Craig L. Frisby · William T. O' Donohue *Editors*

Cultural Competence in Applied Psychology

An Evaluation of Current Status and Future Directions

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Introduction and Overview

Imagine spending 50 dollars of your hard-earned money on a new 200-page spy novel, written by your favorite author, that you have waited for months to be published. When you finally get your hands on the book and open it up, you discover that the first 100 pages are missing and that the very first page begins with page 101.

Besides the obvious problem of feeling financially cheated, the enjoyment that would be had from reading the last 100 pages would be completely gone – as you would have no information about the setting of the story, no idea who the characters are or their importance to the story, and no understanding about how to interpret the significance of events in the pages that you do have to read.

This is analogous to how the cultural competence construct has been marketed to audiences in various branches of applied psychology. A visitor from Mars who has just arrived in the United States for the first time would quickly see that the message to be "culturally competent" is everywhere. Teachers, lawyers, nurses, clergy, advertising executives, medical doctors, the tourism and hospitality industries, politicians, domestic and international business personnel, the newspaper industry, government agencies, military branches, the television/film/music industries, police officers, firefighters, social workers, psychiatrists, and of course applied psychologists are all under some type of mandate to embrace, promote, internalize, and teach cultural competency.

The irony here, in our view, is that some fundamental and basic questions are often left unexplored. For example: Is culture synonymous with race, ethnicity, or language? Is there consensus among psychologists as to what cultural competence is? Do different branches of applied psychology define it in the same manner, or is the nature of cultural competency discipline-specific? What is the difference, if at all, between cultural competence and labels for similar constructs that use slightly different words and phrases (e.g., cultural humility, cultural sensitivity, etc.)? Is cultural competence advocacy a scientific movement, a sociopolitical movement, an ethical claim, or some combination of these? If it is some combination of both science and sociopolitical ideology, then how can psychologists disentangle and distinguish between these influences – if this can be done at all? Is cultural competence a generalized skill or a collection of specific skills? Can a person be culturally competent with one group but not another? Can cultural competence be taught? If so, how? Is there any evidence that cultural competence is being successfully taught to psychologists? Is there a relationship between skin color or ethnicity

and the inner workings of the human mind? Are differences in skin color or ethnicity “primordial” in understanding important differences in how to help people with their problems? Can psychologists expect persons who share the same ethnicity to think and act the same? Are culturally tailored therapies more effective than untailored therapies for members of that culture? Can psychologists use the same assessment instruments with clients of different cultural groups? What sort of psychometric evidence does a measure need to show in order to be culturally fair? Do individual differences in client characteristics weaken the validity or efficacy of cultural competence? Are professionals that are from the same cultural, racial, or ethnic group as their clients automatically culturally competent? Can a professional be effective in serving culturally different clients without being culturally competent? If so, then how can this be? Can cultural competence potentially harm clients, be unethical, or violate clients’ civil liberties? Does the cultural competence movement involve reverse prejudice? Are students in training programs getting fair exposure to a variety of views on cultural competence? Can people be punished for refusing to be culturally competent? If cultural competence has been aggressively written about and discussed for nearly three decades, then why do so many well-meaning professionals have tremendous difficulty understanding what it is, how to “get it,” how to apply it in practice, or how to measure it?

The impetus for this text comes from our observation that (barring a few notable exceptions) relatively little has been written for applied psychology audiences that actually wrestles with these very difficult and challenging questions. Even more disturbing is a lack of intellectual curiosity among pre-service and in-service professionals for *seriously grappling with these issues* – as the current narrative seems to be that all applied psychologists need to do is to simply “get it.” The “it” is presumed to be perfectly clear and extraordinarily important due to its advertised ability to prevent harm and promote a number of positive outcomes. While we make no ambitious claims that our text definitively answers any of these questions, we believe that simply asking these questions – and inviting knowledgeable authors to respond in kind – is the essential foundation for a scientific understanding of any construct. We believe that cultural competence ought to be viewed rationally – and thus critically – instead of dogmatically and blindly. Said differently, we view this text as analogous to providing the first 100 missing pages in the hypothetical spy novel discussed earlier. Not only would this complete the novel, but it also has the potential to significantly change the content of the second 100 pages of the novel in its subsequent revisions.

Overview of Chapter Organization and Content

Part I: General Overview

This text focuses on cultural competence as it has been promoted within the context of applied psychology. Although there are many different branches of applied psychology, we limit our focus to clinical, counseling, and school psychology.

The first two chapters provide an overview of the current state of affairs, at the time of this writing, of cultural competence advocacy in applied psychology. Chapter 1 by Frisby provides an overview of the breadth of the construct, justification for the construct, and how cultural competence emerged as an important force in applied psychology training. Chapter 2 by Frisby and Perez compares and contrasts how cultural competence is promoted within the specific disciplines of clinical, school, and counseling psychology.

Part II: Evaluation of Cultural Competence Advocacy

The evaluation of the cultural competence construct has not been as well publicized as the cultural competence construct itself - but nevertheless has developed in a parallel fashion among social scientists, researchers, and observers. The chapters in this section evaluate the cultural competence movement from a variety of different perspectives. Chapter 3 by Frisby examines how the cultural competence construct has been critiqued primarily from sources within applied psychology.

In Chapter 4, Frisby, O'Donohue, Benuto, and Casas discuss different approaches to cultural competency training and report on a recent systematic review of the literature that establishes the goals of multicultural competency trainings, the mechanisms used to train psychologists, and briefly summarizes outcomes of these trainings.

In Chapter 5, O'Donohue draws from a background in the philosophical underpinnings of science to evaluate the central claims of the cultural competence (sometimes also called "cultural sensitivity") movement. In the process, he shows how these claims are often promoted in an ill-defined and imprecise manner, are often poorly understood, and how evidence and arguments used to support truth claims often fail to meet basic scientific standards.

In Chapter 6, Beagan evaluates the claims of the cultural competence movement from what he argues are inadequate or incomplete responses to four critical questions: What is attended to, and what is rendered invisible? Who is spoken to, and who is spoken of? How might greater cultural competence be attained? What does achieving cultural competence mean?

A fundamental prerequisite for the integrity and longevity of a theoretical construct within the community of scientists is to carefully define its practical utility, and for developers to establish clearly how the construct may differ in subtle or not-so-subtle ways from other constructs. According to cultural competency theory, culturally different clients report experiences of negative psychological reactions in cross-cultural interactions, which in turn require clinicians to be "sensitive" to these. Yet rarely do scholars explore the extent to which abstract theory intersects with concrete realities in therapeutic interactions. In Chapters 7 and 8, Cummings and O'Donohue describe the actual complexities, nuances, and conundrums that can occur when clinicians – often following a variety of professional mandates – attempt to apply ill-defined cultural competence constructs in concrete case examples.

University training programs, professional guilds, journal editorial boards, and granting agencies in applied psychology have a vested interest in promoting only one perspective when understanding social problems and how these problems may be addressed through cultural competency training. Just as a fish is not consciously aware that it is wet, graduate students in training and in-service practitioners are not consciously aware that the ideas in which they have been marinated are only one among many ways of viewing problems and their solutions (assuming solutions can be found at all). In Chapter 9, Frisby discusses a palpable viewpoint bias that is pervasive in cultural competency advocacy. This bias protects professional guilds and journal editorial boards from potential threats to favored sociopolitical ideologies, as well as keeping students in training programs "in the dark" as to alternative viewpoints. By including anonymous interviews by respected applied psychology scholars whose professional lives have been impacted to varying degrees by viewpoint bias, readers can finally be made aware of a more balanced presentation of issues directly relevant to cultural competency.

Part III: Conceptual Difficulties/Challenges from the Perspective of Related Disciplines

The chapters in the previous section reviewed direct challenges to the cultural competence construct primarily from sources within the applied psychology academic community. However, the APA Presidential Task Force on Evidence-Based Practice (2006) states that "[a] wide range of relevant research literature can inform psychological practice" (p. 279). Expanding on this principle, a different approach for evaluating the cultural competence construct is to compare how related disciplines outside of applied psychology may have a very different perspective on the same concepts frequently promoted in cultural competence advocacy, and how this research can more accurately inform issues frequently discussed in cultural competence advocacy in applied psychology. Unfortunately, particular branches of applied psychology too often function as "academic bunkers," where important subject matter is not permitted to be informed by closely related disciplines. As an example, the terms "race," "racism," "culture," "stereotypes," "prejudice," and "sensitivity" are casually disseminated in cultural competence advocacy, often without paying close attention as to their meanings. This inadvertently promotes a distorted picture of the real world for those whose only exposure to these terms is from their own narrow applied psychology discipline. Learning from disciplines outside of applied psychology permits audiences to discover vital material that has been ignored, kept "offstage," or even misrepresented in the service of cultural competence advocacy.

"Culture" and its many semantic derivatives are concepts that sit at the center of the cultural competence construct. Unfortunately, the manner in which these terms are used in applied psychology bears little or no resemblance to the manner in which such terms are conceptually understood by social science disciplines that specialize in the study of culture and its meanings. In Chapter 10, Helen Spencer-Oatey and Vladimir Žegarac bring their

expertise in applied linguistics and intercultural communication to assist readers in understanding the complexities inherent in describing the relationship between culture and human behavior.

Anthropology can be generally described as the study of various aspects of human beings within past and present societies. Anthropology, more than any other discipline in the social sciences, is considered to be at the forefront in leadership in the serious, scholarly study of the culture concept. Cultural anthropology is a narrower branch of anthropology that specializes in the study of cultural variation among humans. In Chapter 11, Scupin draws on his unique perspective and training in the history of the culture concept from cultural anthropology to describe how this concept can be grossly oversimplified and abused when used in applied psychology.

Cultural competence advocacy tends to characterize conflict between groups as always evil, which requires unilateral condemnation and eradication through some sort of focused training. In this type of intellectual environment, it would be quite surprising for some to discover that a certain degree of conflict between and among groups is a normal feature of human nature. In Chapter 12, Park and Hunt draw on the discipline of evolutionary social psychology to discuss the origins of human conflict in intergroup relations and explore the various factors that serve to influence variations in intergroup conflict.

Differential psychology (or the study of individual differences) is one such scientific area that has a direct bearing on the behavior of individuals and groups served by professional psychologists. Unfortunately, there is no other word that has generated more anxiety, fear, misunderstanding, and academic mischief than the word "race" and its many semantic derivatives. In fact, this partially explains why the softer word "culture" (and its semantic derivatives) is the preferred label for characterizing groups in contemporary applied psychology. A popular mantra frequently heard and repeated within applied psychology is that "race is a social construction" – the hope being that by banishing race from the psychological lexicon, this will make progress toward eradicating "racism." In many precincts, the study of racial differences is an activity that is viewed as inherently abhorrent, which is predictably tagged as "racist." The words "racist" and "racism" are recklessly and irresponsibly used as billy clubs for bludgeoning individuals and ideas with whom and about which one disagrees. In addition, shouting "racism" has developed into an effective technique for frightening audiences against the serious study of research that may undermine favored sociopolitical agendas.

Chapters 13 and 14 were written by Frisby as companion pieces to highlight the importance of group and individual differences research that is all but ignored in cultural competence advocacy. Chapter 13 discusses patterns of group differences in variables that have direct bearing on human behavior and hopefully brings clarity in the description of different sides of contemporary debates over the definition and validity of the "race" construct. At the same time, however, the application of psychological services to flesh-and-blood human beings involves a host of individual differences in cultural and psychological traits, treatment paradigms, and service settings (to name a few

among many relevant variables). This, in turn, makes simplistic group generalizations quite problematic. Chapter 14 tackles these issues.

It has become customary for textbooks, training programs, and professional organizations representing the applied psychology and mental health professions to overemphasize racial and ethnic factors in cultural competency advocacy while either downplaying or ignoring altogether the influence that poverty has on clients' "cultural" characteristics and intervention outcomes. Two chapters in this text address this multifaceted issue. In Chapter 15, Svare and Wendel review important American poverty statistics about which practitioners need to have some understanding, as well as discuss the issue of why it is often difficult to achieve positive outcomes with clients of low income and educational levels. In Chapter 16, Phillips turns much needed attention to the issue of how poverty perpetuates cycles of behavioral dysfunction and destitution in vulnerable subpopulations within America.

We note that the cultural competence concept may have originally began from a very real need for health caregivers to develop more effective ways to serve clients whose cultural differences present palpable professional challenges. Unfortunately, it saddens us to observe that it has subsequently lost its moorings and has devolved into a sociopolitical ideology as practiced in some (but certainly not all) applied psychology precincts. In Chapter 17, Patai applies her academic training in literary theory and comparative literature, as well as her over 30 years of experience as a fierce opponent of the politicization of higher education – to criticize destructive movements that use cultural competence as a Trojan Horse for unattainable utopian visions on college campuses.

Despite obvious differences in the focus and areas of application covered within different branches of applied psychology, professional psychologists must have, at minimum, a basic understanding of how psychometricians have grappled with the challenge of designing, administering, and interpreting results from measurements used with individuals from culturally diverse groups. In Chapter 18, Haynes, Kaholokula, and Tanaka-Matsumi carefully walk readers through the psychometric concepts, methods, and evidence for evaluating the appropriateness of the instruments psychologists use in professional practice and research.

Evidence-based practice (EBP) is an interdisciplinary approach to clinical practice that involves making decisions about how to promote optimal care by integrating the best available evidence, practitioner expertise, and knowledge of relevant client characteristics (Spring, 2007). Such care is based on the systematic collection of data gathered through observation, experimentation, and the formulation and statistical testing of hypotheses. Chapter 19 by Beaujean draws on statistical science to explore the question of how researchers would determine if treatment effects differ across population subgroups. The chapter accomplishes this through a conceptual and technical treatment of the aptitude-treatment interaction (ATI) approach.

Part IV: Cultural Competence Issues with Special Populations

A consistent critique of cultural competence theory is that no one individual can accrue expertise with every conceivable group that differs demographically from caregivers. The cultural, psychological, and mental health issues that are unique to the life circumstances of specific groups are substantial. We are fortunate to have contributions from scholars and their students whose research has focused on cultural competence issues with special populations. The contributions from Thao, Jones, Huey, Rubenson, Yarhouse, Sides, Page, Gurak, Maura, de Mamani, de Andino, and Rosenfarb explore the complexities of serving the psychological and mental health needs of Latino communities (Chapter 20), Asian-Americans (Chapter 21), African-Americans (Chapter 22), LGBT+ populations (Chapter 23), and individuals suffering from schizophrenia spectrum disorders (Chapter 24).

Part V: Issues and Implications for Instruction and Training

In Chapter 25, Kemmelmeier and Kusano offer a perspective on the training of intercultural competence that incorporates a more nuanced understanding of culture, avoiding some of the pitfalls that can result from overly simplistic conceptions. The chapter then proceeds to describe how a multicultural orientation includes a significant motivational component that involves a willingness to engage in continual learning.

Social psychology is a discipline that contributes greatly to an understanding of how people think, feel, and behave in response to what is perceived about groups different from themselves. One of the most vibrant and productive areas of social psychological research is in the domain of stereotypes and their accuracy. In Chapter 26, Stevens, Jussim, Stevens, and Anglin draw from this research to show how, contrary to popular received wisdom, stereotypes are often accurate and the acknowledgement of this fact can be integrated into cultural competence training.

"Cultural sensitivity" and cultural competence are two labels ascribed to constructs that have fuzzy boundaries in the minds of many psychologists. Courses, workshops, and seminars advertised as teaching cultural competence often include behavioral objectives purporting to teach cultural sensitivity; and courses, workshops, and seminars advertised as teaching cultural sensitivity often include behavioral objectives purporting to teach cultural competence. In Chapter 27, O'Donohue evaluates cultural sensitivity training in light of the principles of civil liberties and academic freedom, and warns readers of the corrosive hypocrisies and double standards that are implicit in these movements.

The cultural competency movement has been shown to be a "mixed bag," where authors have revealed substantial philosophical, conceptual, and empirical problems while at the same time revealing promising avenues for cutting edge research that can lead to positive outcomes. In the final chapter of this section (Chapter 28), Frisby and O'Donohue synthesize the content of

previous chapters to sketch a proposal for an ideal college/university course in cultural competency. Such a course can be adapted for implementation across all branches of applied psychology while at the same time allowing room for the development of competencies that are idiosyncratic to specific training programs and applied specialties. They argue for a course rooted in seven broad principles that (1) are both informed and constrained by the limitations of the cultural competence movement and (2) highlight the most recent and promising advances in the movement. With regard to the latter, the chapter showcases results from an excellent recent meta-analysis of cultural adaptation research. The strength of this research lies in its ability to return applied psychology to its evidence-based roots while expanding the domain of cultural competence to include concrete interventions that lead to positive outcomes for client groups.

Final Thoughts

We note that a long-standing challenge of the cultural competence movement is for scholars to clearly separate science from sociopolitical advocacy. The essential difference between a scientific approach and a sociopolitical approach to studying the cultural competence construct is clearly articulated by Tavris (2015), who frames the issue as a fundamental distinction between science and "pseudoscience." She writes:

> . . . [P]seudoscience is particularly attractive, because pseudoscience by definition promises certainty, whereas science gives us probability and doubt. Pseudoscience is popular because it confirms what we believe; science is unpopular because it makes us question what we believe. Good science, like good art, often upsets our established ways of seeing the world . . . Pseudoscientific programs, potions, and therapies have always been an entrenched part of American culture . . . The cultural mix of pragmatism, an optimistic belief that anything can be changed and improved, and impatience with anything that takes much time has created a long-standing market for instant solutions. All a clever entrepreneur has to do is apply a formula historically guaranteed to be successful: (Quick Fix + Pseudoscientific Gloss) x Credulous Public = High Income . . . It's the American way. (pp. xvi–xvii)

We are keenly aware that the observations, ideas, and arguments in this text confront readers with having to think about things that they would prefer not to think about. Cultural competence advocacy, as it is currently configured in applied psychology, makes four implicit assumptions: (1) it has correctly diagnosed problems for which solutions are needed, (2) it knows what the most effective solutions are for addressing diagnosed problems, (3) it has sufficient resources and expertise to apply toward developing effective solutions, and (4) its current activities accurately reflect the kinds of solutions needed to effectively address diagnosed problems. The chapters in this text, to varying degrees, call into question one or more of these basic assumptions. This will have the effect of making some readers angry, evoking surprise in other readers, and allowing some readers to breathe a welcome sigh of relief.

In closing, talking endlessly about a psychological construct is *not* the same thing as taking that construct *seriously*. In fact, talking endlessly about a construct may have the unintended effect of dulling the mind, where there is no intellectual curiosity that would motivate one to "go against the grain" and critically evaluate (in a rational and scholarly manner) what many already appear to accept and believe. Taking a construct seriously means that the academic community subjects it to a rigorous and sustained program of scientific vetting, necessary for increasing the confidence in both practitioners and the general public of its value. We are not aware of any published text other than this one that is devoted exclusively to evaluating the cultural competence construct in applied psychology. If readers are indeed serious about understanding the nuances, complexities, strengths, and limitations of this construct, then they would do well to familiarize themselves with the philosophical, conceptual, empirical, and practical arguments that are advanced in the chapters of this text. We view this as one small but important step in the right direction toward improving the training of applied psychologists.

