White Privilege and the Mind-Body Split and in Multi-Cultural Counseling

Frederic Lowen

A White professor of psychology, Mark S. Kiselica, recounts his experience reading the textbook *Counseling the Culturally Diverse* in 1981 as a graduate student: his self-image as a non-racist was shaken to the core. Denial, anger, and rage erupted at the challenge to his self-delusion. It took years to come to terms with the reality of his entitlement and white privilege, and to recognize his complete unawareness of the deep and pervasive double-standards applied by the majority White group onto Blacks and other minority groups.

The author of *Counseling the Culturally Diverse*, D.W. Sue, a Chinese-American, is blunt and realistic as he identifies and illustrates inequities, injustices, and inequalities that currently and historically favor white males. These promote unrealistic self-images of entitlement to un-earned and un-deserved opportunities for wealth, status, and authoritative power. Much of the problem is embedded in the social structure, a reality that psychologists have been reluctant to address, despite their ability, competence, and in my view, their responsibility to do so.

I am struck by Sue's descriptions of the psychological nature of racism: how it effectively describes the mind-body split, a condition in which thinking is disconnected from feelings and emotions, motivations, and attitudes existing outside conscious awareness. White males who deny their own racial biases exemplify the mind-body split. Many believed Obama's election was proof that the USA had transcended its racism against Black people. Obviously though, after George W. Bush's presidency collapsed the economy with its unfettered execution of Republican Political Party agendas promoting inequality and exploitation, the American people would have elected any alternative, Black, Brown, or Green; Mickey Mouse would have been preferable to a Republican candidate. Of course, the election of Donald Trump in 2016 was an extreme, unfortunate, dangerous, and irrational backlash to the US presidency of Barack Obama.

Denial of racism is as pervasive as the mind-body split. Since Trump's election in 2016, the ridiculous idea that Americans have 'transcended racism' is obviously and plainly illusory. It is a fabrication of the mind without a basis in reality. One cannot help but have racially influenced ideas, attitudes, and fears in this American culture.

Modern counseling and therapy has evolved pre-dominantly from a Euro-centric White cultural perspective, although it is only one of a diverse group of cultural backgrounds, each representing differing perspectives on what constitutes mental health, normality, abnormality, disorder, and therapeutic technique and process.

Attitudes towards different races are too often inadequately examined, if examined at all. Clichés such as 'we are all human underneath' only side-steps and avoids the effects of attitudes towards race when client and therapist represent different races. Therapy practitioners, especially White males, representing the cultural group who have predominantly influenced the theory and practice of modern psychology, may not recognize, may even deny, racial attitudes they themselves embody and exhibit.

This is a good example of the mind-body split referenced earlier: many people's behavior and attitudes are influenced by illusions and fears embedded in their cultural up-bringing, of which they have no conscious awareness. While they consider themselves to be enlightened and non-racist, their unconscious prejudices and fears preclude their ability to relate to members of other races as they do with members of their own race and cultural background. How they think of themselves, their cognitive self-image, is not connected to, and does not reflect how they feel about and behave towards other racial groups. Many therapists have not examined their own

attitudes and biases towards race, and it negatively affects their clinical competency. The therapist may be completely unaware of this dynamic.

Another form of racial denial is the dilution of the importance of 'race' as a cultural aspect in counseling and therapy when it is seen as one of many cultural groupings: gender; age; sexuality; physical, emotional, and/or developmental disability; ethnicity; etc. With individual clients often representing multiple social groupings in addition to race, each with its' own culture, the affects of race may be over-looked, especially by practitioners who are uncomfortable with issue of race due to their own lack of self-examination. I believe it is fear, unacknowledged or denied, that obstructs and/or reduces people's capacity for self-examination.

Due to the evolution of psychology and much psychotherapy from a White European background, many therapeutic goals, standards, techniques and process reflects values embedded in a white European culture. While this is workable for a client of the same background as the practitioner, it can be counter-productive for the multi-cultural client if not recognized by the therapist. For example, the value placed on individualism and independence may not fit a client who values collectivism and family or group integrity, e.g. in Asian and African cultures. Such differences are of a sociopolitical nature, representing both the mores and aspirations of specific cultures. This illustrates a distinction between clinical competence and cultural competence. When clinical competence does not recognize multicultural diversity, the affect on therapeutic outcome is negative.

Cultural competence in therapy is dependent on the therapist's

1) awareness of their own biases and attitudes;

2) ability to understand the worldview of clients from other cultures;

3) ability to develop culturally appropriate therapeutic strategy and technique.

Awareness, knowledge, and skill is required.

With these aspects in mind, a tripartite framework exists for understanding the influences on a client's identity. Universally, all humans share certain traits and characteristics. On the group level, members share similarities and exhibit differences based on the different groups they are members of: race, sexual identification, age, vocation, spiritual, etc. Finally, individuals have personalities and characters that are unique to only them. Psychology has historically placed more focus to individual and universal aspects of being human, with less attention to the role of group culture.

Properly, a therapist recognizes four areas that impact clients: 1) the individual level; 2) the clinical level, referring to potential limitations and counter-productive aspects arising from therapy practice; 3) the organizational level, pertaining to groups the client interacts with; 4) the societal level, where reality is prescribed and defined hierarchically from the perspective of the dominant culture. Acknowledging the historical perspective of psychology is White European, the focus of psychology has been disproportionately on the individual.

