culturally Responsive Testing**

Major challenges persist regarding culturally responsive testing, including a lack of appropriate norms, tests, and expert consultation/referral sources; limited training in multicultural testing competence; testing in a second language by assessors with limited second-language proficiency; and an underrepresentation of ethnic minority psychologists.

Too often, educational level and experience have been confounded with culture, resulting in the interpretation of lower test scores as evidence of lower intelligence in people of minority cultures.

Tacit knowledge is action oriented, practical, and usually acquired without the help of others, which means that it is often unspoken and poorly articulated, unlike academic knowledge, which is practiced and reinforced by the academic environment and the dominant culture.

Composite test scores (e.g., an IQ) say little about a client's functioning, whereas focusing on specific measures of strengths and weaknesses is more informative and useful.

During an assessment, make sure the testing environment is culturally responsive, with attention to the physical milieu, respectful behavior, informed consent, a systems orientation, consideration of trauma history, and a thorough explanation of testing procedures.

Always conduct a thorough clinical interview in conjunction with testing.

In general, do not use translated versions of tests unless their validity and reliability have been well established, and try to ensure that the tester speaks the client's language.

Recognizing the ethical dilemma that can occur regarding the prior idea, follow APA's 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" (emphasis added; APA Presidential Task Force on EBPP, 2006, p. 273), and in the final report, always describe limitations and potential cultural biases.

The flexible, dynamic, hypothesis-testing approach involves choosing tests that match the referral question and the client's characteristics, culture, and preferences; following standardized

procedures; and testing the limits to gain a deeper understanding of the reasons for the client's performance.

Remember that no individual's test results can be understood without a thorough understanding of their cultural identity and context.

In summary, standardized tests can be enormously helpful in clarifying a person's strengths, abilities, challenges, problems, behavioral and social tendencies, and needs. However, if used without a solid understanding of the client's cultural identity and context, standardized instruments hold the potential for damage. In the not-too-distant past, people of ethnic and other minority identities were seriously hurt by the misuse of such tests.

Thus, it is essential that psychologists be aware of the cultural biases embedded in standardized tests of intelligence, mental status, neuropsychological functioning, and personality. This awareness, combined with specific steps aimed at obtaining culturally relevant information, can significantly improve the accuracy and usefulness of one's diagnosis, the topic of the next chapter.

## **Chapter 10: Making a Culturally Responsive Diagnosis**

Chapter 10 states that an accurate diagnosis points the way to actions that may eliminate or minimize the problem and/or suggests new ways of thinking about the problem. The DSM-5 contains the ICD-10-CM codes and is organized to match the structure of the upcoming ICD-11.

Diagnostic inflation is a factor in the skyrocketing numbers of adults and children diagnosed with ADHD and bipolar disorder.

Therapists working in public agencies that serve people in poverty usually have huge caseloads consisting of especially ill people, and as a result, medications are often the first line of treatment despite their risks.

The new diagnosis of gender dysphoria is given only if the person is distressed about incongruence between their experienced/expressed gender and assigned gender.

It's important to acknowledge that a culturally responsive diagnosis using the DSM-5 involves moving beyond an individualistic focus to think systemically and consider relational disorders and cultural and environmental influences, including systemic oppression.

Multicultural components of the DSM-5 include greater integration of cultural considerations into the body of the text, elimination of the ethnocentric concept of a culture-bound syndrome, and inclusion of the Clinical Formulation Interview.

A limitation of the DSM-5 is elimination of the front-and-center position of psychosocial and environmental problems, now located in the Appendix.

The Cultural Profile consists of the ADDRESSING acronym listed vertically and then, next to each letter, the salient influences and identities for that client. A culturally responsive diagnosis includes consideration of (a) the person's vulnerability to psychological distress based on childhood experiences; (b) past and current stressors, including traumatic events that may have lingering effects; and (c) strengths and supports.

## **II: BEYOND THE TREATMENT MANUALS**

### **Chapter 11: Culturally Responsive Therapy: An integrative Approach**

APA's definition of evidence-based practice in psychology (EBPP) is "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).

The textbook states that an integrative approach to psychotherapy is guided by one overarching theoretical framework (i.e., home therapy) that also incorporates interventions from outside this home therapy.

A key step in culturally responsive therapy grounded in CBT involves defining what part of the client's stress is due to oppressive environmental influences and what part is internally fueled by the client's thoughts, beliefs, and images.

Premature cognitive restructuring involves moving into thought change strategies inappropriately or too quickly, that is, before exploring and validating environmental influences such as systemic oppression.

Action interventions involve physically doing something (i.e., taking action), whereas thought-change (cognitive) interventions involve mental changes.

CLASS summarizes action interventions including Creating a healthy, supportive environment; Learning a new skill or information; Assertiveness, conflict resolution, and other communication skills; Social engagement and support; and Self-care activities.

Challenging the validity or rationality of a belief is risky, especially if it is a core cultural belief; collaborative exploration of the helpfulness of a thought is often more appropriate and effective.

With families, it is important to consider power dynamics in relation to cultural differences related to ethnic or racial identity, sexual orientation, age, disability, and other ADDRESSING influences.

The development of culturally responsive homework can be facilitated by asking clients at the end of the session, "Based on what we did or talked about today, what is the smallest possible step you could take that would feel like you are making progress?"