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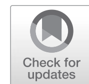
Part I

General Overview



1 History and Development of Cultural Competence Advocacy in Applied Psychology

Craig L. Frisby

The need to prepare professionals for interacting with clients from different countries, languages, racial/ethnic groups, and cultural backgrounds appears to be highly valued in a wide variety of contexts, both domestically and internationally. Within the arena of international business, for example, those charged with improving their leadership effectiveness in the expansion and maintenance of global markets are told that "cross-cultural competency is essential not only for meaningful human relationships, but also for success as professionals, managers, or technicians" (Harris & Moran, 2000, p. xiv). They argue that success in domestic and international business relationships requires an understanding of other "macrocultures" and "microcultures" along ten dimensions: (1) sense of self and space, (2) communication and language, (3) dress and appearance, (4) food and feeding habits, (5) time and time consciousness, (6) relationships, (7) values and norms, (8) beliefs and attitudes, (9) mental processes and learning, and (10) work habits and practices.

In the health-care arena, many writers assert that cultural competence and "diversity management" are important components of the current and emerging health-care systems within the United States (Dreachslin, Gilbert, & Malone, 2013). They cite as justification for this assertion the rapid aging of the general population in comparison to the youth of workers that care for them, the increasing ethnic and racial diversity of the US population, and the fact that groups such as the LGBTQ community have specific health-care needs that they claim are not being met adequately. They argue that there exist a variety of cultural factors that influence the dynamics of health care, which include (but are not limited to) the meaning of symptoms for patients, perceptions of the anatomy and bodily functions, perceptions of the appropriateness of treatment, perceptions of appropriate gender roles, how patients are oriented to prevention practices, how pain is expressed, and differences in dietary practices (p. 189).

Professionals that train individuals to deliver effective health care have opined "[w]ithout specific knowledge of cultural groups for whom they provide care, health-care providers might not know what questions to ask to provide culturally competent care" (Purnell, 2014, p. 2). Health educators view cultural competence as essential for promoting health equity and health literacy and reducing health disparities across a variety of areas that include environmental quality, mental health, nutrition, physical activity, obesity, dental health, tobacco use, cancer screening/management, diabetes management, and immunizations (Pérez & Luquis, 2014).

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Commenting on the need for cultural competence in the field of sports medicine as applied to athletic training, Cartwright and Shingles (2011) write:

> Cultural competence mandates that each and every one of us do all we can to help diversify the athletic training profession. The ethnic diversity of the health care professions is inextricably linked to the delivery of more effective health care and the reduction of health care disparities. We know that racial and ethnic health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care. Also, racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health care professionals. (pp. ix, x)

With respect to what non-racial/ethnic minorities can do, they argue that culturally competent service providers need specific skills for eliciting information from culturally different patients, as well as specific techniques for conducting physical assessments.

"Equity," "diversity," "social justice," and "cultural competence" are also central concepts that future teachers are socialized and trained to value within teacher education programs (e.g., see Darling-Hammond, French, & García-Lopez, 2002; Gay, 2010; https://ed.stanford.edu/step; Moule, 2012). Groups that oversee the professional ethics, guidelines, and certification of teachers allow these concepts to drive policy, standards, and practice for both preservice and in-service educators (Moore, 2016; National Board for Professional Teaching Standards, 2010; National Education Association, 2008, 2015).

Within the field of forensic psychiatry, individuals who are charged with crimes will often be evaluated by a psychiatrist or psychologist as to their competency to stand trial, or to make evaluations as to legal sanity/insanity, so that courts of law can make appropriate decisions for determining proper sentences, providing treatment medications, and/or providing psychotherapy. Given the wide diversity of legal systems around the world, the field of forensic psychiatry is beginning to recognize how cultural factors influence legal systems and procedures, the use of psychological measurements in forensic evaluations, how psychiatric disorders are determined, and how to work with clients around difficult issues related to professional ethics, child custody determinations, disability assessment, and other family-court issues (Tseng, Matthews, & Elwyn, 2004).

In short, cultural competence is touted as an indispensable skill needed for effective practice across a wide breadth of disciplines within changing societies. Within applied psychology, this message is no different. "Training for cultural competence" is a phrase that is familiar to nearly anyone at the preservice or in-service level of training in the subdisciplines of counseling psychology (Sue & Sue, 2016), clinical psychology (Huey, Tilley, Jones, & Smith, 2014), or school psychology (Miranda, 2014) – as well as in the narrower contexts within which applied psychological treatment and mental health care occurs (e.g., clinical supervision, Hardy & Bobes, 2016; health education, Pérez & Luquis, 2014; hospice work, Poag, 2010; social work, Sue, Rasheed, & Rasheed, 2016; psychotherapy, Tummala-Narra, 2015). At the time of this writing, a computerized search of PsycINFO and PsycARTICLES databases using the search terms "cultural competence" yielded approximately 3500 citations, with "cultural competency" yielding approximately 2900 citations.

The purpose of this chapter is to trace the emergence of the term "cultural competence" in applied psychology, describe the various ways in which this term has been labeled in applied psychology and related fields, describe its most important components according to the best available consensus, show how the term has evolved into a best practice requirement for training programs in applied psychology, provide a brief review of scholarly attempts to measure it, and describe methods used to train preservice and in-service applied psychologists in cultural competence. Throughout the chapter, cultural competence is often abbreviated as "CC."

Variation in Labels

The essence of the cultural competence construct describes whatever must be learned, modeled, developed, or understood in order to increase a caregiver's effectiveness in serving clients that are different than themselves in some putatively important characteristic(s). Although cultural

competence is arguably the most well-known phrase that describes this construct, writers representing closely related subdisciplines have employed variations of this term to reflect the same or closely similar meaning. Differences in terminology sometimes reflect differences in the extent to which the work refers to an attribute of the clinician versus an attribute of the services and/or treatment provided. Differences in terminology sometimes reflect different traditions inherent in the specific subdisciplines from which the terms were developed; however other differences appear to be a function of differences in individual taste (even among writers within the same subdiscipline). Some differences in terminology are superficial – reflecting only minor variations in the surface morphological features of root words. Other terms are meant to reflect nuanced but sometimes profound philosophical differences in the essential meaning of the concept. These variations, in no particular order, have been labeled *cultural tailoring*, *cross-cultural effectiveness* (Kealey, 1989), *cross-cultural communication competence* (Matveev & Nelson, 2004), *multicultural competence* (Stuart, 2004), *cultural sensitivity* (O'Donohue & Benuto, 2010), *transcultural competence* (Glover & Friedman, 2015), *culturally congruent practice* (Schim & Doorenbos, 2010), *intercultural competence* (Hammer, 2015), *intercultural effectiveness* (Vulpe, Kealey, Protheroe, & MacDonald, 2001), *culturally adapted interventions* (Griner & Smith, 2006), *multicultural care* (Comas-Díaz, 2012), *culturally responsive therapy* (Hays, 2016), *cultural safety* (Polaschek, 1998), *cultural attunement* (Hoskins, 1999), *cultural empathy* (Pedersen, Crethar, & Carlson, 2008), *cultural humility* (Goforth, 2016; Tervalon & Murray-Garcia, 1998), or *cultural intelligence* (Earley, 2002).

Justifications for Cultural Competence (CC) Advocacy and Research

Demographic Changes in the United States The most fundamental argument used by scholars to justify CC advocacy in America is that the population of nonwhites (and to a lesser extent, non-English language speakers) is growing with each passing decade (Sue & Torino, 2005). Zane, Bernal, and Leong (2016) predict that by 2043, "census officials indicate that ethnic/racial minorities will outnumber Whites" (p. 3). They opine that "[g]iven the … increase in diversity nationwide, mental health providers need cultural competence to work effectively with ethnic minority clients" (p. 5). According to this argument, it is inevitable that "psychologists working in all corridors of this country will be interacting increasingly with a culturally diverse clientele" (p. 19). According to one report, since racial and ethnic minorities are significantly underrepresented in the core mental health professions, "many providers are inadequately prepared to serve culturally diverse populations, and investigators are not trained in research on minority populations" (President's New Freedom Commission on Mental Health, 2003, p. 50).

Sue, Zane, Hall, and Berger (2009) state that the growing diversity in the US population necessitates "changes in the mental health system to meet the different needs of multicultural populations" (p. 525). From this reasoning, it then follows that unless counselors, psychologists, and others in the mental health fields are prepared to work with racially/ethnically diverse populations, their respective fields are vulnerable to facing obsolescence (Hall, 1997).

Reliable Subgroup Disparities in Key Mental Health Resources, Indicators, and Outcomes Sometimes "disparities" are defined as differences in health-care quality not due to differences in health-care needs or patient preferences. In other contexts, "disparities" are defined as any differences with no adjustment for underlying need for care. Regardless of how this term is defined, racial/ethnic group disparities in mental health care are well documented (Alegría, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016; Creedon & LeCook, 2016; Locke et al., 2017; McGuire & Miranda, 2008). In a supplement to the surgeon general's report on mental health (US Department of Health and Human Services, 2001), the following state-

ment was made in the Foreword to this supplement:

> The Supplement causes us concern because of its finding that very serious disparities do exist regarding the mental health services delivered to racial and ethnic minorities. We must eliminate these disparities … As the field learns more about the meaning and effect of cultural competence, we will enrich our commitment to the delivery of evidence-based treatment, tailored to the cultural needs of consumers and families.

According to the surgeon general's report, cultural differences exist in the extent to which individuals are prone to seek psychological help, what types of help are sought, degree of easy access to mental health services, the lack of available service providers of the same race/ethnicity or who speak the same language, the type of coping styles and social supports that are available, the meaning that is attached to mental health problems, how much stigma from external influences is attached to mental illness, and the rates at which treatment is terminated (see also Griner & Smith, 2006). When the cultural characteristics of clients are not congruent with cultural characteristics of individual clinicians or the wider mental health service system, the potential for misunderstanding, misdiagnosis, and mistreatment presumably increases. According to the 2003 President's New Freedom Commission on Mental Health (2003) report:

> Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors lead to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems. (p. 49)

Zane, Bernal, and Leong (2016) cite numerous presidential commissions that have documented ethnic disparities in mental health and mental health services since 1978. They state:

> These commissions concluded that the disparities were not so much due to racial and ethnic differences in rates of psychopathology but rather were due to inaccessible and ineffective treatment. Ethnic minority clients often saw therapists or were administered treatments that did not provide consideration of the clients' lifestyles, cultural and linguistic backgrounds, and life circumstances. (p. 5)

A succinct statement from a massive report prepared by the Minnesota Evidence-based Practice Center at the US Department of Health and Human Services Agency for Healthcare Research and Quality (Butler et al., 2016) effectively captures this sentiment: "Culturally competent care is seen as foundational for reducing disparities" (p. 1).

The Lack of Participation of Racial/Ethnic Minority Groups in "Traditional" Research In the context of school psychology practice, Huckleberry (2009) argues that "the marginalization and quantitative exclusion of the culturally and linguistically diverse permeate most research" (p. 216). As one example, she opines that culturally and linguistically diverse students are not represented significantly in test development and test standardization efforts (see also Martines, 2008). In her view, this state of affairs makes minority groups vulnerable to overrepresentation in lower tracks within school systems, which leads to "inadequate and inappropriate assessments, accommodations, and instruction" (p. 216).

In the context of biomedical and clinical health research, Oh et al. (2015) argue that the inadequate representation of diverse groups in scientific research represents a missed opportunity to fully understand the factors that lead to disease and health. Although the authors acknowledge that racial/ethnic minorities may be just as willing to participate in health research as nonminorities, barriers associated with limited access to specialty care centers, fears of exploitation, financial constraints, lack of access to information, and fears of stigmatization can suppress participation rates (see also George, Duran, & Norris, 2014).

A somewhat related issue is the question of whether or not participation of such groups is simply not reported in studies. In her review of the psychoanalytic literature, Tummala-Narra (2016) summarized large meta-analytic research reviews which found that 75% or more of studies included no information on the race/ethnicity of partici-

pants (dating as far back as 1960; see Leichsenring & Rabung, 2008; Watkins, 2012, 2013).

A Perceived Lack of Research Influenced by Racial/Ethnic Minority Perspectives Tummala-Narra (2016) argues that the Americanization of Sigmund Freud's ideas placed an inordinate emphasis on mental health as solely residing inside the individual's feelings, thoughts, and intrapsychic processes – at the expense of social and/or environmental causes of mental illnesses. For racial, ethnic, language, and cultural minorities residing within the United States, such causes may include the effects of differential socialization processes.

This concern is succinctly stated in the APA Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (American Psychological Association, 2003):

> Psychology has been traditionally defined by and based upon Western, Eurocentric, and biological perspectives and assumptions. These traditional premises in psychological education, research, practice, and organizational change have not always considered the influence and impact of racial and cultural socialization. (p. 395)

This concern, as specifically relating to Black people, was expressed as early as 1970 in an Ebony magazine article "Toward a Black Psychology" (White, 1970), in which the author states "It is difficult, if not impossible, to understand the lifestyles of black people using traditional theories developed by white psychologists to explain white people" (p. 44).

In regard to ethnic psychology as a generalized construct, Monteiro (1996) argues that the proper role of ethnic psychology is to ask and answer questions that are most important to the indigenous groups studied and that in doing so, the research methods used are to be congruent with their cultural traditions and idioms.

Lack of General Familiarity of Service Providers About Culturally Different Groups According to Griner and Smith (2006), "many therapists are not familiar with the cultural worldviews, lifestyles, and histories of various racial/ethnic groups" (p. 4). Wrenn (1962, 1985) introduced the concept of *cultural encapsulation* to describe a mindset that culturally competent counselors need to avoid, which includes (1) defining reality according to a set of cultural assumptions and stereotypes, which in turn becomes more important than the real world, (2) insensitivity to cultural variations among individuals, (3) holding unreasoned assumptions which are accepted without proof and are protected without regard to rationality, (4) adhering to a technique-oriented job definition that preserves encapsulation, and (5) failure to accept the responsibility to accommodate or interpret the behavior of others except from one's own viewpoint (Pedersen, 1991). In short, cultural encapsulation has been defined as a lack of understanding, or ignorance, of another's cultural background and the influence this background has on one's current view of the world (McCubbin & Bennett, 2008). To illustrate, Conner and Walker (2017) opine:

> The culturally competent helper should be aware that African Americans are more likely to be misdiagnosed of a mental disorder compared to whites, possibly due to the bias of practitioners who apply different diagnostic rules to African-Americans than they do to white patients. (p. 115)

These comments depict cultural competence as a construct that enables caregivers to be sensitive to an aspect of clients' lives that may be unfamiliar to helpers belonging to a different racial or cultural group.

Perception that Intercultural/Racial/Ethnic Clinician/Client Professional Interactions Pose Qualitatively Different Challenges When clinicians come from a different racial, cultural, or ethnic group than the clients that are being served, some argue that this creates unique challenges that would not be present if both parties came from the same cultural, racial, or ethnic group. According to Kirmayer (2012):

> Cultural diversity poses challenges to mental health services for many reasons. Culture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or

> treatment interventions. The clinical encounter is shaped by differences between patient and clinician in social position and power, which are associated with differences in cultural knowledge and identity, language, religion and other aspects of cultural identity. (p. 149)

Many have argued that cultural and linguistic differences between clients and service professionals create poor communication, which is seen as a contributor to producing poor care (Fisher, Burnet, Huang, Chin, & Cagney, 2007; Smedley, Stith, & Nelson, 2003; Thomas, Fine, & Ibrahim, 2004).

Perceived Harm to Clients Caused by Bias, Racism, and/or Discrimination Racism has historically become so inextricably linked with subgroup membership (see Albee, 1994; Guthrie, 2004) that experiences of racism have literally become part of the modern definition of group membership status – even in contemporary times. For example, Levant and Sperry (2016) state: "*People of color* refers to anyone who is not White, reflecting a common experience of racism" (p. 19).

Within applied psychology, the argument that "racism/discrimination harms clients" takes one or both of two forms. One version of this argument holds that racial/ethnic/language minority clients experience significantly more instances of discrimination and racism from society than clients who are not members of minority groups (e.g., Ponterotto, Utsey, & Peterson, 2006), which in turn leads to disproportionately higher rates of mental health symptoms and physical health problems (Paradies et al., 2015; Pieterse, Todd, Neville, & Carter, 2012). Others argue that disproportionate rates of morbidity and mortality among racial minorities can be caused by *structural racism*, which has been defined as "the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups" (Gee & Ford, 2011, p. 116).

The second form of this argument asserts that the insensitivity, lack of awareness, or professional ineptitude in handling racism issues – including their own racism – on the part of nonminority service providers fails to help minority clients (at the very least) or may actually harm them, at most (Ridley, 2005). Some will go so far as to argue that the actual behaviors of the helpgiver manifest racism and/or discrimination, thereby harming clients directly. According to some writers, for example, individuals from minority groups are harmed when helpers employ a Eurocentric approach to counseling and therapy (Sue & Torino, 2005, p. 4). They argue that traditional counseling and psychotherapy is based on European philosophical assumptions that (1) the individual is the basic psychosocial unit of operation, (2) the physical and mental aspects of human beings are separate, (3) the world can be understood rationally through cause-effect relationships, (4) individuals must exert mastery and control over people and the environment, (5) people have a future orientation, and (6) the principles of equal opportunity and access are strongly held beliefs (p. 4). In their view, these assumptions are not shared by persons of color "whose worldviews and life experiences are quite different from those of their White counterparts" (p. 4). They then conclude that "the imposition of these cultural beliefs and values on clients of color may result in cultural oppression" (p. 4). Klick and Satel (2006) coined the term "the biased-doctor model" to describe a strand of research and high-profile reports within the medical field which conclude that physicians treat their white patients differently (i.e., better) than racial minority patients solely on the basis of their race.

The combination of these two sources of problems is thought to cause difficulties in the helper/client relationship, which requires cultural competence training. Sue and Torino (2005) opine:

> The failure to recognize the importance of race and culture in counseling may lead to visible racial/ethnic group members underutilizing mental health services and terminating therapy earlier than their White counterparts … , making clients of Color feel that they are at fault because of the failure to consider systemic factors (bias and discrimination) as contributing to their problems … [Multicultural Counseling and Therapy] advocates for alternative helping roles … When, for example, the problems of clients of color reside in prejudice, discrimination, and racism of employers, educators, neighbors, and/or organizational policies or practices in schools, mental health agencies, government, busi-

> ness, and our society, the traditional therapeutic role appears ineffective and inappropriate. To provide adequate [Multicultural Counseling and Therapy], it is imperative that counselors become culturally competent. (pp. 5, 7)

Appeal to Professional Ethics Kirmayer (2012) opines that health services and mental health promotion must consider culture to be ethically sound and clinically effective (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Brach & Fraserirector, 2000). According to Paasche-Orlow (2004), "culturally competent care is a moral good that emerges from an ethical commitment to patient autonomy and justice" (p. 349). Conner and Walker (2017) assert that "[b]ehavioral science helping professionals are ethically obligated to achieve cultural competence in their work with clients" (p. 113). They cite as an example the American Counseling Association Code of Ethics (2014) that describes multicultural counseling competency as "required" across all counseling specialties. They state:

> A primary reason and need for the emphasis on cultural competence is the critical relationship between cultural competence and ethical behavior. Ethical standards exist to benefit the client and to prevent harm. Cultural bias and lack of cultural competency on the part of the helping professional work against any intended benefit to the client and may even result in harm … The rapid rise of the minority population in the U.S. makes it increasingly impossible, if not unethical, for the helping profession to treat multicultural counseling as a specialty area. (pp. 113–114)

This concern not only applies to cross-cultural interactions within the United States, but applies to ethical violations committed within the context of mental health and psychosocial support services delivered by outsiders on different continents (Shah, 2012).