The author D.W. Sue recognizes the important role and responsibility psychologists have in demonstrating, articulating, and changing social structures that create and perpetuate psychological problems in individuals. Such problems may be due to societal inequities and injustices that compromise the quality of individuals' lives. They are external problems that must be addressed and reconciled, or accepted and endured. However, they create stress and anxiety that may lead to individual disorder, dysfunction, debilitation, and/or anti-social behavior.

This resonates strongly with my belief that social dysfunction is primarily psychological in nature. Without understanding the psychological mechanisms/dynamic, political, technological, and educational solutions are impotent and ineffective at mitigating social dysfunction. In fact, it

is my opinion that without an understanding of the psychological factors, politics, technology, and education exacerbate social dysfunction.

The dominant group's biases are manifested in the environment as a whole, including the therapist's views as well as journalists, researchers, policy administrators, and society at large, including all members. Several important points must be recognized.

Firstly, much bias towards minority groups, whether racist, sexist, ageist, etc. is operating in the unconscious, outside of conscious awareness. This is true for individuals and the institutions of society, as well as society at large amongst dominant and sub-ordinate minority groups.

Secondly, structured into the institutions of society are policies and procedures that obstruct minorities' access to the opportunities and benefits enjoyed by the dominant group. In the US, the dominant racial and cultural group is European white.

Thirdly, the health industry, particularly the mental health industry incorporates much cultural bias into much of its' clinical and research practice, to the detriment of the minority groups. In psychotherapeutic practice, it is not sufficiently recognized that definitions and constructs of mental health, normal and abnormal, and therapeutic objectives and goals are often and largely culturally derived. Culturally specific emic applications are conflated or confused with universal etic applications.

Considering these three aspects, it is not unusual that white psychotherapists in the US commonly take the view that mental health is defined by one's ability to adapt, integrate, and engage with society. From the dominant group's perspective, with the institutional benefits afforded them, the individual should shoulder the burden of social adaptation. However, for a minority group individual with institutional and social barriers and obstructions to the individual's attempts to engage socially and vocationally, the social structure is thereby the problem. Certainly

more so than it is an individual problem of 'mental health,' intelligence, or 'work ethic.' Unfortunately, many dominant group practitioners are often blind to these invisible barriers that affect others. This blindness is itself largely a manifestation of the unconsciously held beliefs and attitudes towards the minority group.

This, and similar phenomena result in biased assumptions, policies, and understanding that predisposes minority groups to mis-diagnosis: pathologizing behavior that is rational in the minority groups' circumstances; mis-treatment: in the non-recognition of the additional stresses imposed by social inequality; and mis-characterization of minority groups, as dominant group values are pronounced as the standard.

Psychotherapy practitioners need to engage in a process of self-exploration to uncover their own unconscious biased attitudes, beliefs, and motivations for their own behavior and treatment of minority group members in clinical practice, and in everyday personal life.

It is the responsibility of professionals in the field of social psychology to examine and actively expose institutional policies and practices that perpetuate unequal, unjust and unfair treatment of minority groups.

Trust and Distrust in Multi-Cultural Counseling

A multi-cultural perspective in psychotherapy requires acceptance of the fact that non-dominant groups within a culture are subject to unfair, and often unjust and oppressive conditions, effectively limiting their access to opportunities available to members of the dominant group. In the US, these non-dominant groups may be racial, ethnic, gender, age, sexual preference, etc. Unequal conditions are often pervasive in the culture, existing in institutions as well as in the attitudes and inter-personal exchanges that occur between members of differing groups. Institutionally, whether in the job market or school, or governmental administrative,

health and welfare organizations, access to opportunities for vocation, education, and healthcare structurally favors members of the dominant group. In the US, this group is characterized as White and male.

More insidious are the attitudes held by the dominant group towards minority groups. It is insidious because it exists largely in individuals' unconscious, outside of their conscious awareness. For example, it is a common experience of minority group members to encounter dominant group individuals who are unaware, even deny, their own discriminatory behavior and attitudes. Thereby, someone who professes not to be a racist, may indeed demonstrate their biases in their efforts to assist minority groups when they apply the values of the dominant group to the presumed goals and objectives of the minority group.

In this way, racism and discrimination generally is indicative of the *mind/body split*, a condition in which thinking and feeling are not mutually reflective. That is, thinking and feeling are disconnected. Not acknowledging one's own racist bias, attitude, or fear, is an example of such a disconnected condition. When one's self-image is as a non-racist for example, yet behavior and attitudes betray racist fears and biases, feeling and thinking, or emotions and cognitions, are neither aligned nor connected. It is an example of the mind/body split.

In addition to unconscious biases, attitudes and fear, a lack of perspective also contributes to perpetuation of inequality. The values and expectations (of self and others) of the dominant group most often differ from those of minority groups. Without recognition of that reality, individuals often misapply dominant group values and expectations to minority groups. Minority groups may neither share those values, nor realistically or practically have access to the ways and means of fulfilling expectations and opportunities enjoyed by the dominant group.

Awareness of these invisible and unconscious biases and attitudes is particularly important for therapists of the dominant group. Unaware of their own personal unconscious biases, and unknowingly limited by their dominant culture's prevailing attitude towards minorities, therapists have real and serious problems of credibility with minority clients. If a minority client feels they are being stereotyped, pidgeon-holed, and judged by the therapist, trust that the therapist can help them as a person is diminished or destroyed, along with successful therapeutic outcome.