As therapists, the author of the textbook tells us, we can teach a client coping skills, but given the risks of implementing these strategies, it is the client's call on how and when to use them.

## **Chapter 12: Culturally Adapted Tools and Techniques**

Compassion Voice is a form of cognitive restructuring that involves replacing harsh judgmental cognitions with compassionate thoughts and images about oneself and others. Compassion Voice does not eliminate the need for action though; in the face of abuse or injustice, anger and pain are normal human responses that can motivate us toward personal and social change.

Studies show that positivity strategies such as practicing optimistic attribution (i.e., making generous interpretations of others' behaviors) improve mood and help people feel empowered.

Recognizing another person's suffering helps us see that individual in a holistic way, including their strengths and weaknesses, rather than simplistically dismissing or villainizing them.

Stories can be useful in therapy because they are easier to remember. Metaphors offer guidance, inspiration, and new ways of thinking and are often used in therapy.

Chinese Taoist cognitive psychotherapy conceptualizes psychological distress as resulting from a value system biased toward individual personal gain and rigid attachment to beliefs, goals, and unnecessary desires that do not reflect the natural order of the universe.

Keeping in mind the social orientation of many cultures, many clients may prefer visual imagery exercises that include people who bring them a feeling of love and peace.

During telehealth sessions in which children are distracted by toys and objects at home, one strategy is to incorporate the objects into the therapy session.

The Worry Hill is a four-step therapy for OCD that incorporates a bell-shaped curve to explain how anxiety increases to a peak with exposure, and then if the child persists despite the fear, the anxiety declines.

## **Chapter 13: Indigenous, Creative, Mindfulness, and Social Justice Interventions**

In recent years, European and American cultures have embraced some Indigenous and traditional healing approaches, which are now commonly referred to as complementary and alternative medicine (CAM).

Studies show that time spent in green places improves attention, mood, and stress levels, while decreasing the risk of psychiatric disorders.

Religion can be a powerful source of healing because it addresses spiritual, emotional, physical, and social needs; offers a sense of meaning and purpose; and is supported by the culture in which it originates.

Mindfulness is defined as paying attention to the present moment without judgment.

In therapy sessions, mindfulness can be helpful in staying with the client's experience of pain while at the same time not being engulfed by it.

Solutions to the language-centered bias of psychotherapy may be found in the expressive/creative arts therapies that incorporate art, music, body movement, dance, and play.

Art therapists are generally trained to avoid interpreting clients' creations and instead allow clients to interpret their own work.

Social justice work occurs at the individual (microsystem), community (macrosystem), and structural/societal (mesosystem) levels, and psychologists may be involved at all three levels simultaneously.

The idea that individual healing contributes to community healing is a central tenant of liberation psychology.

Engagement with social action groups can be energizing and offers new opportunities for learning, relationships, and increasing one's multicultural competence.

## **Chapter 14: Pulling It All Together: A Complex Case**

Engage in your own ongoing cultural self-assessment through individually oriented work (e.g., introspection, self-questioning, reading, research) and interpersonal learning (e.g., community activities, diverse media, relationships, and other experiential learning).

Use the ADDRESSING framework to consider the influence of culture and related areas of privilege on your identity, beliefs, and behavior, and to consider cultural influences on clients' identities, beliefs, and behavior.

Consider the interaction of your own identity and context with those of each client.

Think critically about your assumptions regarding the diverse meanings of physical gestures, eye contact, and other nonverbal and verbal forms of communication to prevent inaccurate assumptions.

Seek out and use multiple sources of information regarding clients with appropriate releases of information.

Consider sociocultural historical events that may have affected clients during salient developmental periods in their lives.

Deliberately look for culturally related strengths and supports at the individual, interpersonal, and environmental levels and use a flexible, dynamic, hypothesis-testing approach that includes a clinical interview and tests that match the referral question and the client's characteristics, culture, and preferences.

The textbook recommends using standardized tests cautiously with consideration of possible biases in tests, testing procedures, the testing environment, and the tester, always noting culturally related limitations and potential biases in your report.

Work with cultural consultants and interpreters to develop questions that assess skills and knowledge relevant to clients' experiences and contexts.

In making a diagnosis, consider the client's conceptualization of the problem and self-care practices, along with (a) the person's vulnerability to depression, anxiety, and other forms of distress based on their childhood experiences; (b) past and current stressors, including traumatic events that may have lingering effects; and (c) supports and strengths.

When using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), go beyond an individualistic focus to think systemically and consider relational disorders and cultural and environmental influences.

Regarding culturally responsive therapy, keep in mind the American Psychological Association's 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, p. 273).

Seek out information regarding diverse approaches to health and healing, particularly those preferred in your client's culture(s).

Whatever your "home therapy," consider integrating approaches from other sources, including culturally preferred approaches (e.g., meditation, traditional healers), adaptations of mainstream psychotherapies (e.g., culturally responsive cognitive behavior therapy), expressive/creative arts therapies, and systems-level interventions.

Set goals, develop treatment plans, and choose interventions collaboratively with clients.

Use the ADDRESSING framework as a reminder of the various domains in which power differences may exist in couple and family therapy.

Keep in mind culturally related expectations regarding medications.

When writing your clinical summary/case formulation, include (a) the diagnosis with a list of symptoms justifying it, (b) contributing factors, (c) resilience factors (i.e., strengths and supports), (d) recommendations, and (e) culturally related limitations and potential biases.