How Did Cultural Competence Advocacy Begin in Applied Psychology?

The construct of race, culture, and intergroup relationships have been areas of research for academic psychologists since the beginning of psychology (see Duckitt, 1992, for a historical review; Holliday, 2009; Leong & Okazaki, 2009; McCubbin & Marsella, 2009; Richeson & Sommers, 2016). Scholarly efforts to trace the history and development of cultural competence advocacy typically frame this endeavor as situated within the general context of how psychology has responded to multicultural issues historically (Casas, 2017; Guthrie, 2004). In these reviews, historical psychology is taken to task for its "scientific racism," which involves – but is not limited to – its depiction of nonwhite groups as biologically and mentally inferior, support for racial eugenics, barriers to racial/ethnic minority psychologists entering the psychology profession, and lack of sufficient attention to minority issues and concerns (Albee, 1994; Guthrie, 2004).

Early publications that predate the CC movement began to appear as an outgrowth of the civil rights movement in the United States. The purpose of these publications was to sensitize readers about cultural considerations within the counseling relationship (Heine, 1950; Murphy, 1955). As the nation began to experience major societal changes beginning in the 1950s and 1960s regarding nondiscrimination and civil rights, groups within the American Psychological Association began to advocate for increased progress in the identification, recruitment, retention, and graduation of minority psychologists from psychology training programs (Korman, 1974). Beginning in the late 1960s, representatives from major racial/ethnic groups established their own independent associations outside of the formal APA organizational structure. Such organizations are currently recognized by the APA and serve as nonvoting members of the APA Council of Representatives (Casas, 2017).

Parallel to these developments, scholars such as Padilla, Ruiz, and Alvarez (1975) identified problems in the manner in which therapists interact with ethnic clients, and as early as 1977, Sue provided specific recommendations for modifying mental health interventions for culturally different clients (Sue, 1977). Although the term "cultural competence" or its derivatives was not used, the concerns leading up to interest in cul-

tural competence can be identified in the following comments:

> It would be important in terms of service delivery to direct our research and evaluation efforts at … interpersonal levels to note the interaction of minority client and treatment. Care should obviously be taken to see that institutional policies do not directly or subtly undermine services to ethnic groups … Much of our research direction should also be placed upon finding the match or fit between ethnic background and treatment. (pp. 623–624)

Tummala-Narra (2016) argues that the multicultural counseling movement in mental health fields (beginning in the 1980s) paralleled the American civil rights movement of the 1950s and 1960s, in the sense that traditional approaches to counseling and psychotherapy were being challenged by scholars as not being helpful to racial/ethnic minorities, at best, or harmful to them at worst. She writes:

> The multicultural movement in psychology, along with feminist psychology, challenged traditional approaches to psychotherapy for ignoring issues of power, privilege, and more broadly social context. From this view, Western based psychotherapies, such as psychoanalytic, cognitive-behavioral, and humanistic therapies have historically decontextualized, ahistoricized, and depoliticized individual development. Scholars such as Abram Kardiner and Georges Devereaux, using a psychoanalytic-anthropological framework, challenged the cross-cultural application of psychoanalytic ideas, and a number of psychoanalysts in the middle of the 20th century, such as Eric Fromm, Karen Horney, Harry Stack Sullivan, and Erik Erikson, argued that development is shaped by contextual issues that vary across cultures and time periods. (p. 65)

The Association for Non-White Concerns in Personnel and Guidance, a division of the American Association for Counseling and Development, was established in 1972 (McFadden & Lipscomb, 1985), which was subsequently renamed the Association for Multicultural Counseling and Development (AMCD) in 1985 (Association for Multicultural Counseling and Development, n.d.). Due to what was perceived to be a growing dissatisfaction with the progress of the AMCD, the National Institute for Multicultural Competence was later formed in 1993 (D'Andrea, n.d.).

According to Zane, Bernal, and Leong (2016), APA Division 17 (formerly Division of Counseling Psychology, currently Society of Counseling Psychology) published a position paper in 1982 that inaugurated the multicultural competency movement in counseling and psychotherapy (Sue et al., 1982).

The American Psychological Association Council of Representatives voted to establish the Society for the Psychological Study of Ethnic Minority Issues (Division 45) in August of 1986 (Society for the Psychological Study of Ethnic Minority Issues, n.d.). For a more detailed overview of the history of events that shaped "ethnic psychology" and Division 45 of APA, readers are encouraged to consult the series of articles published within the 2009 special issue of the journal *Cultural Diversity and Ethnic Minority Psychology* (Vol. 15, Issue 4).

In 2002, the American Psychological Association's Council of Representatives approved, and in 2003 published, its *APA Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (hereafter abbreviated as the "Multicultural Standards"; American Psychological Association, 2003). The essence of these guidelines was stated as follows:

Guideline #1 Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Guideline #2 Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

Guideline #3 As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Guideline #4 Culturally sensitive psychological researchers are encouraged to recognize the

importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Guideline #5 Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices.

Guideline #6 Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

In October 2004, the APA Board of Directors asked the Board for the Advancement of Psychology in the Public Interest to recommend a process for infusing and implementing the Multicultural Guidelines throughout APA (American Psychological Association, 2008). The Board requested that a task force be convened, composed of representatives from each of the association's governance groups, the ultimate purpose of which would be to develop a "Diversity Implementation Plan" (p. 1) for boards, committees, and offices that are directly accountable to APA.

As a result of these efforts, the Report of the APA Task Force on the Implementation of the Multicultural Guidelines was published in 2008 (hereafter abbreviated as "Implementation Report"). On p. 7 of this report, the task force recommended that individual psychologists "[p] articipate in continuing education units that will educate about cultural competence and issues related to multiculturalism". In the report's additional comments related to Guideline #3 from the Multicultural Standards, the rationale for the first subsection reads:

> Generally accepted methods for measuring evidence-based cultural competence are not widely available and need to be developed. The development of such measures will provide programs with a means to evaluate students' cultural competence. Using such measures will allow the establishment of benchmarks to assess acquisition of cultural competence. The American Psychological Foundation may be a source of grant funding for such initiatives. (p. 10)

The Implementation Report contained action steps for APA for making resources and materials available to assist faculty in "becoming proficient in teaching from multicultural perspectives" (p. 10). Some recommendations were for the Office of Ethnic Minority Affairs and the Education Directorate to develop a mentoring program for faculty to "assist them in gaining awareness and skills related to multicultural competence" and to "develop awards for training programs that illustrate innovations [and] best practices in training students in multicultural competence" (p. 10).

At the conclusion of the Implementation Report, the task force makes the following statements:

> The recommendations of the task force … are vital in advancing cultural competence … psychology's directive to develop cultural competency is clear. By infusing cultural competency throughout psychology, the field is better positioned to meet the needs of a growing and diverse U.S. society … (p. 18)

Calls for cultural competency within APA were not only limited to initiatives with an explicit focus on multicultural advocacy. The APA Presidential Task Force on Evidence-Based Practice (2006) states that effective psychological treatment involves, among other things, being responsive to the patient's characteristics, culture, and personal preferences. In describing numerous considerations that enter into professional best practices, this document states:

> A … related question concerns the extent to which social factors and cultural differences necessitate different forms of treatment or, conversely, the extent to which interventions widely tested in majority populations can be readily adapted for patients with different ethnic or sociocultural backgrounds. (pp. 278–279)

How Is Cultural Competence Understood Conceptually?

Sue (2001) designed a conceptual framework that would organize dimensions of cultural competence into a meaningful whole, with the intent of providing direction for practice, education, training, and research. These dimensions consisted of (a) specific racial/cultural group perspectives (i.e., African-American, Asian-American, Latino

American, Native American, and European American), (b) components of cultural competence (e.g., awareness of attitudes and beliefs, knowledge, and skills), and (c) foci of cultural competence (e.g., individual, professional, organizational, and societal).

When attempting to answer the general challenge of how to deliver culturally competent treatment to clients, many writers begin by distinguishing among three levels of service delivery. These three levels involve (1) organizational and institutional levels, (2) practitioner identity level, and (3) the service and/or intervention level. Within each of the three service delivery levels, the essential feature of culturally competent services revolves around the concept of "matching." This is to say, services must be matched in some way to the cultural contexts and characteristics of culturally/ethnically/racially different communities and individuals.

Organizational/institutional matching means that mental health services are made physically available to clients within their culturally homogeneous communities as an aid in reducing any stigma that may be attached to accessing services in institutions outside of their immediate communities (Kirmayer, 2012). At the level of practitioners, the concept of matching refers to assigning clients to practitioners who come from the same racial, ethnic, and/or cultural group as themselves. At the level of services and interventions, practitioners can modify their mode of interaction with clients, deliver culturally adapted interventions, or deliver interventions that are drawn intact from clients' own cultural traditions (Kirmayer, 2012).

Cultural Competence Definitions and Components Although far from exhaustive, a fairly representative sampling of definitions for cultural competence within applied psychology is provided in Table 1.1.

Cultural competency advocacy is rooted in an implicit assumption which may or may not be explicitly verbalized, which is that the caregiver is a member of a racially, ethnically, or culturally different group than the clients under his/her care. When institutions are caregivers, the assumption is that the majority of persons in positions of leadership and/or power differ in important ways than the clients served. It is implied that caregivers and/or institutions that are members of the same groups as the clients they serve already possess, at least in part, an intuitive understanding and developed skills in serving clients from their group. Thus, cultural competency theory assumes that caregivers begin with undeveloped (or underdeveloped) areas that must be targeted in training in order to more effectively serve racially, ethnically, and/or culturally different clients. Cultural competency is typically subdivided into the "big three" components of awareness/beliefs/attitudes, knowledge, and skills (see Alizadeh & Chavan, 2016; Ponterotto et al., 1996; Sue, 2001; Sue et al., 2009), with the fourth component of "personal characteristics" being added as a frequently discussed category in the literature (see Tables 1.2, 1.3, 1.4 and 1.5).

Cultural Competence Assessment Strategies

Cultural Competence (CC) Measures

Instruments designed to measure the dimensions of cultural competence can be subdivided using a number of different categorization schemes. One way to categorize CC instruments is to examine whether cultural competencies are assessed by a second party or whether cultural competencies are self-reported. Second-party observation, where a respondent (e.g., client served by an agency; student in a training program) evaluates another entity, occurs whenever entire organizations or training programs are rated by a member of the entity, or a person who has received services from the entity, as to its cultural competence. As one example, the Multicultural Environmental Inventory-Revised (MEI-R; Pope-Davis, Liu, Nevitt, & Toporek, 2000) is a 27-item instrument designed to be used by students and faculty in US counseling psychology graduate programs to address perceptions of the extent to which the program addresses multicultural issues within curriculum, supervision, cli-

Table 1.1 A sampling of general definitions for cultural competence in applied psychology

[T]he ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds (López, 1997, p. 573)
[T]he development of skills that enable the professional to be competent, sensitive, and knowledgeable of the critical factors related to issues of cultural diversity to best serve minority children (Miranda, 2008, p. 1742, quoting Gopaul-McNicol, 1997, p. 17)
Multiculturally competent counselors are counselors who have moved from being culturally unaware to being aware and sensitive to their own cultural issues and to the ways that their own values and biases affect culturally diverse clients (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001, p. 123; quoting Pope-Davis & Dings, 1995, pp. 287–288)
[T]he ability to think, feel, and act in ways that acknowledge, respect, and build upon ethnic, sociocultural, and linguistic diversity (Lynch & Hanson, 1998, p. 50)
The possession of cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture (Sue, 1998)
[R]efers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. [It is] a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time (US Department of Health and Human Services, 2001, p. 12)
[T]he ability to understand and constructively relate to the uniqueness of each client in light of the diverse cultures that influence each person's perspective (Stuart, 2004, p. 3)
Multicultural counseling competence is achieved by the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups (Sue & Torino, 2005)
[C]ultural competence is reflected by the ability to recognize when and where cultural issues might be operating in the course of school psychology service delivery (Ortiz, Flanagan, & Dynda, 2008)
A system that acknowledges the importance and incorporation of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs (Sue et al., 2009, p. 528, citing Whaley & Davis, 2007)
[T]he ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds (Sue et al., 2009, p. 529)
[A] Set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (Oakes, 2011, p. 47)
[culturally competent] individuals…value and respect cultural differences, engage in continuing self-assessment regarding culture, pay attention to the dynamics of difference, continue expanding their knowledge and resources, and endorse a variety of adaptations to belief systems, policies, and practices (Comas-Díaz, 2012)
The ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own (DeAngelis, 2015, p. 64)
[T]he essence of cultural competence involves scientific mindedness, which encourages therapists to resist premature conclusions about clients who are from a different sociocultural context than themselves; dynamic sizing, which involves the therapist's ability to appropriately generalize and individualize the client's experiences such that stereotyping is minimized; and culture-specific expertise, which involves the therapist's specific knowledge about his or her own sociocultural context and that of the clients with whom he or she works (Tummala-Narra, 2016, p. 66, citing Sue, 1998)

Table 1.2 Specific components of multicultural "awareness, beliefs, and attitudes" identified in cultural competence advocacy within applied psychology (when clinicians are from a different racial/ethnic/cultural group than clients)

An understanding of potential barriers to communication that exist as a result of cultural differences (Pope-Davis et al., 2001)
Understanding "white privilege" and what one's "whiteness" means to them (Ancis & Szymanski, 2001; O'Neil, 2010)
Self-awareness of one's own values, assumptions, and biases related to race and race relations (Sue & Torino, 2005)
Recognizing that everyone possesses a racial and cultural heritage (Sue & Torino, 2005)
Recognizing that people of color do not universally hold "white/European" assumptions and values (Sue & Torino, 2005)
Understanding how both "group-specific" and "person-specific" meanings of identity are important within the life of clients (Hays, 2016)

Table 1.3 Specific components of multicultural "knowledge" required in cultural competence advocacy within applied psychology (when clinicians are from a different racial/ethnic/cultural group than clients)

Knowing definitions of diversity-related terminology such as privilege, oppression, race, and culture (O'Neil, 2010)
Recognition that helping styles and counseling methods may be "culture-bound" (Rogers & Lopez, 2002)
Acquiring accurate information related to cultural heritage, life experiences, and the historical background of diverse groups in society (O'Neil, 2010; Sue & Torino, 2005)
Knowledge about the legal rights of minority groups and historical legal challenges related to issues of equality (O'Neil, 2010).
Knowledge about theories and models of racial/ethnic/cultural identity development (Sue & Sue, 2016)
Understanding how race and culture affect personality formation, vocational choices, help-seeking behavior, the manifestation of psychological disorders, and the appropriateness or inappropriateness of counseling and therapy approaches (Sue & Torino, 2005)
Understanding how racial/cultural differences are perceived and how meaning is attached to these differences by society (Sue & Torino, 2005)
Acquiring specific knowledge of how social systems can negatively affect the lives of people of color (Sue & Torino, 2005)
Understanding the dynamics of test translation procedures in working with interpreters (Rogers & Lopez, 2002)

Table 1.4 Specific components of multicultural "skills" required in cultural competence advocacy within applied psychology (when clinicians are from a different racial/ethnic/cultural group than clients)

Using instruments/assessments that are sensitive to cultural and linguistic differences (Rogers & Lopez, 2002)
The ability to consider multiple variables that affect the client's life, such as one's sociopolitical history (Pope-Davis & Dings, 1995)
Counselors develop a varied repertoire of helping responses and/or interventions that match clients' culturally ingrained preferences (Hays, 2016; Sue & Torino, 2005)
Develop the ability to engage in indigenous healing practices having roots in the cultural traditions of clients from diverse groups (Sue & Torino, 2005)
The ability to refer clients to appropriate healers in the communities from which clients come (Sue & Torino, 2005)
Flexibility in adopting alternative roles as consultants, advocates, advisers, teachers, or facilitators of indigenous healing (Sue & Torino, 2005)
Furnish office with objects representing different cultural influences; stock office reception area with a variety of multicultural reading materials (Comas-Díaz, 2006)
Using mnemonic guides to assess cultural and diversity variables that can comprehensively describe clients (Comas-Díaz, 2006)
Use and understanding of culturally specific communication styles and language patterns in racially/ethnically different clients (Comas-Díaz, 2006)
The ability to diagram and interpret clients' ethnocultural heritage (using multigenerational genograms) and the clinician's own cultural backgrounds (using culturagrams) for signs of similarities or differences with clients (Comas-Díaz, 2006).
Willingness to engage in appropriate therapist self-disclosure (Hays, 2016)
Working with interpreters for the benefit of clients (Hays, 2016; Rogers & Lopez, 2002)
Integrating family/child cultural background, language proficiency information, and learning style information into psychological/educational reports (Rogers & Lopez, 2002)
Interpreting legal and regulatory decisions that are relevant to protecting linguistically and culturally diverse children from bias and/or discrimination (Rogers & Lopez, 2002)

mate, and research (Pope-Davis et al., 2000, p. 57). MEI-R items are rated as to the degree to which each statement is reflective of their counseling psychology program, with 1 = "not at all," 3 = "moderately," and 5 = "a lot." Sample items include "Being multiculturally competent is valued," "I am encouraged to integrate multicultural issues into my work," and "Faculty members are doing research in multicultural issues." For descriptions of other similar "second-party" cultural competence rating scales, readers are encouraged to consult Cornelius, Booker, Arthur,

Table 1.5 Specific components of "personal qualities/characteristics" required in cultural competence advocacy within applied psychology (when clinicians are from a different racial/ethnic/cultural group than clients)

Compassion (the ability to appreciate people who challenge my beliefs and values; Hays, 2016, p. 27)
Courage (in the face of fear or in the midst of pain, the willingness to reach across cultural divides; Hays, 2016, p. 28)
Critical thinking (the ability to "question my assumptions and look for explanations that go beyond what appears to me to be self-evident"; Hays, 2016, pp. 27–28)
Humility ("my way of looking at things is not always the best, which helps me to avoid judging differences as inferior"; Hays, 2016, p. 27)
Maintaining a sense of humor (Hays, 2016, 35)
Mindfulness (the ability to become nonjudgmentally aware of one's experience "in the moment"; Hays, 2016, p. 34)
Respect for clients demonstrated by avoiding communication errors and inaccurate assumptions (Hays, 2016)

Reeves, and Morgan (2004); Ponterotto, Alexander, and Greiger (1995); and the National Center for Cultural Competence (https://nccc.georgetown.edu/assessments/).

Other instruments designed to measure cultural competence use a self-report format, where the respondent self-reflects and evaluates his/her own perceived cultural competence. Within this category, measures vary considerably in the degree of psychometric sophistication supporting their development. Some "scales" are little more than subjectively developed questions and/or checklist items (e.g., Goode, 2009) or are designed to provide information unique to only a particular organization (e.g., see Satel & Forster, 1999). As an example, the *Promoting Cultural & Linguistic Competency Checklist* (Goode, 2009) requires respondents to rate the cultural competency of individuals working within organizations that serve young children and their families. The instrument includes statements that are to be rated on a 3-point scale: A = "Things I do frequently, or statement applies to me to a great degree"; B = "Things I do occasionally, or statement applies to me to a moderate degree"; or C = "Things I do rarely or never, or statement applies to me to a minimal degree or not at all." Sample items include "I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served in my early childhood program or setting"; "I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency"; and "I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others." Such instruments appear ubiquitous in health care, social work, and mental health-care organizations (e.g., see Transcultural C.A.R.E. Associates, 2015) – hence providing an overview of every conceivable organization-specific cultural competence scale/checklist of this type would be considerably beyond the scope of this chapter.