Authenticity, sincerity, and openness are important in the therapeutic relationship to foster trust, especially with marginalized minorities. Defensive reactions and feelings of anger on the part of the therapist must be carefully examined for source and impetus: we are extremely protective of our illusions. If anger and defensiveness results from a challenge to unconscious biases and a sense of superiority fostered by the values and attitudes of the dominant group, these reactions are inappropriate forms of acting-out. Sensitized minorities see and feel this clearly for what it is: dominant group stereo-typing and discrimination, destroying any possibility of positive therapeutic outcome. In such situations, minorities rightly and accurately feel that therapy is a tool of the dominant culture to perpetuate subordination and subjugation of minority groups.

Microaggressions

> Microaggressions are "brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group" (Sue, 2008, p. 110).

Sue maintains that these microaggressions, which may be further categorized into microassaults, microinsults, and microinvalidations are commonplace frequent and everyday occurrences that serve to maintain the status quo of inequality. They most often arise from the

unconscious and may not be consciously intended to harm, yet have a deleterious effect. They affect the target person or group in ways that are still being fully understood. Microaggressions are manifestations exhibiting at least four aspects:

1) the clash of racial realities;

2) unconscious, invisible, and unintentional expressions of bias and prejudice;

3) unnoticed by aggressor, resulting harm seems minimal if not imaginary on part of target;

4) more covert than overt, appropriate response to microaggressions are unclear and difficult.

As part of understanding one's own prejudices and biases, therapists need to maintain awareness of their own capacity to engage in microaggressions. Similarly, therapists must understand that their minority clients' experiences have a validity that is not represented in the perspective of the dominant group. Minority individuals have experiences, knowledge, and attitudes not shared by a therapist who is a member of the dominant group.

Sue (2008) suggests a view of therapy as "a process of interpersonal interaction, communication, and social influence," in which "the therapist and client must be able to *send and receive both verbal and nonverbal messages appropriately and accurately*" (p. 137). Barriers to this process include breakdown of communications arising from misunderstandings due to variations in cultural communications and values, which exacerbate diminished rapport and trust. Differences in values appear as differences between the groups' cultures (e.g. individualism versus family/collectivism), and class-bound values such as upper middle class contrasted with lower class (e.g. importance of long-range goals vs. short-term goals and practicalities). A lack of common language in culturally diverse therapy typically compounds difficulties arising from clashing values. Whether different language, dialect, or manner of speaking on the part of the

client, therapists' use of standard English only may lead to misunderstandings and unfair assessments/assumptions of intelligence and health.

Culture-bound values of the dominant white Euro-American therapies commonly include enhancing individualism and independence, personal verbal and non-verbal expressiveness, insight, self-disclosure, scientific empiricism, concepts of mental vs. physical health, therapeutic ambiguity, and patterns of communication. Class-bound differences of values largely stem from the economic inequality seen between lower, middle, and upper and elite classes. Professionals such as therapists typically have a relatively privileged background compared to their clients from lower classes. If the therapist is unaware of the effects of economic inequality on opportunities relating to social mobility or survival, the therapist's ability to communicate, develop rapport, trust, and understanding will be compromised. Indeed it may negatively affect the therapist's ability to accurately assess or diagnose the client. Similarly too, the therapist may over-value therapeutic insight, when the client's needs for practical advice and guidance may be greater.

Language barriers present obvious problems to communications and greater potentialities for misunderstandings in therapy. Also, the need and use of translators presents additional problems for the conduct of personal, intimate, and confidential exchanges between client and therapist.

Differing communication styles may create myriad potential misunderstandings and misinterpretations that hinder and obstruct positive multicultural therapeutic outcomes. Distinguishing verbal (what is said) and non-verbal (how it is said) communication, some researchers believe 60-70% of communication is non-verbal. Non-verbal aspects of communications include *proxemics, kinesics, paralanguage,* and *high/low context communication.* The use of much non-verbal communication is outside of conscious awareness, that is, it is unconscious.

Proxemics refers to how interpersonal space is utilized during communications. Distance between subjects varies with relationship: intimate, personal, social, and public. It also acknowledges the affect created by space and furniture arrangement.

Kinesics refers to body movements during communication: facial expressions and gestures, posture and position, eye contact, movement mannerisms. Smiling for example, may connote different internal feeling states and emotions across different cultures; likewise the use of eye contact; and head movements indicating "yes" or "no."

Paralanguage refers to vocal cues that accompany content: loudness of voice, intonations, speaking rate, silences and pauses are examples. Speaking manner and style, directness vs. ambiguity, aggressive vs. humble, are considered paralanguage aspects that are culture-bound and determined.

High/low context communication (H/LCC) refers to the balance, or ratio of verbal/non-verbal communication. High context communication (HCC) utilizes cues, props, gestures and other non-verbal communications to make much explicit verbal content unnecessary. Low context communication (LCC) is less dependent, reliant, or opportunistic of the situation providing context for non-verbal communication. Instead it relies on verbal content for communication. H/LCC also includes considerations of the affect accompanying verbal content. Affect includes emotionality, passion, and expression of subjective feeling states to add emphasis and sincerity, or not, to the communication.

In contrast to many other cultures, Euro-American White culture is LCC, in which objective, dis-passionate verbal communication is favored and rewarded. It is however known amongst minority groups that they must attend to what White people do and how they behave, rather than to what they say, as there is often a disconnect and a difference. Cognitive verbalizations are too

often not reflective or representative of feelings, motivations, and behaviors. The degree to which this is unintentional and outside conscious awareness reflects the severity of the mind/body split of the individual. It is interesting to speculate whether the mind/body split afflicts the Euro-American White culture group more than others.