Other self-report scales make more of an effort to provide psychometric information about internal consistency reliability, test-retest reliability, factor structure, and convergent, discriminant, and/or criterion-related validity – as the intent is for such scales to be used broadly in mental health counseling research and/or practice (e.g., Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sheu & Lent, 2007; Sheu, Rigali-Oiler, & Lent, 2012).

Psychometrically developed self-report scales vary considerably in the specific aspect of cultural competence that is measured as a function of the scale's supporting theoretical base, item content, response format, and factor analytic results. As examples, the *Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD;* Sheu & Lent, 2007) assesses a respondents' perceived ability (self-efficacy) to counsel racially diverse clients within the context of specific, difficult situations potentially encountered throughout the entire therapy process. On a 10-response scale ranging from 0 (no confidence at all) to 9 (complete confidence), respondents rated items such as "Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses," "Openly discuss cultural differences

and similarities between the client and yourself," and "Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues."

Some cultural competency scales are advertised as being specific to a particular subdiscipline within applied psychology. As one example, the *School Psychology Multicultural Competence Scale* (SPMCS; Malone et al., 2016) is a 45-item self-report measure that evaluates school psychologists' cultural competence skills in the domains of assessment, consultation, and intervention activities carried out within the context of schools. Thus, items are targeted to the specific kinds of activities in which school psychologists are engaged, as well as the age demographics (i.e., children and youth) typically served by school psychologists. Respondents indicate their response to each SPMCS item using the following Likert scale: 1 = strongly disagree to 4 = strongly agree. Sample items include "I can make culturally relevant curriculum and classroom management recommendations," "I can explain test information to culturally diverse parents," "I have knowledge of research on assessing culturally and linguistically diverse children," and "It is important to integrate cultural and language background of a student into a psychoeducational report."

A slightly different cultural competency construct is measured by the *Concerns About Counseling Racial Minority Clients Scale* (CCRMC; Wei, Chao, Tsai, & Botello-Zamarron, 2012), which assesses the discomfort counselors may feel in discussing racial issues in counseling or therapy. Respondents rate each item as 1 = "strongly disagree" to 5 = "strongly agree." In the scale instructions, respondents read a generic item stem "When seeing racial minority clients, I am concerned that…"; then respondents rate the following item examples: "I do not know how to let my clients know that I have limited knowledge of their group," "I may unknowingly offend my minority clients," "I may not be aware of my own biases," and "My clients perceive me negatively."

O'Neil (2010) developed a multicultural competence self-report scale based on the idea that cultural competence is "developmental and cyclical in nature" (p. 22) and thus can be better understood as proceeding through five developmental stages of pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska, DiClemente, & Norcross, 1992). O'Neil applied this change model to the assessment of cultural competence that would not be limited to any particular field of application but rather can be used by caregivers from a variety of disciplines. She developed the Multicultural Competence Stage of Change Scale (MCSCS), which assesses "people's change in willingness to consider diversity important, to engage in trainings, and to engage in multi-culturally competent practices" (p. 28). The MCSCS is a 47-item scale in which respondents indicate their reaction to each item using the following Likert scale: 1 = This statement is not at all true for me, 2 = This statement is not very true for me, 3 = This statement is moderately true for me, 4 = This statement is mostly true for me, and 5 = This statement is very true for me. Sample items include "I do not see the need for activities related to diversity," "Treating everyone as equals is one of the most important aspects of any job working with people," "I am not a racist person," and "I have a community of close friends and colleagues who are all engaged in social justice and diversity efforts."

Instead of assessing perceived cultural competency knowledge, one novel method that is beginning to emerge is to assess *actual multicultural competency knowledge*. The *Multicultural Counseling and Psychotherapy Test (MCPT)* is a 50-item multiple-choice test that assesses knowledge of a wide variety of findings from the cultural competence research literature (e.g., racial identity development, cultural group norms/histories, culturally respectful language, stereotype threat, and microaggressions – among other topics) – through use of a multiple-choice format (Gillem et al., 2016). MCPT items displayed impressive levels of discriminative power between multicultural counseling experts and non-experts, as well as significant correlations between MCPT scores and a variety of professional experiences (i.e., number of conferences

or workshops attended, graduate courses taught, multicultural texts read, and multicultural professional presentations) in a sample of licensed counselors, psychologists, social workers, and marriage/family therapists.

For psychometric reviews of a variety of similar self-report cultural competence scales in mental health counseling and closely related fields, readers are encouraged to consult Gamst et al. (2004), Kumas-Tan, Beagan, Lopple, MacLeod, and Frank (2007), Munroe (2006), and Pedersen, Lonner, Draguns, Trimble and Scharrón-del Río (2016, chapter 3).

Multicultural Interviewing Protocols Jones (2009b) proposed the *Multicultural Interview With Children and Adolescents*, which consists of a series of 36 interview questions covering the 5 categories of family, peers, race, ethnicity, and personal questions. Pamela Hays (2016) proposed the ADDRESSING framework (i.e., *A*ge, *D*evelopmental and Acquired *D*isabilities, *R*eligion, *E*thnicity, *S*ocioeconomic status, *S*exual orientation, *I*ndigenous heritage, *N*ational origin, and *G*ender) as one approach to clinical interviewing that would help therapists to understand and organize sociocultural influences on clients' well-being.

The *culturagram* is a visual mapping procedure that is described as an assessment tool for helping clinicians understand culturally diverse clients and their families (Substance Abuse and Mental Health Services Administration, 2014). The need for this method is based on the conviction that the tremendous diversity both across and within racial/ethnic groups requires "a multidimensional approach in understanding the role of culture in the lives of clients and their families" (p. 65). The culturagram is a sheet of paper on which is depicted a diagram of ten boxes arranged in a circle around a middle box. Within the middle box is the name of the client or individual family member of a client family. On each of the ten boxes is written one of the following labels: Legal/socioeconomic status; Time in community; Language spoken at home/Community; Health beliefs/Beliefs about drug and alcohol use; Impact of trauma and substance abuse/Other crisis events; Oppression/Discrimination; Religious and cultural institutions; Food, clothing, and holidays; Values about education/Work; Values about structure, power, myths, and rules; and Reasons for relocation/Migration.

Each person is given a culturagram containing his/her name during the course of individual or family therapy. Throughout the session, the counselor asks questions that relate to each of the ten categories. Both the counselor and the client can write brief responses in each box to display unique attributes of the client's history, and culturagrams can be collated at a later time in order to gain a fuller picture of the components that describe the client's cultural context.

With the publication of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), a framework for gathering information about cultural (racial/ethnicity-based) features of an individual's mental health functioning was introduced. This framework, called the *Outline for Cultural Formulation*, was updated with the publication of the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-V; American Psychiatric Association, 2013). The revised Outline for Cultural Formulation identifies five categories within which clinicians can conduct systematic assessments (pp. 749–750):

1. *Cultural Identity of the Individual* – refers to a description of the individual's racial, ethnic, or cultural reference group that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments.
2. *Cultural Conceptualizations of Distress* – refers to cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others.
3. *Psychosocial Stressors and Cultural Features of Vulnerability and Resilience* – refers to key stressors and supports in the individual's social environment and the role of religion, family, and other social networks in providing emotional, instrumental, and informational support.
4. *Cultural Features of the Relationship Between the Individual and the Clinician* – refers to differences in culture, language, and social status

between an individual and clinician that may cause difficulties in communication or influence diagnosis and treatment.

5. *Overall Cultural Assessment* – refers to implications of the information identified in previous sections for diagnosis and other clinically relevant issues, problems, management, and treatment intervention.

The DSM-V also includes a set of 16 questions, called the *Cultural Formulation Interview* (CFI), that clinicians may use to obtain information during a mental health assessment about the impact of cultural variables on important aspects of the client's care (pp. 752–754). A Cultural Formulation Interview – Informant Version is a set of 17 questions that can be used with an informant who is knowledgeable about the clinical problems and life circumstances of the client under the clinician's care (pp. 755–757).

Characteristics of Culturally Competent (CC) Treatments

Many within the CC movement have argued that mental health interventions be adapted to clients' cultural contexts and values (see Griner & Smith, 2006). Griner and Smith (2006) partition these adaptations into the following four categories: (1) incorporate cultural values of the client into treatment/therapy; (2) match clients with caregivers of the same race/ethnicity who speak the same native language; (3) mental health interventions and systems should be easily accessible and targeted to clients' circumstances (e.g., delivered within the community where clients reside); and (4) mental health practitioners should cooperate with support resources available within clients' community, spiritual traditions, and extended family.

Turner (2000) recommends the following principles to use as broad guidelines for culturally adapting model intervention programs to racial/ethnic minority families: (1) sensitivity to the degree of influence of specific cultural family risk and protective factors; (2) level of acculturation, identity, and lifestyle preferences; (3) differences in family members' acculturation levels that may lead to family conflict; (4) family migration and relocation history; (5) levels of trauma, loss, and possible posttraumatic stress disorder related to war experiences or relocation; (6) family work and financial stressors; and (7) language preferences and impediments due to English as a second language and/or level of literacy in the native language.

Cultural Competence (CC) Training

According to Sue and Torino (2005), the purpose for cultural competence training guidelines issued by the American Psychological Association is to provide psychologists with:

> (1) the rationale and need for addressing racial and ethnic issues in education, training, research, practice, and organizational change; (2) basic information, relevant terminology, and current empirical research from psychology and related disciplines; (3) references to enhance ongoing education, training, research, practice, and organizational change methodologies; and (4) paradigms that broaden the purview of psychology as a profession. (p. 3)

CC advocacy promotes best practices for preservice training within the framework of two perspectives: (1) the optimal overall structure of university training programs and (2) the content of specific training activities within specific courses, practica, or internship experiences.

Overall Preservice Training Program Structure

Ponterotto and Austin (2005) review research from scholars that have identified at least six designs for multicultural training. The *traditional design* is defined as a training model that "does not acknowledge the salience of cultural factors in counseling" (p. 22). The *workshop design* does not require changes to the existing curriculum; however students are required to attend one-time workshops devoted to special topics dealing with multicultural issues. The *separate course design* describes a separate course or two that is exclusively devoted to multicultural issues within a curriculum (whereas other courses within the curriculum do not). The *concentration area/subspecialty cognate*

and interdisciplinary designs require students to take a cluster of conceptually linked courses devoted to multicultural issues. The interdisciplinary design approach requires students to take multicultural courses in a variety of different disciplines, such as (but not limited to) counseling, sociology, anthropology, and ethnic studies (p. 23). Finally, the *integrated program design* infuses multicultural issues throughout the entire curriculum, as the natural outgrowth of a program philosophy that places multiculturalism at the center of all clinical training.

D'Andrea and Daniels (1991) describe counseling psychology training programs as being located along a continuum of four stages, representing the degree to which the program recognizes, values, and infuses multicultural issues into training. For the highest stage, called the *cultural infusion* stage, training programs can be described by the following characteristics:

> Programs at this stage are committed to culturally diverse representation among students and faculty and integrate multicultural issues into all courses, externship supervision, comprehensive exams, research mentoring, and student/faculty competency evaluations. (p. 22)

Ponterotto and Austin (2005) present a 24-item Multicultural Competency Program Checklist that has been used to examine the general status of counseling training programs nationwide (Ponterotto, 1997). Each checklist item can be rated as either "Met" or "Not Met." Multicultural competencies are "Met," if, as examples, 30% or more of the program faculty are racial/ethnic minorities, multicultural issues are integrated into all coursework, students are exposed to 30% or more multicultural clientele, students are actively mentored in multicultural research, multicultural issues are reflected in comprehensive examinations completed by all students, and the physical surroundings of the program area reflect an appreciation of cultural diversity (e.g., artwork, posters, paintings, languages heard).

Exemplary Multicultural Training Programs Rogers (2008) identified 27 clinical, counseling, and school psychology programs that, at the time of her writing, can be labeled "exemplary models" for multicultural training. She identified four features that these programs shared in common, described below (pp. 161–163):

Use of an Integration Model of Multicultural Training Most exemplary programs use an integration model of multicultural training (see LaFromboise & Foster, 1992), in which all courses in the training program are infused with multicultural theories, research, and perspectives. Here, courses are infused with diversity topics, readings about the needs and issues relevant to diverse clients, and diversity-related research and assignments.

Students Acquire Clinical Skills with a Diverse Clientele Students matriculating through most of the exemplary programs reported having access to minority clients through urban and suburban practices and internship placements where they learned how to deliver services in supervised settings.

Research Training Focuses on Diversity Issues All programs rated as exemplary provided students with supervised opportunities to develop their research skills while working on projects dealing with diversity issues. Faculty in exemplary programs estimated that between 10% and 100% of their students completed theses and dissertations about diversity topics.

Cross-Cultural Knowledge Assessed on Comprehensive Examinations A majority of exemplary programs included questions about multicultural issues on "comprehensive examinations," which are capstone evaluations of students' accumulated knowledge and skills at a critical point in the program.

Preservice-Specific Training Activities

Self-Assessment When learners first participate in a course designed to develop cultural competencies, it is beneficial to first gain an understanding of one's own cultural values, worldview, biases, and beliefs at the beginning of the course,

workshop, or training experience. (Jones, Sander, & Booker, 2013). Some writers advocate for the administration of standardized questionnaires that assess some aspects of cultural competency knowledge, awareness, and skills (see Tables 1.2, 1.3 and 1.4). These questionnaires can be administered pre- and post-training to assess growth or change in cultural competency components (Jones et al., 2013).

Readings At the core of cultural competence training are core readings from researchers, scholars, and/or writers that (1) describe relevant advances in counseling, therapy, assessment, and mental health knowledge and intervention techniques; (2) raise awareness and/or empathy of important issues related to the traditions, lifestyles, beliefs, and worldviews of different groups; (3) present case studies of culturally different clients seeking treatment for various psychological, mental health, and educational problems (e.g., Jones, 2009a; Sue, Gallardo, & Neville, 2014); and (4) describe methods for conducting research (Jones, Sander, & Booker, 2013).

Priester et al. (2008) analyzed 64 course syllabi collected from counseling programs. They noted that, although sexual orientation was included in 72% of the syllabi reviewed, much less attention was devoted to gender (41%), religion (35%), disability (25%), social class (17%), and older adults (13%). Pieterse, Evans, Risner-Butner, Collins, and Mason (2009) evaluated 54 multicultural course syllabi from a sample of US counseling programs and found that the majority of courses used textbooks that devote separate chapters to African-American, Asian-American, Latinos American, and Native Americans and LGBTQ persons. Whites, Arab American/Middle Easterners, and Appalachian groups – as well as disability, gender, age, homelessness, immigration, socioeconomic status, and sizism issues – were less explored or not explored at all.

Didactic Instruction Within any formal learning context, instructors must impart, in a systematic fashion, concepts, definitions, rule relationships, procedures, and principles. The cultural competence literature includes a constellation of core topics that must be understood as a foundation for understanding more complex topics. These fundamental topics include (but are not limited to) basic concepts in child and adolescent development, psychological pathology, counseling and mental health, defining key terms (e.g., race, culture, ethnicity, cultural competence), the elements of culturally sensitive treatment, language and communication issues, and cultural issues in assessment (Weil, 2010).

Written Reflection Papers/Journals A reflection paper is a written document that requires students to think more deeply and critically about a topic or issue, which may involve questioning one's existing knowledge and beliefs, looking at an issue from different perspectives or angles, or "digging deeper" to discovering that there are areas about which one's knowledge is limited (Taylor, 2017).

Smith, Jennings, and Lakhan (2014) describe a reflection paper entitled "Who Am I, Culturally Speaking?" in which students are required to draw from interviews with relatives (among other sources of information) and assigned readings "to further their understanding of their own cultural development" (p. 1197). Students are also required to immerse themselves in a different cultural group through interviews, field visits, reading assignments, attending plays/films, and sampling different cuisines and then write a paper on the cultural characteristics of the group that acknowledged identity issues and relevant within-group differences.

There are many similarities between written reflection papers and journals (as this term is frequently used in classroom instruction). Nevertheless, the biggest difference is that a written reflection paper is a "one-time" product submitted in response to a specific assignment, whereas "journaling" represents an ongoing written recording of one's thoughts, emotional reactions, reflections, and experiences throughout an entire course of study. According to Jones et al. (2013), instructors can "individualize" journals as a means for encouraging growth in specific areas needing skill/awareness development. In

their view, journal feedback from instructors focuses on the process of exploring issues, rather than giving the impression that there are "right or wrong" answers (p. 15).

Testimonials Well-known texts for developing cultural competence in counseling will often include brief narratives of the life stories of racial/ethnic minority counselees or prominent multicultural scholars in the field, primarily as a means for illustrating how they have overcome various life obstacles and/or what they have learned from their life experiences as a member of an "oppressed" or "marginalized" group (Casas, Suzuki, Alexander, & Jackson, 2017; Marbley, 2011; Schwarzbaum & Thomas, 2008). Many courses designed to build cultural competence will often include guest lectures from expert therapists who deliver services to culturally different clients (Smith, Jennings, & Lakhan, 2014) or from representatives of different groups who can discuss their life experiences.

Visual Media Multicultural issues are often explored and/or dramatized for preservice students and in-service practitioners through films, television programs, or training videotapes. Such visual media can bring a reality and immediacy to issues, which in turn can serve as a catalyst for discussion, reflection, and critical analysis. Jones et al. (2013) provide a useful list of documentary or feature films that explore a variety of issues related to intergroup attitudes and prejudices, the meaning of racial/ethnic identity, and difficult social/political conditions experienced by individuals, families, or groups both domestically and internationally.

In-Class Group Discussion Exercises In-class discussion exercises take a wide variety of forms, a few of which are briefly described below:

Integrating Cultural Knowledge in Case Conceptualization Case conceptualization can be defined as the clinician's collective understanding of the client's problems as viewed through a particular theoretical orientation; as defined by the biological, psychological, and social contexts of the client; and as supported by a body of research and practice that links a set of co-occurring symptoms to a diagnosis and, ultimately, a treatment plan (John & Segal, 2015).

Cultural knowledge, skills, and awareness can be integrated into case conceptualization in a number of ways (see Jones et al., 2013). If assessments are considered for data gathering, students can examine the degree of language/culture loading of instruments and their possible effects on the accurate interpretation of results. Students are encouraged to ask questions about cultural background (race, ethnicity, language background, racial/ethnic identity development) and socioeconomic status (i.e., education, economic living conditions, parental occupations) if such information is not provided in the case presentation.

Awareness Exercises DeGannes, Woodson-Coke, Henderson, and Sanders-Phillips (n.d.) describe an in-class group exercise designed to increase awareness of cultural stereotypes. Here, signs are posted on the classroom walls, each of which includes the name of a group (e.g., Muslims, Elderly, Blacks, Lesbians, Women, Whites, Latinos, Christians, No Insurance). Participants then think of stereotypes they personally hold, write these on Post-it® notes, then walk around the room, and stick the notes on the poster to which the stereotype relates. After this is done, participants read the stereotypes aloud and then discuss their answers to the following questions: "How does hearing these stereotypes about each group make you feel?" "How might positive/negative stereotypes be problematic?" "How do (or might) these perceptions affect health care/education/psychology?"