Much non-verbal communication is sent and received by the unconscious; it occurs outside and 'below' the level of conscious awareness. As such, it is much less subject to conscious and self-conscious control and censorship. It often reflects, and triggers, culturally-induced biases and fears, depending on whether the speaker is a member of the dominant cultural group, or a minority group. It also indicates that much racial, gender, sexual, class, etc. discrimination, bias, and fear is a societal problem requiring societal solutions, not individual solutions or adaptations.

Multi-Cultural Family Therapy

Family therapy involves the *identified patient* (IP) and others in familial relationship: couples, parent-child, or work with other members of the family. The goal is to modify the behavioral and attitudinal relationships between family members to promote harmony within the group. Typical assumptions in family therapy practice includes:

1) treatment of multiple family members together is beneficial and economical;

2) the problems of the IP are actually symptoms of dysfunction within the family;

3) problematic behaviors and symptoms of the IP serve a purpose;

4) behaviors within the family group are interactive, interlocking, and patterned;

5) the object of therapy is to improve communication and/or modify relationships between family members.

Characteristics of approach in clinical family therapy include the *communications approach*, and the *structural approach*. A focus on communications highlights faulty communications and

misunderstandings in the context of interactions and relationship quality. It pertains to explicit or implicit rules, agreements, and perceptions. The structural approach refers to the interlocking dynamics and relationships within the family group. While communications are important, analysis of the family structure concerns alliances and relational characteristics that change over time, and the boundaries and expectations existing within family member relationships.

Difficulties encountered in therapeutic practice involving a white therapist and a minority client include the therapist's tendency to base their concept of individual and family health on a Euro-American White perspective, which may be at variance with the racial, ethnic, etc. culture of the client. Many White therapists highly value independence and individualism, spousal egalitarianism, nuclear family structure, expression of feelings, and achievement. However, such values may clash with many minorities' cultural values and aspirations towards collectivism vs. individualism and self, or patriarchy and elder respect vs. egalitarianism and youth; control and containment vs. free expression of feelings; being and becoming in the context of the past and present vs. controlled doing and achievement for future benefit; extended family including non-blood relationships vs. the nuclear family; etc.

Class, race, and ethnicity create realities for minority groups and members that middle- and upper-class members of the dominant White Euro-American group culture have never experienced, and have little awareness of. Similarly, the dominant group is not bicultural, as minority group members are. Minority members must learn and negotiate two cultures, often with distinct and mutually exclusive cultural values. Biculturalism may also present challenges across generations, as younger members increasingly adopt the values of the dominant cultural group in contrast and often to the disappointment of older members within the minority group. The four principal minority groups in America have their distinct backgrounds and histories:

1) impact of slavery on Blacks, and centuries old stigma and association of "black" with bad and evil;

2) Native Americans were victims of racism and colonialism, and like African Americans experienced "conquest, dislocation, cultural genocide, segregation, and coerced assimilation;

3) Latino/Hispanic and Asian Americans largely immigrants and refugees who experience intensely negative anti-immigrant sentiment, behavior and consequences.

Treatment of these ethnic/racial minority groups by the dominant White culture is both inter-personal and institutional.

In addition to skin color, many physical attributes of the dominant culture are idealized, creating negative associations with differing appearances, creating a negative psychological impact. Similarly, sociolinguistic style, dialect, and manner of speaking convey much more about class, gender, background, ethnicity, etc. than does the primary content of speech.

There are 5 important distinct differences in general, with many exceptions noted, in cultural perspective pertaining to psychotherapy practice:

1) relationship between man-nature, in which White culture uniquely values control and mastery over nature;

2) time orientation is basically and uniquely towards the future in the White culture, while Native-, African-, Asian-Americans and Latino/Hispanics are comparatively past and present oriented;

3) White culture uniquely places greater value on the individual in contrast to the individual in group relationship with others;

4) mode of activity tends to be doing for White, Black, and Asian Americans, while being/becoming is more important to Native- and Hispanic-Americans;

5) conception of the nature of man is "good" Asian-, Native-, and Hispanic-Americans, while White and Black Americans see "good" and "bad" in man's fundamental nature.

All these factors require a therapist to explore their own cultural perspectives and lack of familiarity with the backgrounds and cultural values of others, particularly in the context of family therapy, in which mis-understandings, cultural judgment and unhelpful goals may compound the errors resulting in ineffective and even harmful therapeutic outcomes.

Indigenous Healing

Sue reviews cases of Southeast Asian Vietnamese, Laotian, and Hmong refugees, the latter suffering sudden death and nightmare death phenomena. While Western style therapy was ineffective, indigenous healers working with a spiritual aspect in their healing achieved positive outcomes. One problem that arises is that Western therapeutic methods do not recognize the manifestation (symptom) as a spiritual aspect of disorder, nor do they have any tools to address it. As such indigenous healing is often inappropriately denigrated as useless 'witchcraft.' It is an example of Western bias.

Nonetheless, DSM-IV recognizes ethnic and cultural aspects pertinent to psychiatric diagnosis. Some culture-bound (culture specific) syndromes are listed with ethnic description, and the APA advises consideration of cultural/ethnic awareness of symptoms, causes and explanations (diagnoses), and possible use of indigenous sources for care when working with minority individuals.

The many forms of indigenous healing is thought to fundamentally have three important components in common, call the *universal shamanic tradition*:

1) group and communal participation;

2) integral religious or spiritual aspect;

3) participation of a healer, or shaman, as keeper of timeless wisdom.

In contrast, Western healing culturally assumes a high value for individual responsibility, autonomy and health; with no regard to spiritual or religious views, values, or affect; and with the participation of an army of specialists expected to utilize the newest scientifically recognized methods and knowledge.

Indigenous healing is also characterized by differing worldviews and philosophies. In contrast to Western values of individual autonomy, independence, and freedom, indigenous healing and non-Western approaches to life typically place greater value on harmony and inter-connectedness, with a holistic spiritual view that seeks a place in nature. Again in contrast, Western orientations to life and science pre-dominantly assume human ability to improve upon and control nature. Indigenous approaches are characterized by ways and means of utilizing nature in healing, while Western practitioners seek to fix and control nature's problems.

This is a comparatively unique feature of Bioenergetic Analysis: achieving health and well-being is a matter of re-establishing and restoring natural functioning and energetic processes that have been distorted and suppressed by negative and crazy-making emotional experience. Identification of blocks and distortions of energy flow and emotional expression, with understanding of their formation and perpetuation on cognitive and somatic feeling levels, characterizes the Bioenergetic approach to healing dysfunction and the mind-body split, the fundamental basis of dis-order and dis-ease.

Similarly, Western views of the individual as the source and solution of health problems, thoroughly resists notions of the social structure as the source. Indigenous views typically view individual problems in the context of the social, family, group, and spiritual environment with significant inter-connectivity. Too, Western interest is primarily in psychopathology and ridding

disorder while indigenous healing objectives are towards enlightenment and seeking 'higher states.' Western spirituality is more of a cognitive, intellectual mental phenomenon, while indigenous, particularly Eastern spirituality is more embodied as a felt subjective sense.

Historically, science and religion were quite inter-related. For example "soul" was as important in science as in religion. However, some centuries ago a schism between science and religion has become a split today, with no scientific recognition of any spiritual or religious phenomena. Recent evidence indicates there is increasing popular interest and need for non-material experience and fulfillment, recalling the historic role of spiritual pursuits.

Racial Identities

Identity development of racial minorities is unique to minority groups. It is an experience not shared by members of dominant groups. Racial/cultural (R/C) identity development models are useful and important for several reasons. R/C identity development for minority members has a typical trajectory of stages, none of which are within the experience of members of the dominant race. The models are useful because they describe the changing nature of minorities' identity in therapeutic and transformative processes, and they represent very deep aspects of the structure of one's personality in regards to minority racial/cultural groupings.

Unlike members of the dominant cultural group, the personalities of minority group members are deeply shaped by growing up and living in a subordinate cultural environment. Depending on class (degree of wealth/poverty), minority members may exhibit personality traits across a spectrum of characteristics that reflect their relationship with others, whether of the same minority group, other minority groups, or of the dominant group. The Black Identity Model developed by Cross et al in the 1970s is one of several models developed by Black social scientists and educators. It describes a 5 stage process of *nigrescense* (the process of becoming

Black), a transformation by which one's worldview is transformed from a White frame of reference, to a positive Black frame of reference: pre-encounter; encounter; immersion-emersion; internalization, and internalization-committment.

This process typically begins with a Black person's common worldview that has been acculturated with White values, including implicit and explicit devaluations of Black cultural values. Prior to the civil rights movement of the 1960s it is likely that most Black citizens in the US carried that view of the world and themselves. During the process of nigrescense, one is potentially transformed through the stages to end with a healthier self-identity as a person of color, such as the positive Black frame of reference. The stages include:

1) adoption of Black cultural values with a rejection of White values and perspective;

2) then a recognition and relaxation of militancy and rejection of White values, along with discrimination of accepting Black values of White bigotry;

3) leads to a true bi-cultural outlook from which realistic efforts may be made to mitigate the split and disparity existing between the dominant and minority groups.

This process is neither linear, nor experienced by all. The stages are not distinct nor necessarily sequential. Also, as much as describing a process of transformation, they also describe the variety of personality traits that Black citizens exhibit, which may be static and unchanging in individuals. At the core of these traits is the individual's own identity, which may range from Black self-deprecation to self-acceptance, or Black militancy to collaboration, fear of commitment to change, etc.

Models of identity development have been independently and separately proposed for Asian-Americans, Native-Americans, and Latinx/Hispanic minority groups as well. Although each is slightly different, they share similar characteristics. The principal shared aspect is that each group

experiences a subordinate, if not oppressive position relative to the dominant social group. A uniform racial/cultural identity development (R/CID) model has emerged from an integration of the models based on specific groups. It features five distinct characteristics of identity: conformity, dissonance, resistance and immersion, introspection, and integrative awareness. It turns out this model may also be applied to dominant groups as well, such as to Whites in the US.

It is important to note that these models should be used only as a guide to understanding, and not as stereotypes, therapeutic goals/values, or as distinct sequential stages of development.

White Racial Identity

In contrast to people of color, when asked the question "What does it mean to be White?" many White Americans are perplexed, sometimes confused, indignant, and seemingly defensive. The reality is that the dominant culture, White male in the US, is itself invisible to its' members. Meanwhile the White culture's values are quite obvious to people of color, along with a restricted access to the benefits enjoyed by Whites. The contrast is striking to people of color, and they have little difficulty answering such a question.