One "Facilitator's Guide" for cultural competence training (PROCEED, Inc., 2012) describes an exercise designed to "help the participants become aware of 'otherness'" (p. 17). Here, the facilitator asks a series of questions, and participants are instructed to stand or raise their hands if their answer to each question is "yes." Examples of questions are as follows: "Do you remember the day Martin Luther King was shot?", "Is your heritage any part Jewish?", and "Do you live in what you would consider to be a truly integrated

neighborhood?" In the debriefing activity that follows this exercise, participants are asked with the following: "What reactions to and/or surprises do you have regarding the diversity in the room?", "Share your thoughts/feelings about being among the majority/minority in the group", "How might others feel if they were in the minority?", and "What should be the responsibility of those in the majority?"

Many writers observe that the open discussion of multicultural issues can often evoke anxiety, discomfort, and fear in participants (e.g., see Sue & Sue, 2016). Jones et al. (2013) describe an exercise whereby students can submit sensitive questions anonymously to instructors without the threat of unwanted exposure or fear of judgment. For a wide variety of multicultural awareness activities, readers are encouraged to consult Pedersen (2004).

Simulation Games Simulation games can be defined as a miniaturized version of some sphere of real-life activity that mimics clinical reality (Koskinen, Abdelhamid, & Likitalo, 2008). Using an example drawn from the field of nursing education, the BaFa BaFa game divides participants into two groups called Alphas and Betas. Both groups retreat to separate rooms in which they are taught the "rules" of their culture. Alpha culture is a relationship-oriented culture in which hugging, touching, and verbally expressed interest in male family members are central modes of communication. In contrast, Beta culture is a highly competitive trading culture, in which the communication is conducted by the code language, and the exchange of play marks and cards (p. 57). All of the players from both groups visit the opposing culture one after the other in pairs and then communicate their observations and feelings upon reentry into the home culture. This, in turn, prepares those from their home group who will go next. Discussions that follow these and similar games help students to understand communication styles, expectations of others, and coping strategies when interacting within an unfamiliar cultural milieu. Jones et al. (2013) provide numerous examples of simulation games that can be used to develop cultural competence.

Role-Playing Pedersen (2000) describes a role-playing exercise called *The Triad Training Model*, which is based on the assumption that each counseling interview contains three simultaneous conversations: (1) the explicit verbal exchange between the counselor and the client, (2) the internal dialogue of the client, and (3) the internal dialogue of the counselor. The second assumption on which this method is based posits that the more cultural differences there are between the counselor and the client, then the more difficult it will be to "hear" the client's internal dialogue.

In the role-playing exercise, four individuals simulate a counseling exchange: the counselor, the client, the "anticounselor," and the "procounselor." The anticounselor openly articulates the negative things that a culturally different client may be thinking but not saying, and the procounselor openly articulates the positive things that a client may be thinking but not saying. According to this model, the goal of this exercise is to enable counselors in training to develop four skills: (1) articulating the problem from the client's cultural perspective, (2) recognizing resistance in specific rather than general terms, (3) reducing the counselor's defensiveness, and (4) practicing recovery skills for getting out of trouble.

Laboratory Experiences Pedersen (2004) describes laboratory experiences as learning experiences that can take the form of a separate weekend workshop or a separate class that is held for an extended period of time. No additional details are provided except to say that laboratory experiences typically require more complex learning objectives (p. 159). Carter (2005) describes a "Racial-Cultural Counseling Laboratory" (hereafter abbreviated as RCCL) that is required by students after taking basic courses in counseling theory, counseling skills, and group counseling (among other courses). Prior to the beginning of the course, students are required to write a brief autobiography that explores how their race, ethnicity, social class, and religion have played a role in the life development. The RCCL then includes a lecture component where the instructor and teaching

assistants disseminate information to students about a variety of multicultural issues (for details, see extended discussion in Carter, 2005). Also included in the RCCL is a series of experiential activities where students are interviewed and challenged in small groups about the content of their written autobiographies. Throughout the process, students keep written journals that chronicle their feelings about the process – to be handed in to the instructor (for comments and observations) on a weekly basis.

Outside-of-Class Experiences Pedersen (2004) describes outside-of-class experiences as "homework" that can be discussed later in class. In his view, "the advantage of homework is to encourage immersion by the student into community cultures and to blur the boundary between the classroom and the community" (p. 239). Because the environment in which students learn from these experiences is not controlled, these assignments need to be "tightly structured" in order to properly guide students in a desired direction (p. 239). In addition, the instructor needs to engage in "debriefing" for each out-of-class experience either in the classroom or elsewhere.

Interviews Smith et al. (2014) describe a course requirement where students are required to conduct a structured interview with an interviewee who is from a different cultural group, for the purpose of seeking information on their help-seeking behavior and perceptions of psychological services.

Cultural Immersion Experiences Pope-Davis, Breaux, and Liu (1997) describe a university training experience which requires students to identify a group perceived to be racially/ethnically different from their own group. The student is required to immerse him/herself in the group's organizational events, social gatherings, and meetings during the course of the academic semester. During the concluding weeks of the class, students and members of the group in which students were immersed discuss their experiences in a final class presentation/discussion. Students are assessed pre- and post-experience on a self-report multicultural competency scale.

Service Learning Projects Research studies have provided support for the efficacy of service-learning projects as a means to improve diversity awareness, moral development, self-knowledge, tolerance, spiritual growth, altruism, and personal efficacy in college students (Eyler & Giles, 1999; GreyWolf, 1998; Marullo, 1998; Smith, Jennings, & Lakhan, 2014; Wade, 1997).

O'Brien, Patel, Hensler-McGinnis, and Kaplan (2006) describe a required service-learning experience for a counseling psychology class, in which students were assigned in pairs to volunteer for 4 hours per week in programs serving battered and homeless women and their children in the Washington, DC, area. Specifically, students worked in teen support groups, anger management and life skills groups for women struggling with addictions and trauma, homework clubs, and groups designed to enhance self-esteem in children.

Some psychology training programs in the United States had discovered the benefits of overseas service-learning activities for developing cultural competence. Smith et al. (2014) describe a short-term (31-day) program for counseling psychology students to study overseas in Singapore. In the context of this experience, students attended classes with master's level counseling Singaporean students, conducted site visits to mental health settings (e.g., family service centers, college counseling centers, hospitals, and private practice settings), and explored homogeneous ethnic communities and places of worship in Singapore. Students also assisted staff in designing curriculum content at a residential program in Singapore serving adolescent female abuse survivors.

Bias Awareness/Detection Activities Jones et al. (2013) opine that taking the Implicit Association Test (IAT) increases self-awareness of potential areas of bias. The IAT is a computerized test that measures the reaction times between the presentation of an image and a participant pressing one of two buttons on the computer keyboard repre-

senting a binary response choice (Greenwald, McGhee, & Schwartz, 1998). Images of faces representing various racial/ethnic groups, as well as "ethnic-sounding" names, are presented, and respondents are asked to press a button representing positive or negative evaluations. Faster reaction times between the appearance of an image and the pressing of a button represent stronger associations, while slower reaction times represent weaker associations. Researchers suggest that IAT research results infer subconscious biases and/or prejudices (e.g., McConnell & Leibold, 2001; Rudman & Ashmore, 2007).

Evaluation of Cultural Competence Development Fouad et al. (2009) outline core competencies to be expected of students matriculating through professional psychology programs within three levels of professional development: readiness for practicum, readiness for internship, and readiness for entry into practice. Within each level, they cite the following examples of behavioral indicators that operationalize expectations for the foundational competency domain of *Individual and Cultural Diversity*: "articulates how ethnic group values influence who one is and how one relates to other people"; "demonstrates knowledge, awareness, and understanding of the way culture and context shape the behavior of other individuals"; "demonstrates awareness of effects of oppression and privilege on self and others"; "critically evaluates feedback and initiates consultation or supervision when uncertain about diversity issues"; and "habitually adapts one's professional behavior in a culturally sensitive manner, as appropriate to the needs of the client, that improves client outcomes and avoids harm."

Jones et al. (2013) mention the degree to which trainees demonstrate introspection in reflecting on their work products, involvement in classroom discussions, or the degree to which trainees express awareness of their own biases, ignorance, and/or prejudice in group discussions and writings as tangible examples of measurable behaviors that demonstrate cultural competence.

Cultural competency knowledge can also be assessed by assessing whether trainees can understand and articulate definitions for key terms in cultural competence training (e.g., racism, discrimination, assimilation, and acculturation), understand individual and group differences in acculturation, understand the pitfalls of stereotyping, and have a basic understanding of the psychometric principles that guide test selection and interpretation (Gillem et al., 2016; Jones et al., 2013). These knowledge areas can be assessed through use of classroom tests, standardized measures, research papers, or oral presentations (Kaslow et al., 2009).

Jones et al. (2013) describe an example of how social advocacy and action can be evaluated in training courses. They describe the problem of racial/ethnic group disproportionality in school systems (e.g., see Office of Special Education and Rehabilitative Services, 2016) and how psychologists working for systems impacted by disproportionalities can apply a problem-solving approach that establishes measureable goals, action steps to implement a school-wide prereferral intervention program, and then a reevaluation of referral rates at the end of the program to assess change.

Continuing Education

In a general sense, continuing education activities are designed to enable working professionals to develop knowledge and/or skills for application within the context of his/her work or to build an individual's expertise within a given field. For applied psychologists, continuing education activities are required to maintain certification and/or licensure status. This education can occur via in-person training, via observed pre-recorded videos, or through the use of live, real-time interactive "webinars" (e.g., see Matza, Sloan, & Kauth, 2015).

As examples, Alexander Street Press (2013) offers "The Five Forces of Counseling and Psychotherapy Series," where viewers can observe an interview with leading therapists, a demonstrative counseling session, and a debrief-

ing session that illustrate one of five "forces," or paradigms, within counseling psychology: Psychoanalytic (First Force), Cognitive-Behavioral (Second Force), Existential/Humanistic (Third Force), Multiculturalism (Fourth Force), and Social Justice (Fifth Force).

The American Psychological Association offers a continuing education course for doctoral-level psychologists called "Applying the APA Multicultural Guidelines to Psychological Practice," developed by Divisions 42 (Psychologists in Independent Practice) and 45 (Society for the Psychological Study of Ethnic Minority Issues). According to a website that describes the course, the successful completion of the course is contingent on reading online the course content, passing a quiz at the end of the course, and submitting a course evaluation (Comas-Díaz & Caldwell-Colbert, 2006).

ContinuingEdCourses.Net provides internet-based continuing education courses for mental health professionals, which included, but certainly are not limited to, social workers, marriage and family therapists, and applied psychologists. One course, offered by Dr. William M. Liu, is entitled "Multicultural Competency: How Are We Different? Let Us Count the Ways." The course is advertised as an intermediate-level course that purports to enable learners to achieve the following objectives: (1) discuss why multicultural competency is important, (2) explain the roles of self-assessment and self-awareness and their relationship to multicultural competency, (3) describe the major dimensions of marginalization and oppression, (4) discuss identity and worldview frameworks, and (5) explain acculturation and its importance in diverse communities (Liu, 2016).

Conclusion

The material previously reviewed examined cultural competency advocacy with only oblique references to specific areas of applied psychology. The next chapter focuses on the nature of cultural competency advocacy as it has been uniquely interpreted by clinical, school, and counseling psychology.

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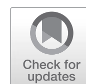

2 Current Status of Cultural Competence Advocacy in Clinical, School, and Counseling Psychology

Craig L. Frisby and Oscar Rojas Perez

Introduction

All applied doctoral psychology training programs, as a condition for accreditation by the American Psychological Association, must demonstrate adherence to conditions specified under Domain D: Cultural and Individual Differences in Diversity within the *Guidelines and principles for accreditation of programs in professional psychology* (American Psychological Association, 2013). These guidelines read (in part):

> 2. The program has and implements a thoughtful and coherent plan to provide students with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of professional psychology. The avenues by which these goals are achieved are to be developed by the program.

Although all accredited applied training programs in doctoral psychology must demonstrate adherence to these requirements, there are several important differences that exist in the history and roles/functions of psychologists representing clinical, school, and counseling psychology. The purpose of this chapter is to provide readers with a general overview of similarities and differences among clinical, school, and counseling psychology disciplines – with a particular emphasis on the unique identity of each discipline as it relates to cultural competence advocacy.

Brief History

Clinical Psychology

In the eighteenth and nineteenth centuries, many psychological practitioners calling themselves phrenologists, physiognomists, graphologists, mesmerists, spiritualists, seers, psychics, and mediums practiced their "craft" in giving aid to persons in psychological distress (Benjamin, 2005). During this period, no certification or licensure laws existed to define training or practice, nor were there significant laws that protected the public from incompetent and fraudulent practices (p. 3). By the beginning of the nineteenth century, the medical profession of psychiatry had the major responsibility for the assessment, diagnosis, and treatment of serious mental illnesses (see Shorter, 1997), where most American psychiatrists worked in hospitals for the insane (pejoratively referred to as "lunatic asylums"), state hospitals, or mental hospitals.

The beginnings of clinical psychology in America are generally credited to the work of Lighter Witmer, the head of the psychology program at the University of Pennsylvania. In 1897,

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Witmer urged his academic colleagues to use their knowledge of psychology to "throw light upon the problems that confront humanity" (Witmer, 1897, p. 116). This challenge was exemplified in the highly publicized case in his successfully treating a 14-year-old boy with spelling problems who was referred to Witmer by a school teacher. Although these activities are also credited with the beginnings of school psychology (see next section and Fagan & Wise, 2007), the setting in which Witmer and his staff operated was called a "clinic."

Witmer began a new journal in 1907 entitled *The Psychological Clinic* that published case studies describing presenting symptoms, diagnoses, and treatments. According to Benjamin (2005), the lead article in the first issue was called "Clinical Psychology" and laid out a program for doctoral training for this new field.

Prior to World War I, most psychologists were employed in university settings with a very small number making their living in applied settings such as schools, hospitals, and businesses. In 1917, J.E. Wallace Wallin founded the American Association of Clinical Psychologists (AACP). Eventually, the AACP dissolved and reestablished themselves in 1919 as the Section on Clinical Psychology within the American Psychological Association (Routh, 1994).

During the 1920s, more than a dozen regional and state organizations formed for applied psychologists, the largest of which was the New York State Association of Consulting Psychologists founded in 1921. In 1937, the American Association for Applied Psychology was founded (which later merged with the American Psychological Association), along with the creation of the *Journal of Consulting Psychology*.

The inauguration of World War II in 1941 led the Subcommittee on Survey and Planning of Psychology (see Boring et al., 1942) to plan for the development of the science and profession of psychology after the war. This proved critical for the emergence of what is now known as modern clinical psychology (Benjamin, 2005). The war created the conditions necessary for the full institutionalization of clinical psychology, with the federal government working with the Veterans Administration (VA) and the US Public Health Service to expand the pool of mental health professionals that could address the psychological and mental health needs of war veterans. By 1950, APA created an accrediting system for clinical psychology, massive amounts of federal dollars were spent on clinical research and training, and hundreds of jobs in the Veterans Administration were created for clinical psychologists, and national conferences established training guidelines (Benjamin, 2005). According to Benjamin (2005), the Veterans Administration (VA) was adamant that psychologists working in VA hospitals needed to have skills in delivering psychotherapy services, as there were not enough trained psychiatrists to meet this need. As a result, psychotherapy courses became standard practice in clinical psychology programs in the late 1940s (Benjamin, 2005).

The Boulder Conference met from August 20 to September 3 in 1949, attended by professionals representing academic and applied psychology, medicine, and other education disciplines (Baker & Benjamin, 2000). The scientist-practitioner model that emerged would become the dominant mode of training in professional clinical, counseling, and school psychology programs – a dominance that continues today at the time of this writing. However, dissatisfaction among clinical psychologists with the Boulder model eventually led to the creation of professional schools, spurred in part by the Vail, Colorado conference of 1973, designed to explore new alternative training models (Benjamin, 2005).

The following quote from Benjamin (2005) describes clinical psychology's new "golden age":

> The successes of the 1960s and 1970s marked the culmination of a dream for clinical psychologists who, with the exception of prescribing psychotropic medications and the obvious annual income differences, found themselves enjoying near parity with their psychiatrist colleagues in the mental health field. [Clinical] Psychologists now dominated the practice of psychotherapy [and] the golden age of clinical psychology had arrived. (p. 22)

Currently, clinical psychology is both a general practice and a health service provider specialty in professional psychology.

School Psychology

Fagan and Wise (2007) subdivide the historical development of school psychology into two major periods: The Hybrid Years (1890–1969) and The Thoroughbred Years (1970–present). In the late nineteenth and early twentieth centuries, several child-protection- and child-service-related reform movements such as compulsory schooling, juvenile courts, child labor laws, the rise of standardized psychoeducational testing, special education, and the emergence of child guidance clinics provided the impetus for serving children and youth in the context of schools. The Hybrid Years derives its name from the fact that the field that was later called "school psychology" consisted of a blending of education and psychology practitioners (e.g., teachers, guidance counselors) "loosely mobilized around a dominant role of psychoeducational assessment for special class placement" (Fagan & Wise, 2007, p. 26). Educational and psychological testing (for sorting students for specialized instruction) became the predominant role of professionals (teachers, administrators, psychologists) who worked in school settings.

Although Ohio formed a state organization for school psychology in 1943 (Fagan & Wise, 2007), the major event that inaugurated The Thoroughbred Years was the creation of the first national organization for school psychologists (National Association of School Psychologists, or NASP). According to Fagan and Wise (2007), The Thoroughbred Years of school psychology are characterized by increased state and federal regulation, the growth of state professional associations, improved professional identity, and broadened arenas for practice.

Counseling Psychology

The history of counseling psychology in the United States dates back to the early 1900s. The origins of the specialty reflect historical, social, political, and professional influence and developments during the beginning of the twentieth century (Munley, Ducan, Mcfonnell, & Sauer, 2004). Whiteley (1984) identified five principal historical roots of counseling psychology: (1) the development of the vocational guidance movement and the writing of Frank Parsons (1909); (2) the social hygiene movement of the late nineteenth and early twentieth centuries; (3) the development of psychometrics and the scientific study of individual differences; (4) the increasing interest of psychologists in psychotherapy and practice from a nonmedical and non-psychoanalytic approach, particularly under the influence of Carl Roger's writings in *Counseling and Psychotherapy* (1942); and (5) social and economic progress in the United States, during and after World War II (WWII). Post WWII, the US government identified and filled a need for counselors to assist the millions of veterans returning home with personal and vocational adjustment problems and concerns. With the country's involvement in WWII, the Veterans Administration (VA) adopted the postwar responsibility to provide comprehensive services for veterans, which promoted the rise and growth of counseling psychology.