The full access to cultural benefits for Whites is *White privilege*. It denotes unearned privilege, as it is determined only by skin color. Whites largely deny White privilege because they are invested and identified in the idea of individual meritocracy and personal ability. Thought of White privilege is demeaning and threatens their personal and cultural identity. This denial extends to their self-image as not being racist, biased, or discriminatory. Such denial is evidence that Whites too are victims of the dominant culture's worldview and values. Without recognizing biases and prejudices, White therapists make poor multi-cultural counselors.

Beginning in the 1980s, there have been several White racial identity development models proposed. Author Sue has drawn upon these models and proposes the R/CID model applies

equally well to Whites. When it is recognized that Whites have been victimized too, that they have become prejudiced racists, the 'phases' of conformity, dissonance, resistance and immersion, introspection, and integrative awareness are also applicable to the White experience. Sue suggests that two more phases/stages be added to the model: 1) a first stage *naïveté*, and 2) a last stage *commitment to antiracist action* phase.

Multi-Cultural Therapy and Social Justice

Multicultural counseling and therapy needs to consider the lack of social justice experienced by racial/ethnic minority clients. Equal opportunity and access, inclusion, lack of individual or systemic access to fair and competent mental health treatment are elements of social justice that must be considered for minority clients. Also, treatment must be cognizant of the micro, mesa, and macro levels of clients' experience.

Social justice considerations in therapy essentially distinguish between individual client and the social system as the source, responsibility, and focus of treatment effort. Unlike Euro-American White approaches to treating majority clients emphasizing independent individual responsibility with a value on personal insight to guide therapy, racial/ethnic minorities are subordinated and limited in their access to the benefits and privileges White members of the dominant US culture take for granted with little, if any, conscious awareness.

A lack of awareness of social justice realities can prevent the therapist from developing a balanced perspective of the individual client's relationship with the social system or organization with which he/she is engaged. This may lead to an improper attribution of the problem to client or system, and use of ineffective or damaging treatment. Therapy needs to consider the possibility the organization is the problem source, which in turn is a reflection of the larger culture. Organizations are defensive and resistant to criticism and positive change, and are able

to affect compliance and react punitively. Systems intervention may be required, however, because prevention is most effective.

Locus of Control/Responsibility

Differences in the worldviews of clients, therapists, organizations and individuals across cultures affect thinking, behavior, beliefs, feeling, and expression. Worldviews, from a social justice and therapy perspective define and characterize *locus of control*, and *locus of responsibility*. These loci may be internal or external, and imply four categories: internal control and responsibility (IC-IR); external control and responsibility (EC-ER); external control - internal responsibility (EC-IR); internal control - external responsibility (IC-ER). IC-IR individuals believe they have internal control and responsibility for their outcome, with little impact from external factors. A typical self-entitled White Republican male is a fair example. Diametrically, the EC-ER individual believes they have no control or responsibility for their situation. These individuals may be exemplified either as having given up, or as placating the dominant White culture, typically with a conformist identity.

Sue refers to the EC-IR individual as the *marginal person*. Living on the edge of two cultures, accepted by neither, the marginal person accepts the dominant view of personal (internal) responsibility while struggling against external forces beyond their control. Perhaps more so than the other types, these people are victims of inequality: if the dominant-subordinate relationship did not exist, marginality would disappear. The IC-ER individual is one who does not feel internally powerless, and recognizes the external factors that negatively shape their social and personal circumstances. This category includes social and civil rights minority activists.

Beyond effects on individuals, the *micro* level, social justice also recognizes the effects on the *meso* and *macro* levels. The meso level includes families, sub-groups and work, educational, or other organized entities with which a client is engaged. The macro level focus is on society as a whole, pertaining to laws and policies. Therapists are increasingly recognizing a role in assessing the mental health implications for the structure of organizations and societies, and a need to effect organizational and social change for enhancing mental health on the micro level, and that change should be focused ideally on prevention rather than intervention.

On the meso level, multicultural organizational development (MOD) is a newer specialty area that aims to identify and eliminate oppression and discrimination. It recognizes dysfunction likely arises from monopolies of organizational control and power, and that conflict is inevitable and potentially healing. Similar to the stages of minority cultural identity development, organizations, including mental health organizations exhibit characteristics reflective of their stage in the range of multicultural awareness or sensitivity: cultural destructiveness; cultural incapacity; cultural blindness; cultural pre-competence; cultural competence; cultural proficiency/advocacy.

Change for enhanced social justice on the systemic, or macro level is equally indicated for enhancement of mental health on the micro level. Macro social justice issues include racism, classism, sexism, etc., discrimination and unequal treatment or access to benefits and opportunities for work, education, healthcare, immigration, etc. for sub-ordinated groups, and poverty and oppression.

Section II: *Multicultural Counseling and Specific Populations*

Part VI: *Counseling and Therapy Involving Minority Group Counselors/Therapists*

Chap. 13: *Minority Group Therapists: Working with Majority and Other Minority Clients* pp. 317-327.

Minority group therapists can be as blind to their cultural social structures as can Whites.

One mechanism by which White culture resists anti-racial efforts is by promulgating, perpetuating, and actualizing the view that minority groups are also racist, and for that reason, cannot themselves get along together peacefully. This perspective assuages White feelings of guilt, divides and conquers, and diverts attention from injustices entitling the dominant White group. Regardless of racial enmity and discrimination between minority groups, it exists within a culture of White superiority. Unlike the power of possible systemic-based harm held by the dominant White groups over sub-ordinate groups, subordinate groups have no such power, especially over Whites. It is possible, if not likely, that interracial strife between minorities benefits the dominant group.

This circumstance promotes a characteristic of "not airing dirty laundry in public" amongst minority group members, in turn adding to the situation of mis-communications and mis-understandings between people of color. These have grown since earlier alliances existed when minority population proportions were smaller. Examples are Black-Korean conflicts in the 1990s, and also in non-racial minority groups including sexism and sexual orientation. Distrust and hostility varies and exists between groups, however all minority groups have high distrust, hostility, and negative feelings towards Whites. As a minority therapist, these may color (no pun intended ;-)) the therapist-client relationship, especially if the therapist is not self-aware.

In cross cultural therapist-client situations, the therapist not only needs self-examination, but awareness of clients' reactions to cross cultural stimulations. Research on favorability of racial/ethnic matching of clients and therapists is unclear, and is affected too by aspects pertaining to gender matching. Awareness of differences in styles of communication, including therapist's

accent, and stage of ethnic identity of client are important. Finally, the therapist must use clinical judgment, but it is often advisable to discuss "the elephant in the room" more directly.

Counseling and Therapy With Racial/Ethnic Minority Group Populations

African-Americans represent ~ 13% of the US population, at 34 M (2005), plus 2 M of mixed blood. Poverty rate is 2x higher than for Whites; 12% of 25-29 year old Black males were incarcerated compared to 1.7% of Whites; 20% of Black males are banned from voting in FL, TX, and VA; lifespan is 5-7 years shorter. African-American families are more often single female head-of-households, with 70% of low-income families headed by women, and 60% of births are by single black women, mostly teen-agers. The African-American family is considered generally matriarchal. Importantly, family is more extended than nuclear White families, with the involvement of older children, relatives outside the immediate family, clergy, and community. Family members do exhibit greater adaptability to different family roles, strong kinship, ethic of work and achievement, and religious orientation. Interestingly, while physical discipline within the family is likely more frequent, it does not lead to acting out behavior as commonly seen in White families. Cultural differences in family structure may have important implications in therapy.

Although narrowing, the gap between White and Black educational attainment is perpetuated by *dis-identification,* higher rates of academic discipline, and parental lack of acknowledgment of racism, and differences in cultural values between White administrators and Black students. Attendance and participation at church, and spiritual values are more important as a source for positive mental health than for Whites. The stage of racial/ethnic identity is another variable with implications for therapy. Amongst Black females, it is shown that racial/ethnic identity is a more

salient factor than gender identity. Compared to White female adolescents, Black females exhibit higher self-confidence, lower levels of substance abuse, and more positive body/self image.

Racial identity largely depends on parental guidance, reflecting the parents' stage of racial/ethnic identity. Parental de-emphasis of the race factor may be detrimental to Black children's future mental health and anxiety levels. African-American clients struggle with four interactive racial factors:

1) influence of the majority culture;

2) reactions to racial oppression;

3) influence of African-American culture;

4) personal experiences and characteristics.

In comparison, members of the White culture typically only deal with 4) above.

Counseling American Indians and Alaskan Natives

Unlike other minority groups, native American Indians did not immigrate. It is estimated that 90% of the native American population had died by the end of the 1700s due to disease and extermination brought on by colonial and imperial White Europeans. Until the Indian Child Welfare Act of 1978 there was a systematic destruction of indigenous language and culture, along with a forced assimilation of Euro-American White cultural values, which were radically different.

In 2005, the American Indian, Eskimo, and Aleut populations numbered 2.5 M, with another 1.81 M claiming Indian heritage. However, who is accepted as, and the definition of an American "Indian" is clouded in White and Indian political controversy. The group suffers from double average rates of poverty and alcohol abuse, with much higher rates for mood disorders, obesity, diabetes, and injury-related deaths, and a 6-fold higher rate of alcoholism mortality.

Tribal belonging is a significantly important value, along with identification with reservation life. Family structure is more extended, and tends towards matriarchy. It exhibits high rates of fertility and out-of-wedlock births, and features strong roles for women. Indian values include sharing, in contrast to the White value of accumulation of material wealth; co-operation, valuing group benefit over individual benefit/achievement/performance; non-interference with others, is also reflected in parenting style; time orientation: unlike White orientation towards the future, American Indians place greater value on living in the present; spirituality reflecting connection and harmony of mind, body, and spirit; non-verbal communication.

Education is a huge problem, with 11% vs. 24% of Whites (2006) in the US population holding BA degrees. Similar to Black males, loss of motivation towards education is significant during 4th through 7th grades. Thought to coincide with recognition of being "Indian," many report feeling 'pushed out' and distrustful of schooling. It is contributory to poverty, alcoholism, and a higher suicide rate, particularly amongst young males. This exemplifies the need for systemic change to create positive outcomes. Schools must recognize that the mono-cultural environment they favor is dysfunctional.

The conflict and resulting struggle between the two cultures, acculturation and assimilation of the majority culture vs. Indian identity, and the degree of each is unique amongst individuals. It needs to be assessed in clinical practice. It may be traditional, marginal, bicultural, assimilated, or pantraditional. Native Americans suffer significantly higher rates of known domestic violence, likely under-reported, along with substance abuse, and suicide.