Accompanying these historical influences, counseling psychology endured several challenges in formulating and refining its identity. During the early and late 1950s, counseling psychology experienced two identity crisis: (1) Division 17, formally known as the Division of Personnel Counseling and Guidance Psychology, officially changed its name to the Division of Counseling Psychology (Scott, 1980; Super, 1955), and (2) The Educational and Training Board of APA contemplated eradicating counseling psychology as a recognized specialty (Blocher, 2000). The life-threatening identity crisis of the late 1950s, as described by Pepinsky (1984), was a result of jurisdictional disagreements over entitlements between clinical and counseling psychology. This was due to the lack of distinction and identity of counseling psychology as a separate and unique specialty. According to Thompson and Super (1964), the Greyston Conference of 1964 became the most important event in the history of counseling psychology because it examined the professional preparation and work of counseling psychologists.

The founding of *The Counseling Psychologist* in 1969; the change in social outlook during the 1960s and 1970s; the counseling psychology conference in Atlanta, GA, in 1987; and the emphasis on diversity throughout the 1980s, 1990s, and 2000s have been noted as pivotal events in the recognition and establishment of counseling psychology as a specialty.

Professional Organizations and Scholarly Outlets

Clinical Psychology

Professional Organizations Representing Clinical Psychology Clinical psychologists can belong to any number of organizations devoted to specific areas of clinical interest. Nevertheless, three organizations stand out as being strong voices for clinical psychology "with the highest number of enrollments and networking opportunities" (BestPsychologyDegrees.com, 2017). The largest scientific and professional organization representing psychology in the United States is the American Psychological Association (APA), which also has the distinction of being the world's largest organization of psychologists. Division 12 of the American Psychological Association (Society of Clinical Psychology) includes APA members who are active in practice, research, teaching, administration, and/or study within the field of clinical psychology. Membership in Division 12 includes a subscription to *Clinical Psychology: Science and Practice* and the quarterly newsletter *The Clinical Psychologist*. Members and graduate student affiliates may also join one or more of the APA Division 12 sections: Clinical Geropsychology; The Society for a Science of Clinical Psychology; Clinical Psychology of Women; Clinical Psychology of Ethnic Minorities; Emergencies and Crises; Association of Psychologists in Academic Health Centers, Assessment, and Graduate Students; and Early Career Psychologists.

The Association for Psychological Science (APS) is generally considered to be the largest general organization that focuses primarily on psychology research and the advancement of scientific psychology studies at both the national and international levels. The APS is open to scientists, educators, clinicians, researchers, and administrators who possess a doctoral degree in psychology or a closely related field. APA publishes six journals: *Psychological Science*, *Perspectives on Psychological Science*, *Current Directions in Psychological Science*, *Clinical Psychological Science*, *Psychological Science in the Public Interest*, and *Advances in Methods and Practices in Psychological Science.*

The National Alliance of Professional Psychology Providers (NAPPP) is an organization that focuses on supporting, educating, and connecting mental health providers who provide direct care to clients. The NAPPP represents licensed doctoral psychologists, retired psychologists, and Ph.D. students aspiring to deliver healthcare related services. The NAPPP's mission is to promote doctoral-level practice toward the improvement of healthcare policy. NAPPP members receive *The Clinical Practitioner* monthly newsletter.

Scholarly Outlets Given the size and scope of all of the branches of psychology and mental health with which clinical psychology overlaps, listing all of the journal and newsletter scholarly outlets for applied clinical psychology is indeed a daunting task. Some of the leading peer-reviewed journals for clinical psychologists are *Journal of Clinical Psychology*, *Clinical Psychology: Science and Practice*, *Journal of Consulting and Clinical Psychology*, *Clinical Psychology and Psychotherapy*, *Psychotherapy*, *Professional Psychology: Research and Practice*, *Journal of Psychotherapy Integration*, *Psychological Assessment*, and *Journal of Clinical Child and Adolescent Psychology*, to name a few. *The Clinical Psychologist* is a quarterly publication of APA Division 12 (The Society of Clinical Psychology) that publishes timely information on a broad domain of topics of interest to Division 12 members. *Advances in Psychotherapy: Evidence-Based Practice* is a book series edited in consultation with the Society for Clinical Psychology (APA Division 12), the purpose of

which is to provide an outlet for empirically supported treatments for the most common disorders seen in clinical practice.

School Psychology

Professional Organizations Representing School Psychology The professional practice of school psychology is represented by two organizations: the American Psychological Association Division 16 (School Psychology) and the National Association of School Psychologists (NASP). The National Association of School Psychologists (NASP) has the largest membership of American professional school psychologists, which includes doctoral and non-doctoral members. Merrell, Ervin, and Peacock (2012) estimate that NASP membership is approximately 26,000 members and roughly 60–65% of American school psychologists are members of NASP. Merrell et al. (2012) estimate that roughly 2200 school psychologists are members of the American Psychological Association (APA) Division 16, which limits its full membership to doctoral-level professionals only.

Approximately 70–75% of professionals who call themselves school psychologists do not have doctoral degrees. Since APA is the oldest and largest organization representing professional psychologists, it comes as no surprise that its stance has always been that the doctoral degree should be the minimum level for the use of the title "psychologist." However, the language of most state psychology licensing boards includes a provision for individuals trained at the master's or education specialist level (and appropriately credentialed by their state department of education) to use the title "school psychologist" within the scope of school-based practice. However, only state-licensed doctoral-level school psychologists may practice privately and call themselves "psychologists" (without the preceding adjective "school"). As of 2010, there are approximately 60 APA-accredited school psychology training programs in the United States and 156 specialist-level and 63 doctoral-level programs that were approved by NASP (Merrell et al., 2012).

Scholarly Outlets Members of APA Division 16 automatically receive the *School Psychology Quarterly* journal and *The School Psychologist* newsletter. Members of NASP automatically receive the *School Psychology Review* journal and the *NASP Communiqué* newsletter. Additional journals directly relevant to school psychology science and practice include, but are not limited to *Contemporary School Psychology*, *Journal of Applied School Psychology*, *Journal of Psychoeducational Assessment*, *Journal of School Psychology*, *Psychology in the Schools*, *School Psychology Forum: Research and Practice*, and *School Psychology International.*

Counseling Psychology

Professional Organizations Representing Counseling Psychology The most recent study on the demographics and employment of professional counseling psychologists (e.g., Munley, Pate, & Duncan, 2008) estimates that there are roughly 8709 members and fellows of APA that identify counseling psychology as their major filed. The professional practice of counseling psychology is represented by the following organizations: the American Psychological Association Division 17 (Society of Counseling Psychology), Division 29 (Society of the Advancement of Psychotherapy), Division 35 (Society for the Psychology of Women), Division 40 (Division of Clinical Neuropsychology), Division 42 (Psychologists in Independent Practice), Division 43 (Society of Couple and Family Practice), Division 45 (Society for the Psychological Study of Culture, Ethnicity, and Race), and Division 52 (International Psychology). Counseling psychologists are also significantly represented in the Asian American Psychological Association (AAPA), the Association of Black Psychologists (ABPsi), the National Latina/o Psychological Association (NLPA), and the Society of Indian Psychologists (SIP). According to Munley et al. (2008), a significant number of counseling psychologists do not hold affiliation with Division 17 or any other division within APA. Munley et al. (2008) estab-

lished that of the 8709 counseling psychologist in their study, 53.9% belonged to a state association. In addition, the relatively low percentage of counseling psychologists' membership in APA divisions may be a result of their memberships in racial/ethnic national psychological organizations such as AAPA, ABPsi, NLPA, and SIP.

Individuals who call themselves counseling psychologists in the United States have received doctoral-level training and usually have received a Ph.D. from an APA-accredited counseling psychology program (Gelso & Fretz, 2001; Munley et al., 2004). The majority of counseling psychology programs follow the scientist-practitioner training model, regardless of the programs' special emphases. Counseling psychologists looking to practice must successfully complete the Examination for Professional Practices in Psychology (EPPP); however additional exam requirements differ by state. Furthermore, according to the Association of State and Provincial Psychology Boards (ASPPB), in order to practice independently in the United States, counseling psychologists must have obtained the doctorate. However, there are a number of counseling programs that offer master's degrees that allow graduates from these programs to work at the master's level psychological practice in the corresponding state. Master's level graduates have the option of obtaining other types of professional counseling licensure (e.g., licensed professional counselor, licensed mental health counselor). As of January 2014, there are approximately 67 APA-accredited counseling psychology training programs in the United States. Of the 67 counseling psychology programs in the nation, 62 issue Doctor of Philosophy degrees and 5 issue Doctor of Psychology degrees (Society of Counseling Psychology, 2016).

Scholarly Outlets Counseling psychology has two prominent and keystone journals in which science and practice articles are published: *The Counseling Psychologist* (*TCP*) and *Journal of Counseling Psychology* (*JCP*). Today, *The Counseling Psychologist* continues to serve as the official journal of APA Division 17, while the *Journal of Counseling Psychology* remains as one of the APA journals with the highest number of subscriptions. In addition to the two major counseling journals, twelve major journals are prominent outlets for theoretical and empirical work in the field: *Journal of Counseling and Development*, *International Journal for the Advancement of Counseling*, *Journal of Cross-Cultural Psychology*, *Journal of Multicultural Counseling and Development*, *Journal of Vocational Behavior*, *Journal of Career Development*, *Psychology of Women Quarterly*, *Journal of Gay & Lesbian Mental Health*, *Journal of Career Assessment*, *Asian American Journal of Psychology*, *Journal of Latina/o Psychology*, and *The Journal of Black Psychology*.

Practice Roles and Functions

Clinical Psychology

The Division of Clinical Psychology (Division 12) of the American Psychological Association (APA) defines clinical psychology as follows:

> The field of Clinical Psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development. Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels. (American Psychological Association, 2012)

According to the American Board of Professional Psychology (2017), clinical psychologists provide professional services for the diagnosis, assessment, evaluation, treatment, and prevention of psychological, emotional, psychophysiological, and behavioral disorders across the lifespan. These services may be provided directly or support and facilitate the provision of services through supervision, teaching management, administration, or advocacy.

According to Pomerantz (2017), private practice has been the primary employment site of 30–41% of clinical psychologists since the 1980s. Up to 19% of clinical psychologists work in university psychology departments, with a wide

variety of other settings listed as psychiatric hospitals, general hospitals, community mental health centers, medical schools, Veterans Affairs medical centers, government agencies, public schools, substance abuse centers, and university counseling centers. Consistently across several decades, psychotherapy is the primary professional activity for clinical psychologists (Norcross & Karpiak, 2012).

Most clinical psychologists in private practice work within some form of managed care, which are systems within which healthcare providers provide services that are overseen (i.e., managed) by a third-party payer or a company hired by the insurance company. In these systems, the psychologist (designated by the managed care company as a provider) contracts with the company to provide services to people whose insurance benefits are managed by that company. The fee for specific services is set by the company, as is the number of clinical sessions for which the psychologist will be reimbursed. Clinical psychologists seeing clients for psychotherapy must have their treatment plans approved by the managed care company – which often involves a set number of sessions (Herz, 2017). This is a topic of considerable debate and consternation among clinical psychologists (e.g., see Northrup, 2011).

School Psychology

The overwhelming majority of professional school psychologists work in public schools, although some school psychologists also work in private and/or faith-based schools and a very small minority work in hospital settings (Curtis, Castillo, & Gelley, 2012). Understanding school psychologists' roles and functions first requires that a distinction be made between the profession's "official" view of ideal roles and functions, versus empirical surveys documenting *actual* roles and functions.

According to the National Association of School Psychologists (NASP) official website (Accessed March 2015 from http://www.nasponline.org/about_sp/who-are-school-psychologists.aspx), school psychologists:

> . . . are uniquely qualified members of school teams that support students' ability to learn and teachers' ability to teach. They apply expertise in mental health, learning, and behavior, to help children and youth succeed academically, socially, behaviorally, and emotionally. School psychologists partner with families, teachers, school administrators, and other professionals to create safe, healthy, and supportive learning environments that strengthen connections between home, school, and the community . . . . School psychologists provide direct support and interventions to students, consult with teachers, families, and other school-employed mental health professionals (i.e., school counselors, school social workers) to improve support strategies, work with school administrators to improve school-wide practices and policies, and collaborate with community providers to coordinate needed services.

A consistent theme in writing on school psychology professional issues within the last 50 years is the persistent dissatisfaction with an overemphasis on the role of "tester" in response to special education referrals, coupled with a preference for consultation. Surveys of practitioners conducted between the 1950s and 1990s reveal that anywhere from one half to two thirds of school practitioners' time is spent on testing and attending eligibility meetings for special education placement (Bramlett, Murphy, Johnson, Wallingsford, & Hall, 2002; Curtis, Lopez, Batsche, & Smith, 2006; Fagan, 1996; Hosp & Reschly, 2002; Reschly, 1998; Reschly & Wilson, 1995).

Counseling Psychology

Understanding counseling psychologists' roles and functions first requires the understanding of the definition and parameters of counseling psychology, defined as follows:

> Counseling psychology is a general practice and health service provider specialty in professional psychology. It focuses on personal and interpersonal functioning across the lifespan and on emotional, social, vocational, educational, health related, developmental, and organizational concerns. Counseling psychology centers on typical or normal developmental issues as well as atypical or disordered development as it applies to human experiences from individual, family, group, systems and organizational perspectives. Counseling psychologists help people with physical, emotional, and mental disorders improve well-

> being, alleviate distress and maladjustment, and resolve crises. In addition, practitioners in this professional specialty provide assessment, diagnosis, and treatment of psychopathology. …Within the context of life-span development, counseling psychologists focus on healthy aspects and strengths of the client (individual, couples, family, group, system, or organization), environmental/situation influences (including the context of culture, gender, and lifestyle issues), and the role of career and vocation on individual development and functioning. (APA, 1999, p. 589)

Several surveys provide current data on the percentage of counseling psychologists in the United States who are employed full-time. According to the most recent Division 17 employment information (based on 2014 membership data for 2053 full-time employed members of Division 17; American Psychological Association, 2014, Table 4), the percentages of persons indicating full-time primary employment in different settings were as follows: university/college (48%), independent practice (13.3%), other human service setting (20.4%), hospitals (2.9%), other academic settings (3.3%), clinics (1.6%), medical school/academic medical centers (2.2%), government (2.4%), and other (3.8%). These findings are comparable to earlier surveys of Division 17 members (Fitzgerald & Osipow, 1986; Gelso & Fretz, 2001; Munley et al., 2004; 2008; Watkins Lopez, Campbell, & Himmell, 1986).

Today, the role of counseling psychologists extends beyond the principal boundaries of vocational guidance (Leong, 2008). Survey findings on counseling psychologists (e.g., Gelso & Fretz, 2001; Watkins et al., 1986) demonstrate that counseling psychologists participate in various activities: psychotherapy, consultation, teaching, administration, supervision, research, personality diagnosis and assessment, and vocational counseling and assessment.

Racial/Ethnic Demographics

According to findings from the American Community Survey (Lin, Nigrinis, Christidis, & Stamm, 2015), the racial/ethnic composition of the active psychology workforce surveyed is approximately 83% White, 4% Asian, 5% Black/African-American, 5% Hispanic, and 1% other racial/ethnic groups. Survey authors concluded that the active psychology workforce is considerably less diverse compared to the overall American workforce (i.e., across all fields, including psychologists), as well as slightly less diverse compared to the doctoral/professional workforce (i.e., doctoral or professional degreed workforce only, including psychologists). Despite these figures, the overall proportions of all non-White groups have grown significantly over time, growing at an increase in 8 percentage points from 2005 to 2013 (Lin et al., 2015).

Clinical Psychology

According to the findings from the APA Survey of Psychology Health Service Providers (Total N = 4611; Hamp, Stamm, Lin, & Christidis, 2016), almost half (45.1%) of respondents reported their primary specialty as clinical psychology, 15.5% reported their primary specialty as clinical child and adolescent psychology, 7% reported their primary specialty as clinical health psychology, and 6% reported their primary specialty as clinical neuropsychology. Of the total survey sample (which included primary specialties other than clinical psychology), 87.8% reported their race/ethnicity as White/Caucasian, followed by 4.4% Hispanic, 2.6% Black/African-American, 2.5% Asian, and 0.3% American Indian.

School Psychology

Practitioners Curtis et al. (2012) surveyed practitioners (from a parent pool of 20% of the national NASP membership) during the 2009–2010 school year and recorded the following racial/ethnic breakdown: 90.7% non-Hispanic Caucasian, 3.4% Hispanic, 3% African-American, 1.3% Asian/Pacific Islander, and 0.6% Native American or Alaskan Native. According to similar data collected at 10-year intervals since 1980–1981, these percentages have not changed markedly over the last 30 years.

Faculty At the time of this writing, the latest data on the racial/ethnic breakdown of school psychology faculty members as of 2008 (n = 306, representing about 30% of all school psychology university faculty), broken down by gender, is as follows: 62.4% female and 37.6% male. Within the female subgroup, 88% are non-Hispanic Caucasians, 3.7% are African-American, 3.1% are Hispanic, 2.1% are multiethnic, and 1.6% are Asian. Within the male subgroup, 90.4% are non-Hispanic Caucasians, 3.5% are African-American, 2.6% are Asian, and 1.7% are multiethnic (Crothers, Schmitt, Hughes, Theodore, & Lipinski, 2009).

Counseling Psychology

According to the most recent 2014 data on racial/ethnic characteristics of 2053 APA Division 17 members (American Psychological Association, 2014, Table 4), 60.7% are non-Hispanic White, 4.8% are African-American, 4.7% are Asian, 3.1% are Latina/o, 0.3% are American Indian, and 1.3% report as "multiracial/multiethnic." According to similar surveys of Division 17 members and non-members conducted in the past, these current percentages have not changed significantly over the past 13 years (Munley et al., 2008).

Faculty Addressing issues of multiculturalism, diversity, and social justice has been commonly cited as a signature contribution of counseling psychology (Neimeyer & Diamond, 2001). Not surprisingly then, counseling psychology has made various strides and efforts to increase representation of racial/ethnic communities in the field. As Moradi and Neimeyer (2005) opine: "the presence of racial-ethnic minority faculty is essential for recruiting, retaining, and graduating minority students…racial-ethnic minority faculty can make important theoretical and research contributions that integrate sociocultural perspectives into psychology" (p. 657). Although the current state of racial-ethnic minority counseling psychology faculty is unclear, the latest data available at the time of this writing was obtained from annual surveys conducted by the Council of Counseling Psychology Training Programs (CCPTP). The number of counseling psychology faculty who are racial/ethnic minorities across counseling psychology programs as of 2002–2003 totaled 26%. Across ranks (e.g., assistant, associate, full professor), 4% are Asian, 11% are Black, 9.2% are Latina/o, and 5.1% reported as belonging to other groups (e.g., Native American, Middle Easter, South Asian).

Exposure to Racial/Ethnic Subgroups in Practice

According to the 2015 American Psychological Association Survey of Psychology Health Service Providers (N = 5325; Hamp et al., 2016), the vast majority of psychologists (96%) reported seeing White/Caucasian patients at higher frequencies than any other racial/ethnic group. These figures were 38% for Black/African-American clients and 33.6% for Hispanic clients. Approximately 80% of respondents reported "rarely or never" providing services to American Indian/Alaska Native patients, and 48% reported "rarely or never" providing services to Asian patients. The vast majority of psychologists surveyed (96%) reported seeing heterosexual patients at higher frequencies than any other sexual orientation group. Very low percentages of respondents reported "frequently or very frequently" provided services to homeless and rural populations (Hamp et al., 2016).