Suicides and attempts occur at 2x the rate of other youth, and are related to alcoholism, poverty, boredom, and family breakdown. Substance abuse and alcoholism during child-bearing years causes a disproportionately high rate of fetal alcohol syndrome. Alcoholism is likely driven

by a 50% school drop-out rate exacerbating low self-esteem, cultural identity conflict, peer pressure enhanced by a sharing tradition, family breakdown, hopelessness, and lack of agency.

Counseling Asian Americans and Pacific Islanders

Although Asian-Americans are stereotyped, and are actually comparatively successful in modern Western culture, the averages do not capture the variance that exists within the community. They have nearly double the national rate for poverty, 14% vs. 8%. Educational achievement is strikingly bimodal, with both highly educated individual and very poorly educated individuals. The urban areas, Chinatowns and Korean areas are attractive for tourists, but are ghetto-like in fact. Of course, racism and discrimination is still active today if not as obvious as when the Chinese built the railroads.

While many Asian cultures raise young children with high degrees of freedom of emotional expression and autonomy, even compared to Western standards, the hierarchal and patriarchal family structure, based on respect for elders and ancestors, demands obedience and parental direction to produce and instill a commitment towards parental care and pride. After childhood, strong displays of emotionality are constrained to demonstrate self-control and maturity. Behavior and demeanor is governed and enforced by motivating avoidance of shame and guilt.

Asian cultures have historical roots in ancient Eastern traditions of health and spirituality, affecting their attitudes towards mental health, and their perceptions of the connectedness of mind and body, and relationships in families and groups. Like many of the sub-ordinated cultures and minority groups, orientation tends towards benefits and responsibility for the family or group over individual benefits for self. Identity issues are similar to those of other minority groups, with struggles related to the clash of two cultures, the dominant and the sub-ordinate. Familiar

conflicts result in varied identity types, characterizing assimilation, separation, integration and biculturalism, and marginalization.

Counseling Hispanic/Latino Americans

Hispanic/Latinx Americans themselves are the largest and materially diverse ethnic minority culture group in America. As of the 2004 Census, they included 35 million people. Consisting primarily of Mexicans, Latinx group members include individuals and families from every country of Central and South America and the Caribbean. Diversity includes much within sub-group and between sub-group differences, and appearance of hispanics ranges from black to brown to white. Annual income, housing, and living standards are substantially below Caucasians with nearly 3x the poverty rate, at 21.4% compared to 7.8% for Whites in 2002.

Family is more highly valued than in White culture, with Hispanics valuing family loyalty, elder respect, religiosity, and strictness in child rearing more than Whites. Family structure is large and extended to include close family friends and other relatives; it is hierarchical with respect to elders and male authority; sex roles are clearly defined, with materially greater male freedom granted; children are expected to be obedient, and contribute financially as able, while parents reciprocate their support even through children's marriages, which often occur at early ages and are considered to be stabilizing. Reciprocal inter-generational financial support is often life-long.

Traditional defined sex roles are often at least partly associated with therapeutic issues. The man is expected to be machismo and dominant and forebearing, while the woman is expected to be submissive and obedient, nurturing, and self-sacrificing. When men or women feel they cannot live up to those roles, conflict, stress, and anxiety arise. Women may complain of their inability to

express anger, and men may suffer from the isolation produced from the expectation to be strong, and/or sexually potent.

The ethnic minority groups all face common experiences within the dominant White Euro-American culture, with unique ethnic characteristics. The common challenges are those discussed previously in some detail, involving the clash of the dominant culture with the individual subordinate culture, racism and discrimination, and cultural identity. For those who seek to mediate the clash of cultures, transformation of personal identification goes through similar stages or characteristics ranging from identification with the dominant culture and self-deprecation, to being bi-culturally comfortable.

Multi-Racial Individuals and Arab- and Jewish-Americans

Unique difficulties arise with multi-racial individuals who must additionally confront a higher level of isolation and alienation as they often face acceptance challenges from the cultures of each bi-racial parent. Compounding that issue is the fact that unlike minority individual who share the same race and culture as the parents, multiracial individuals are different from both parents, and do not have the same degree of support and parental experience for guidance.

Arab Americans, especially of the Muslim faith uniquely face the undeserved outrage and White fear of terrorism since the World Trade Center attacks of 2011. Unfairly made into the enemy, Arab Americans face denigration of their culture and religion, and an illogical fear of terrorism instilled into the dominant White culture. Americans have spent much of the past 20 years at war with Muslim Arab nations, and Arab Americans are subjected to similar treatment and atrocities as experienced by some Japanese and German Americans during the Second World War, short of the concentration camps the Japanese were interred in.

Jewish Americans are perhaps the smallest 'major' minority group. Since the Holocaust reduced the European Jewish population by 6 million, it is estimated that there are only about 15 million Jews worldwide, with 5.2 million in the US in 2006, down from 5.5 million in 1990. It is the only minority group that is in decline in the US.

Jews suffer historic and worldwide discrimination going further back in history than perhaps any other group. Although successfully embedded in Euro-American White culture, Jewish Americans suffer never-ending micro-aggressions, insults and aspersions of their character and their culture. Although it is surprising, it should perhaps not be a surprise that over 2/3 of all hate crimes in America are committed against Jewish Americans. The genocides of the Second War, and the pogroms before may represent the very most horrendous treatment of minorities in history, and it has left multi-generational scars from horrendous individual and cultural trauma. Holocaust survivors are often materially successful in their lives, however, it disguises the fact that many are emotionally unresponsive, even to family and friends. It is a condition that potentially infects subsequent generations as well.