The APA Health Service Providers survey asked respondents to answer questions about cultural competency, to which 1909 persons responded. Over 52.7% of respondents reported being well prepared or extremely well prepared by their doctoral training programs, 44.4% felt that they were slightly or fairly prepared, and only 3% felt not at all prepared. Respondents were also asked how knowledgeable they felt about working with particular racial/ethnic subpopulation groups. The group to which respondents reported the highest percentages of feeling "extremely knowledgeable," "quite knowledgeable," or "fairly knowledgeable" was Black/African-Americans, followed by Hispanics. The groups to which respondents reported the highest

percentages of feeling "lightly knowledgeable" or "not knowledgeable" were Native Hawaiian/Pacific Islanders and American Indian/Alaska Natives (Hamp et al., 2016).

Cultural Competence Training, Research, and Advocacy

Specific statements found in ethics codes – applicable to all psychologists – inform practitioners of the importance of cultural sensitivity and competence in their work (Pomerantz, 2017). As one example, Principle E (Respect for People's Rights and Dignity) of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017) states in part:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (p. 4)

Clinical and Counseling Psychology Training

White (2013) surveyed 169 graduate students and 38 training directors across 307 APA-accredited clinical and counseling psychology training programs with respect to their opinions and practices related to cultural competence training. All training directors reported that their programs integrated multiculturalism into training practices. The majority (86.8%) of training directors indicated that multicultural competence was considered in student evaluations, while a small portion (13.2%) reported that their programs directly assesses multicultural competence in students. In addition, the number of multicultural courses completed, years of multicultural clinical experience, number of clients seen from culturally different backgrounds, perceived levels of importance for multiculturalism, and a program's multicultural course requirements were all positively associated with graduate students' self-identified levels of cultural competence.

School Psychology Training

Rogers (2005) reviewed empirical survey data up to the time of her writing on the characteristics of exemplary programs for multicultural school psychology training. Her analyses revealed that exemplary school psychology training programs infused multicultural topics throughout courses, offered specific courses in diversity and minority issues, provided exposure to and actual contact with diverse clients during practica and internship experiences, assessed students' cross-cultural competencies, and engaged students in active and productive research programs that focused on diversity issues.

Clinical Psychology Resources and Publications

A select chronological sampling of seminal books and articles that offer education and guidance to clinical psychologists in working with racial, ethnic, and culturally diverse populations is listed in Table 2.1.

In addition, a sizeable number of scholarly journals oriented to clinical psychology audiences have been created to deal almost exclusively with racial, ethnic, and cultural issues in the field. These include *Cultural Diversity and Ethnic Minority Psychology*; *Hispanic Journal of Behavioral Sciences*; *Journal of Gender, Culture, and Health*; *Journal of Black Psychology*; *Psychoanalysis, Culture, and Society*; *Journal of Cross-Cultural Psychology*; *Asian American Journal of Psychology*; and *Journal of Cultural Diversity*.

School Psychology Resources and Publications

The most accessible source of cultural competence advocacy for school psychologists is the

Table 2.1 Chronology of select seminal publications on cultural competency issues for clinical psychology audiences

Year published	Authors/editors	Article/text/publisher
1982[a]	McGoldrick, M., Pearce, J.K., & Giordano, J. (Eds.)	*Ethnicity and Family Therapy*. New York, NY: Guilford Press
1998	Kazarian, S.S. & Evans, D.R. (Eds.)	*Cultural Clinical Psychology: Theory, Research, and Practice*. New York, NY: Oxford University Press
2000[a]	Dana, R.H. (Ed.)	*Handbook of Cross-Cultural and Multicultural Personality Assessment.* New York, NY: Lawrence Erlbaum
2002	Ferraro, F.R. (Ed.)	*Minority and Cross-Cultural Aspects of Neuropsychological Assessment*. The Netherlands: Swets & Zeitlinger
2004	Echemendia, R.J. (Ed.)	Special Issue: Cultural diversity. *Applied Neuropsychology, 11*(1)
2012	Bernal, G. & Rodriguez, M. (Eds.)	*Cultural Adaptations: Tools for Evidence-Based Practice with Diverse Populations*. Washington, DC: American Psychological Association
2014	Huey, S.J., Tilley, J.L., Jones, E.O., & Smith, C.A.	The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10*, 305–338
2016	Tummala-Narra, P.	*Psychoanalytic theory and cultural Competence in psychotherapy*. Washington, DC: American Psychological Association
2016	Zane, N., Bernal, G., & Leong, F.	*Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical strategies*. Washington, DC: American Psychological Association

[a]Multiple Updated Editions have been published

NASP cultural competence website http://www.nasponline.org/resources/culturalcompetence/. On this page, cultural competence is defined as

> . . . a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations . . . Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

The cultural competence page also contains an official statement from NASP supporting the organization's commitment to culturally competent practice (in addition to other diversity-related position statements); personnel directories, discussion boards, and contact information for sexual orientation and race-/ethnically specific committees and interest groups; links to multicultural and bilingual school psychology training programs; links to books, articles, and training videotapes on racial/ethnic diversity issues; information on minority scholarships; and information on how and where to obtain state certification in bilingual school psychology.

Rogers and Lopez (2002) published a study that comes closest to representing the prototype for an empirical approach for identifying and understanding cultural competences in school psychology. These researchers used a Delphi technique (Hsu & Sandford, 2007) to build consensus among professionals in the field as to the specific cross-cultural competencies needed for practice. Here, surveys were sent to a national sample of school psychology faculty, practitioners, and school administrators previously known for their expertise in cross-cultural service issues, 62% of whom belonged to a racial/ethnic minority group. The initial survey asked respondents to rate a group of cultural competencies identified from the academic literature, as well as generate their own competencies gleaned from experience. This yielded 260 distinct items, which were collated and sent to the same respondents in a second round of surveys. In this second round, respondents rated the

importance of each competency, which eventually reduced the list to 102 competencies representing 14 major domains of practice (e.g., academic interventions, assessment, consultation, counseling, culture, language, laws and regulations, organizational skills, professional characteristics, report writing, research methods, theoretical paradigms, working with interpreters, and working with parents).

A select chronological sampling of seminal books and articles that offer education and guidance to school psychologists in working with racial, ethnic, and culturally diverse populations is listed in Table 2.2. In addition, the journal *School Psychology International* publishes articles that highlight mental health, educational, therapeutic, and support services to schools and their communities throughout the world.

Counseling Psychology Resources and Publications

Pedersen (1990) was the first to coin the phrase "multiculturalism as a fourth force" in psychological counseling. The phrase suggests that it represents a significant paradigm that equals in importance previous movements represented by psychoanalysis (the first force), behaviorism (the second force), and humanistic/person-centered psychology (the third force).

Most recently, social justice has been called the "fifth force" among counseling paradigms (Ratts, 2009).

The two most comprehensive source of multicultural competence advocacy for counseling psychology is the American Counseling Association (ACA) competencies website https://www.counseling.org/knowledge-center/competencies and the APA website http://apa.org/. Cultural competence is defined as:

> The ability to engage in actions or create conditions that maximizes the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effetely to develop new theories, practices, polices, and organizational structures that are more responsive to all groups. (D. W. Sue & Torino, 2005)

The ACA's competencies page contains information on providing competent counseling services to the LGBTQQI community and multicultural populations. In addition, the APA page contains guidelines and practices on multicultural counseling, education, training, research, and practices; sexual minority, ability status, and race-/ethnically specific task force and interest groups; link to multicultural counseling training programs; links to articles, books, and training guides on racial/ethnic issues; information on minority scholarships, grants, and fellowships; links to advocacy issues, minority congressional caucus, and minority health; and personnel directories and contact information for cultural minority issues.

Sue & Sue (2013) describe cultural competence in counseling psychology as an active, developmental, and ongoing process, making it aspirational rather than a product. The multicultural competencies, commissioned by Thomas Parham, established by leading scholars in the field, and modified in the late 1990s, consist of 31 multicultural counseling competencies and standards that guide ethical practice from a multicultural and culturally specific approach (American Psychological Association, 2003; Arredondo & Perez, 2006; Sue et al., 1982; Sue, Arredondo, & McDavis, 1992; Sue et al., 1998). The competencies are organized in three domains: (a) counselors awareness of own cultural value and biases (attitudes and beliefs), (b) counselor awareness of clients worldview (knowledge), and (c) culturally appropriate interventions strategies (skills). For more lengthy justification and explanatory statements for these competencies, refer to Arredondo et al. (1996) and Sue et al. (1992).

A select chronological sampling of seminal books and articles that offer education and guidance to counseling psychologists in working with racial, ethnic, and culturally diverse populations is listed in Table 2.3.

Table 2.2 Chronology of select seminal publications on cultural competency issues for school psychology audiences

Year published	Authors/editors	Article/text/publisher
1970	Zach, L.	Training psychologists for the urban slum school. *Psychology in the Schools, 7*, 345–350
1977	Oakland, T. (Ed.)	*Psychological and educational assessment of minority children*. New York: Brunner/Mazel
1988	Jones, R.	*Psychoeducational assessment of minority group children: A casebook*. Berkeley, CA. Cobb & Henry
1990	Barona, A. & Garcia, E. (Eds.)	*Children at risk: Poverty, minority status, and other issues in educational equality.* Washington, DC: National Association of School Psychologists.
1992	Gopaul-McNicol, S. (Ed.)	*School Psychology Review* Miniseries on *Understanding and Meeting the Psychological and Educational Needs of Minority Students*, Vol. 21, No. 4.
1999	Frisby, C.L. & Braden, J.P. (Eds.)	*School Psychology Quarterly Miniseries on Straight Talk About Cognitive Assessment and Diversity*, Vol. 14, No. 3
2000	Ingraham, C.L. & Meyers, J. (Eds.)	*School Psychology Review* Miniseries on *Multicultural and Cross-Cultural Consultation in Schools*, Vol. 29, No. 3
2002	Marshall, P.L. (2002)	*Cultural diversity in our schools*. Belmont, CA: Wadsworth/Thomson
2004	Nastasi, B.K., Moore, R.B., & Varjas, K.M.	*School-based mental health services: Creating comprehensive and culturally-specific programs*. Washington, DC: American Psychological Association
2005	Frisby, C.L. & Reynolds, C.R. (Eds.)	*Comprehensive handbook of multicultural school psychology*. Hoboken, NJ: Wiley
2005	Rhodes, R., Ochoa, S.H., & Ortiz, S.O. (Eds.)	*Assessing culturally and linguistically diverse students: A practical guide*. New York: Guilford Press
2006	Jimerson, S.R., Oakland, T., & Farrell, P.T. (Eds.)	*The handbook of international school psychology*. Thousand Oaks, CA: Sage
2007	Esquivel, G.B., Lopez, E.C., & Nahari, S.	*Handbook of multicultural school psychology: An interdisciplinary perspective*. Mahwah, NJ: Erlbaum
2008	Martines, D.	*Multicultural school psychology competencies: A practical guide*. Thousand Oaks, CA: Sage
2009	Jones, J.M. (Ed.)	*The psychology of multiculturalism in schools: A primer for practice, training, and research*. Bethesda, MD: National Association of School Psychologists
2010	Clauss-Ehlers, C.S. (Ed.)	*Encyclopedia of cross-cultural school psychology*. New York, NY: Springer
2013	Clauss-Ehlers, C.S., Serpell, Z.N, & Weist, M.D. (Eds.)	*Handbook of culturally responsive school mental health: Advancing research, training, practice, and policy*. New York, NY: Springer
2013	Frisby, C.L.	*Meeting the psychoeducational needs of minority children: Evidence-based guidelines for school psychologists and other school personnel. New York, NY: Wiley*
2016	Graves, S.L., & Blake, J.J.	*Psychoeducational Assessment and Intervention for Ethnic Minority Children: Evidence-Based Approaches.* Washington, DC: American Psychological Association

Table 2.3 Chronology of select seminal publications on cultural competency issues for counseling psychology audiences

Year published	Authors/editors	Article/text/publisher
1976[a]	Pedersen, P., Lonner, W.J., Draguns, J.G. (Eds.)	*Counseling Across Cultures*. Honolulu, HI: University Press of Hawaii
1981[a]	Sue, D.W.	*Counseling the Culturally Different: Theory and Practice*. New York, NY: Wiley and Sons
1991	Ponterotto, J.G.	*Handbook of Racial/Ethnic Minority Counseling Research.* Springfield, IL: Charles C. Thomas
1992	Sue, D.W., Arredondo,P., McDavis, R.J.	Multicultural Counseling Competencies and Standards: A Call to the Profession. *Journal of Counseling & Development, 70, 477–486*
1995[a]	Ponterotto, J.G., Casas, J.M., Suzuki, L.A., Alexander, C.M. (Eds.)	*Handbook of Multicultural Counseling.* Thousand Oaks, CA: Sage
1996	Sue, D.W., Ivey, A.E., Pedersen, P.B.	*Theory of Multicultural Counseling and Therapy*. Boston, MA: Cengage Learning
1998	Sue, D.W., Carter, R.T., Casas, J.M., Fouad, N.A., Ivey, A.E., Jensen, M., LaFromboise, T., Manese, J.E., Ponterotto, J.G., Vasquez-Nutall, E.	*Multicultural Counseling Competencies: Individual, professional and organizational development.* Thousand Oaks, CA: Sage
1999	Pedersen, P. (Ed.)	*Multiculturalism as a Fourth Force*. Philadelphia, PA: Brunner/Mazel
2000[a]	Perez, R., DeBord, K., Bieschke, K. (Eds.)	*Handbook of Counseling and Psychotherapy with Gay, Lesbian, and Bisexual Clients*. Washington, DC: American Psychological Association
2005	Carter, R.T. (Ed.)	*Handbook of Racial-Cultural Psychology and Counseling (Vols 1 & 2).* New York, NY: John Wiley & Sons
2006	Toporek, R.L., Gerstein, L.H., Fouad, N.A., Roysircar, G., Israel, T.	*Handbook for Social Justice in Counseling Psychology: Leadership, Vision, and Action*. Thousand Oaks, CA: Sage
2012	Gallardo, M.E., Yeh, C.J., Trimble, J.E., Parham, T.A.	*Culturally Adaptive Counseling Skills.* Thousand Oaks, CA: Sage
2013	Liu, W.M (Ed.)	*The Oxford Handbook of Social Class In Counseling*. New York, NY: Oxford University Press
2016	Ratts. M.J., Singh, A.A., Nassar-McMillan, S., Butler, S.K., McCullough, J.R.	Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*, 28–48

[a]Multiple Updated Editions have been published

Comparing and Contrasting the Three Applied Psychology Areas in Their Approach to Cultural Competence Advocacy

Common Themes

All American Psychological Association (APA) members and state-licensed psychologists are bound to adhere to the APA's Code of Professional Ethics (American Psychological Association, 2017), which includes any material related to serving persons from culturally diverse groups. However, specifics of ethical codes for psychologists are open to a variety of different interpretations – including interpretations that may uncover a lack of clarity in the codes themselves (e.g., see O'Donohue & Ferguson, 2003).

The first theme that unites cultural competence advocacy across applied psychology disciplines is the often unspoken yet obvious impression that cultural competency messages are, for all practical purposes, directed toward

English-speaking Whites. Specifically, target audiences for cultural competency are educated middle-class Whites currently enrolled in – or having graduated from – training programs for professional psychologists. This comes as no surprise, as demographic data on pre- and in-service psychologists validate Whites' numerical dominance (e.g., see Hamp et al., 2016; Lin et al., 2015). The choice of topics chosen to educate audiences in cultural competency feature a gallery of groups presumed to be "disadvantaged," "oppressed," "ignored," "victimized," "misunderstood," "marginalized," or "underserved" – which by implication includes groups that are fundamentally not English-speaking or White. As will be discussed in the next section, applied psychology areas differ considerably as to the attention given to groups circumscribed by nonracial variables (e.g., gender, religion, immigration status, sexual orientation, disability status).

A second common theme that ties together the treatment of cultural competency across clinical, school, and counseling psychology is the hope that mental health problems impacted by social issues involving culturally different groups have applied psychological solutions. That is, by training pre- and in-service psychologists to embrace the content, philosophy, methods, and dispositions of the cultural competence movement, the hope is that culturally different groups will finally be treated fairly, will be more prone to seek out psychological and mental health services, will receive higher quality services, and will experience better outcomes (Sue, Zane, Hall, & Berger, 2009; Zane, Bernal, & Leong, 2016).

A third common theme that ties together applied psychology's approach to cultural competence is the implicit belief in the validity of *culture x treatment interactions* (CTI; see Frisby, 2013). In statistics, an interaction effect is said to be present whenever the impact of one independent variable on a dependent variable differs depending on the level of another variable (Jaccard & Turrisi, 2003). In cultural competence theory, the word "culture" is most often (but certainly not always) used as a proxy for race, ethnicity, or language status. In this context, a CTI means that if psychologists interact with clients that are culturally different from themselves, they must think, feel, behave, speak, or use assessment instruments differently (than would normally be the case for clients who are not culturally different) in order for the outcomes to be successful. To do so would be viewed as an example of culturally competent services.

Areas of Difference

Despite these commonalities, each of the three applied psychology areas are noted for having their own unique "personality" with respect to which aspects of cultural competency advocacy are emphasized relative to other aspects. Although there will always be some degree of overlap among these applied psychology areas (see "Areas of Overlap" section), the unique "personality" of each applied psychology area is described below:

Clinical Psychology Federal agencies and professional organizations issue guidelines that specify "best practices" for addressing a given medical problem or mental health disorder. The Agency for Healthcare Research and Quality, in partnership with the American Medical Association and the American Association of Health Plans Foundation, produces The National Guidelines Clearinghouse, which is a publicly available database of evidence-based clinical practice guidelines and related documents (accessed at https://www.guideline.gov/). These guidelines indicate the level or quality of the evidence supporting practice recommendations and frame treatment recommendations nomothetically (Spring, 2007).

Spring (2007) defines evidence-based practice (EBP) as "the conscientious, explicit, judicious use of current best evidence in making decisions about the care of individual patients" (p. 611). The APA Presidential Task Force on evidence-based practice coined the acronym EBPP (evidence-based practice in psychology) in referring to "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences"

(p. 273). Empirically supported treatments (EST), in contrast, are compiled based on psychological interventions rather than clinical problems (for applications of EBT to psychology, see Chambless & Hollon, 1998; Chambless & Ollendick, 2001).

Division 12 of APA (Society of Clinical Psychology) adopted Cochrane's (1979) call for evidence-based practice in developing guidelines for empirically validated treatments (EVTs; see Zane et al., 2016). In 2005, the American Psychological Association adopted a policy statement on evidence-based practice in psychology (APA Presidential Task Force on Evidence-Based Practice, 2006). This document states:

> EBPP requires attention to many other patient characteristics, such as gender, gender identity, culture, ethnicity, race, age, family context, religious beliefs, and sexual orientation . . . these variables shape personality, values, worldviews, relationships, psychopathology, and attitudes toward treatment. A wide range of relevant research literature can inform psychological practice, including ethnography, cross-cultural psychology . . . , cultural psychology . . . , cultural psychiatry . . . , psychological anthropology . . . , and cultural psychotherapy . . . Culture influences not only the nature and expression of psychopathology but also the patient's understanding of psychological and physical health and illness. Cultural values and beliefs and social factors . . . also influence patterns of seeking, using, and receiving help; presentation and reporting of symptoms, fears, and expectations about treatment; and desired outcomes. (p. 279)

Of the three applied psychology areas, researchers in clinical psychology have most closely attended to these guidelines in evaluating the efficacy of services for racial/ethnic minority populations using appropriate quantitative methods. As such, clinical psychology is arguably the most scientific in its general approach to academic writing in cultural competency (e.g., see Zane et al., 2016).

A number of scholars from clinical psychology have attempted to reconcile the EBPP movement with the cultural competency movement as applied to psychotherapy and other clinical outcomes. These scholars apply the latest techniques in meta-analysis to summarize extant evidence on treatment outcomes for studies that employ ethnic minority samples (e.g., see Barrera, Castro, Strycker, & Toobert, 2013; Griner & Smith, 2006; Healey et al., 2017; Huey, Tilley, Jones, & Smith, 2014). However, such studies often involve nuanced distinctions. For example, Lau, Chang, Okazaki, and Bernal (2016) make careful distinctions between studies of evidenced-based practices (i.e., interventions validated on majority samples) with cultural minority samples; studies of culturally adapted interventions (i.e., treatments that retain most features of an original intervention but alter a component for a better fit with a cultural group); and studies of culturally sensitive therapies (CSTs; defined as healing traditions, indigenous folk practices specific to certain cultural groups) with minority samples.

As an outgrowth of this research, culturally competent practice involves the following recommendations (adapted from Huey et al., 2014): (1) adopt evidence-based treatments in their original form but incorporate cultural content only if it is already part of the treatment protocol, (2) use cultural adaptation models with clear implementation protocols and acceptable levels of empirical support (p. 329), (3) use empirically supported skills-based or process-oriented approaches to cultural competence, and (4) individualizing treatment to match the specific needs of ethnic minority clients. All four approaches are elaborated in Huey et al. (2014), along with a discussion of their advantages and disadvantages.

School Psychology Of the three applied areas, school psychology is arguably the discipline that most closely bases cultural competency advocacy primarily on concerns over the meaning and interpretation of disproportionality statistics. Although school psychologists are trained to deliver a variety of direct and indirect services to school populations, their work is primarily associated with psychoeducational assessment for special education eligibility determinations (Brown, Holcombe, Bolen, & Thomson, 2006; Watkins, Crosby, & Pearson, 2001). Within these assessment activities, intelligence (IQ) testing is the activity that occupies the bulk of school psychologists' assessment time (Shapiro & Heick, 2004).

However, intelligence tests have been subjected to intense criticism since their widespread use, primarily because IQ scores reveal significant and stubborn average mean differences across racial/ethnic population subgroups (Rushton & Jensen, 2005). The interpretation of these differences has split the school psychology academic community. On one side are scholars who argue that such differences reflect cultural test bias and thus do not provide an accurate assessment of the cognitive capabilities of cultural minority groups, and additionally leading to inappropriate placements of minority children in special education (Codrington & Fairchild, 2012) or unacceptably low proportions of children from certain groups who are identified as gifted (Gottfredson, 2004; Grissom & Redding, 2016). These scholars advocate for alternative assessment methods, instruments, and interpretive schemes that would presumably be more fair to individuals from culturally different groups (e.g., Armour-Thomas & Gopaul-McNicol, 1998; see summary in Frisby, 2013, chapter 6; Tzuriel, 2001; Utley, Haywood, & Masters, 1991). On the other side are scholars who have argued that scores obtained from intelligence tests are not culturally biased and provide accurate assessments for all English-speaking American-born population groups (e.g., Brown, Reynolds, & Whitaker, 1999; Gordon & Rudert, 1979; Gottfredson, 1997; Jensen, 1980). These scholars and others argue that alternative cognitive assessment and interpretation techniques introduce more problems than they solve (e.g., see summary in Frisby, 2013, Table 6.1, pp. 270–272).

School psychology has also focused attention on the meaning and implications of statistical disproportionalities in special education placement in schools (Harry & Klingner, 2014; Noltemeyer & McLoughlin, 2012) and racial/ethnic disproportionalities in school discipline referrals and punishments (Kunesh & Noltemeyer, 2016; Skiba et al., 2014; Skiba, Eckes, & Brown, 2010; Skiba, Michael, Nardo, & Peterson, 2002). Within this context, cultural competency advocacy means that psychologists use assessment instruments and techniques that are presumed to be "fair" and "nondiscriminatory" with the hope that such methods will reduce disproportionalities in negative outcomes (Graves & Blake, 2016; Lopez, 2008; Rhodes, Ochoa, & Ortiz, 2005; Valencia & Suzuki, 2000). In addition, culturally competent school psychologists are expected to assist teachers, administrators, and schools to be more culturally sensitive in responding better to the cultural needs of students and families (Elizalde-Utnick & Guerrero, 2008; Ingraham, 2000; Jones, 2008; Lopez, 2000).

Counseling Psychology Of the three areas, counseling psychology adopts the most explicit ideologically oriented approach to cultural competency. By ideologically oriented, we mean that counseling psychology openly promotes a sociopolitical viewpoint that counseling psychologists must embrace and adopt if they are to be considered culturally competent by mainstream thinking within the profession. This viewpoint views race and ethnicity as "primordial" in determining the most important client characteristics to which counselors must attend (Carter, 2005; Helms, 2007; Helms & Cook, 1998) while promoting awareness of other demographic characteristics that are typically underemphasized in counseling (Casas, Suzuki, Alexander, & Jackson, 2017; Sue & Sue, 2016). Culturally competent counselors are expected to be keenly aware of racial/ethnic conflicts and sensitivities in multiracial societies (Liao, Hong, & Rounds, 2016; Shouhayib, 2015; Sue, 2010; Williams, 2013). Within an American context, this involves counselors recognizing their "white privilege," unconscious biases, and racism toward non-White groups, ways in which they have intentionally or unintentionally harmed non-Whites, and how prejudice, racism, and discrimination affect mental health (Ancis & Szymanski, 2001; Chou, Asnaani, & Hofmann, 2012; Cokley, Hall-Clark, & Hicks, 2011; Miserocchi, 2014; Panko, 2017; Ridley, 2005; Sue, 2003; Utsey, 1998). Culturally competent counseling psychologists are also expected to be sympathetic to the goals of "social justice," which requires an awareness of how privileged, powerful groups oppress less privileged and less powerful groups in society (Goodman et al., 2004; Motulsky, Gere, Saleem, &

Trantham, 2014; Ratts & Pedersen, 2014). Furthermore, a current trend in counseling psychology is to encourage psychologists to be actively involved in social justice efforts outside of strictly professional roles (Bradley, Werth, & Hastings, 2012; Donald & Moro, 2011).

Areas of Overlap

We want to be careful to note that the material discussed in the previous section reflects very broad generalizations. The boundaries between the three applied psychology areas are not rigid or impermeable, as sub-specializations within each discipline have overlapping areas of mutual interest (e.g., school psychology, child clinical psychology, school counseling), and scholars within each of the applied areas freely cite and borrow from the intellectual contributions of scholars from their cousin disciplines. As such, clinical psychologists will often devote their scholarship to interpreting the meaning of racial/ethnic disproportionalities (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009; Sue et al., 2009; Yamada & Brekke, 2008), writers in school psychology will advance models of social justice advocacy (Shriberg, Song, Miranda, & Radliff, 2013; Speight & Vera, 2009), and counseling psychologists will apply rigorous methods of quantitative analysis in answering scientific questions (Peterson, 2013; Quintana & Minami, 2006; Worthington, Soth-McNett, & Moreno, 2007).

Conclusion

This review leaves little doubt that multiculturalism, diversity, and cultural competency are "hot topics" that will be promoted within applied psychology for some time to come. In crafting this review, however, we have been careful to suspend any critical evaluations of this movement from sources both inside and outside of applied psychology. This broad topic is addressed at length in the chapters highlighted in the next two sections of this text.

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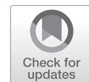
Part II

Evaluation of Cultural Competence Advocacy



3 History and Development of Cultural Competence Evaluation in Applied Psychology

Craig L. Frisby

The history and development of cultural competence (CC) research and advocacy have advanced to the point where, at the time of this writing, it is a ubiquitous concept that is aggressively promoted by the federal government; professional groups representing various branches of applied psychology, social work, healthcare, education, and business; academic/training institutions and their accrediting bodies; state/national boards that license and certify applied psychologists; as well as the agencies that employ psychologists and counselors who deliver mental health services to the general public (see previous chapter). As a result, publications on the topic assume implicitly that the existence, validity, and benefits of cultural competence are "settled law", and that the issue of pressing concern is how to train practitioners to "get it" and subsequently deliver its benefits more efficiently and effectively to the general public.

This chapter covers the history and development of a parallel movement in applied psychology that has seriously questioned many of the implicit and explicit assumptions that support cultural competence theory and advocacy. These criticisms originate from sources both within applied psychology and from various sources outside of applied psychology. These criticisms of CC can be broadly subdivided into two somewhat correlated categories: (1) criticisms that question and/or call into doubt the fundamental construct validity of the CC concept and (2) criticisms based on assumptions that fundamentally support the construct validity of CC, but are offered as a means for improving its conceptualization, measurement, and/or application.

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Criticisms that Undermine Cultural Competence (CC) Theory/Advocacy

A construct can be defined as a skill, attribute, or ability that is based on one or more established theories (Study.com, 2017; see also Slaney, 2017, for a more in-depth discussion and analysis). The concept of "construct validity" has traditionally been discussed within psychology as an attribute of a test or assessment instrument in measuring entities that are largely unobservable (Smith, 2005). In the context of this chapter, construct validity refers to the extent to which cultural competence is clearly articulated in theory, as well as reliably observed to exist in real-life practice.

A number of critics have described numerous shortcomings of CC theory and advocacy that are so fundamental as to cast doubt on its construct validity. These criticisms can be categorized as originating from semantic, logical/conceptual, empirical, philosophical, pedagogical, and professional best practices perspectives - each of which are briefly described below.

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Semantic Critiques

Critiques within this category essentially argue that key words and phrases frequently used in CC advocacy are poorly and/or inaccurately defined when examined closely. When this happens, words function as euphemisms instead of as direct referents, communication lacks clarity, and the use of poorly defined terms distorts an accurate picture of conditions as they actually occur in the "real world."

Culture/Cultural Differences The word "cultural" functions as an adjective that modifies the noun "competence." There is a general agreement among social science historians that the root word "culture" (and its derivatives) is arguably one of the most difficult terms to define with precision. Kroeber and Kluckhohn (1952) compiled approximately 150 working definitions of culture found in a variety of disciplines up to publication of their book. Four decades later, Baldwin and Lindsley (1994) published a compilation of 200 definitions of culture. A little over two decades later, Baldwin, Faulkner, Hecht, and Lindsley (2006) published a list of more than 300 definitions of culture.

These compilations highlight four important observations: First, the serious study of culture occurs within sub-disciplines whose primary focus is in understanding the dynamics of the culture concept (cultural anthropology, cultural sociology, cultural psychology). Second, culture is an *extremely* difficult concept to define. As quoted in Trimble (2007):

> Although people may be able to achieve a modicum of consensus on what culture is in general, the agreement seems to fall apart when scholars attempt to break down its meaning into some reasonably well-defined components … the [culture] construct often is used too casually for descriptions of the human condition … "culture" is a summary label, a catchword for all limits of behavioral differences between groups, but within itself [has] virtually no explanatory value. (p. 248)

Trimble (2007) then proceeds to quote Geertz (2000), who in turn writes:

> [T]he trouble is that no one is quite sure what culture is. Not only is it an essentially contested concept … it is fugitive, unsteady, encyclopedic, and normatively charged, and there are those … who think it vacuous altogether, or even dangerous, and would ban it from the serious discourse of serious persons. (p. 11, as quoted from Trimble, 2007, p. 248)

Third, among serious culture theorists, "culture" is not so much viewed as a static, unalterable entity needing to be accurately captured by any one definition. Rather, culture is viewed as a constantly evolving and fluid entity which requires definitions to adaptively shift over time in concert with emerging developments in particular disciplines. Although some sources within applied psychology candidly acknowledge that precise definitions of "culture" will always be elusive (see US Department of Health and Human Services, 2001, p. 7), it is *de rigueur* for applied social science publications to portray culture as being captured by a static definition to which practitioners must adhere (e.g., see American Psychiatric Association, 2013; American Psychological Association, 2003; Schim & Doorenbos, 2010). Fourth, since contemporary culture definitions must incorporate insights from the accumulation of decades of study on culture, proffered definitions tend to be highly abstract. As examples:

- "Cultures … are not material phenomena; they are cognitive organizations of material phenomena" (Tyler, 1976, p. 177).
- "One useful way to think about culture is to think of unstated assumptions, standard operating procedures, ways of doing things that have been internalized to such an extent that people do not argue about them" (Triandis, 1994, p. 16).
- "By approaching culture through the use of the idea of hegemony, culture can be conceptualized as a space within which struggles between social forces are conducted" (Smith, 2000, p. 81).

In contrast, "culture" has a considerably more simplified and concrete meaning when used in contemporary applied psychology, generally, and in the cultural competence movement, specifically. For all practical purposes, "culture" simply serves as an easy euphemism for racial, ethnic, or language group membership. By extension, the

term "cultural differences" functions as a softer and much more gentle phrase that is popularly used to connote simple differences in racial, ethnic, or language group membership.

Although such concrete connotations may make communication easier within applied psychology, many have argued that this does not accurately reflect the complexities of everyday American life (e.g., see Naylor, 1998; Wood, 2003). On this point, Triandis (2007) writes:

> Attributes such as nationality, religion, race, or occupation are not appropriate criteria for defining cultures. The use of a single criterion is likely to lead to confusion, as would happen if all people who eat pizza were placed in one category. Culture is a complex whole, and it is best to use many criteria to discriminate between one culture and another. (p. 65)

Stuart (2004) argues this point looking through a developmental lens, in which he writes:

> Parenting is the ultimate form of socialization, through which children learn how to function in society. But parents vary in their ability and desire to transmit cultural beliefs to their children, and children are not passive recipients of their parents' values and practices. This explains the fact that the culture with which young adults leave their families of origin is rarely a carbon copy of parental beliefs, making for a diversity of characters at every family reunion. (p. 4)

This quote points to the truism that cultural differences are *multidimensional, not unidimensional*, a point that is acknowledged – at least in passing – by most cultural competence advocates. Frisby (2005b) argues that it is more accurate to acknowledge that two or more persons can be culturally similar (according to one set of criteria) and culturally different (according to another set of criteria) *at the same time*, depending on which criteria are under consideration. As an illustration, Hispanic and Anglo comrades who are childhood friends growing up in the same city neighborhood may be "culturally different" with respect to their ethnic group membership, yet be "culturally similar" when it comes to their formative neighborhood socialization experiences. As a result, the notion that persons A and B are "culturally different" *in all areas* – simply because they belong to two different racial or ethnic groups – is a gross oversimplification of complex reality (see Frisby, 1996). Stuart (2004) writes:

> …[E]very individual is a unique blend of many influences. Whereas culture helps to regulate social life, specific beliefs are products of individuals' minds. Because of this complexity, it is *never* safe to infer a person's cultural orientation from knowledge of any group to which he or she is believed to belong.

It has become *de rigueur* for cultural competence articles, chapters, and books to assert as a fundamental principle that "everybody has a culture," "we are all multicultural beings," or similar variations on this idea (e.g., see American Psychological Association, 2003, p. 382; Ratts & Pedersen, 2014, p. 13). Many writers who are faced with the task of defining "culture" discover quickly that many variables other than race are implied by the concept. As an example, the APA Task Force on Evidence-Based Practice (2006) defines "culture" as follows:

> Culture, in this context, is understood to encompass a broad array of phenomena (e.g., shared values, history, knowledge, rituals, customs) that often result in a shared sense of identity. Racial and ethnic groups may have a shared culture, but those personal characteristics are not the only characteristics that define cultural groups (e.g., deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social, class, and personal characteristics that make each patient unique. (p. 278)

This "tension" between the need to provide a concise definition of culture – balanced against the need to encompass all of its complex attributes – creates a definitional conundrum. When culture is then defined so broadly as to encompass everything, then it comes to mean nothing.

Competence As a noun, "competence" can be defined as the ability to do something well, successfully, or efficiently. It is the quality or state of being functionally adequate or capable, as when an individual possesses sufficient knowledge or skill to carry out a task or to do one's job (https://www.merriam-webster.com/dictionary/competence). Synonyms for competence include "capability," "facility," "prowess," "skill," "effectiveness,"

"fitness," "usefulness," or "talent." Antonyms for competence include "disability," "inability," "ineptitude," "impotence," or "inadequacy" (https://www.merriam-webster.com/thesaurus/competence).

Frisby (2009, p. 867, adapted from Jensen, 1992) argues that in order to objectively measure competence within any area, eight conditions must be met: First, the construct to be measured must involve *observable units of behavior* that results in some type of product (i.e., something spoken, written, created, or acted out). If a construct does not manifest itself with something that can be observed, then by implication it cannot be measured. Thus, unobservable constructs such as "attitudes," "knowledge," "dispositions," "sensitivities," and "awareness" do not meet this criterion (unless they result in observable products, behaviors, or verbalizations). Second, the behavior to be measured must be intentional, as opposed to an involuntary reflex. Third, there must be a high degree of agreement among different observers that the behavior of interest has occurred. Fourth, the units of behavior must be classifiable (e.g., judged as poor, fair, or excellent) or quantifiable in terms of a clear standard (e.g., solving 90% of math problems on a worksheet, putting a puzzle together within a given time limit). Fifth, there must be a high degree of agreement among different observers in judging the quality of the behavior. Sixth, the behaviors to be measured must be clearly demonstrated across fairly fixed conditions for all respondents, so that individual differences in performance can be attributed to differences in skill level rather than to differences inherent within the conditions of measurement/observation. Seventh, the units of behavior must demonstrate some degree of consistency and temporal stability (as opposed to displaying random patterns), so that mastery can be inferred.

These previous two criteria would be particularly difficult to meet given the almost infinite variation in the combination of client characteristics (e.g., age, gender, personality type, disability, personal history); the nature of clients' presenting problems, external factors influencing conditions for counseling/therapy (e.g., school-related vs. daily living problems, court-ordered vs. voluntary counseling, group vs. individual counseling); or the length of counseling/therapy (e.g., brief therapy spanning a few sessions vs. extended therapy spanning years). In short, the conditions under which mastery is inferred must be standardized to some degree. Eighth, consistency must be displayed across similar classes of observable behaviors, in order to infer a generalized ability.

According to Frisby (2009), there exist no published measures or clinical observation protocols that would enable psychologists to reliably evaluate a person's cultural competence in cross-cultural situations according to all eight of these criteria. Thus, when "culture" and "competence" are combined and the definitional challenges of both words are taken seriously, then a compelling case can be made that efforts to clearly understand the meaning of the phrase "cultural competence" are akin to trying to grasp smoke. This perception is echoed by Kleinman and Benson (2006), who write:

> Cultural competency has become a fashionable term for clinicians and researchers. Yet no one can define this term precisely enough to operationalize it in clinical training and best practices (p. 1673).

Some describe cultural competency as an ethereal entity that one is always pursuing but can never be fully attained. According to the Center for Substance Abuse Treatment (2014), "Gaining cultural competence, like any important counseling skill, is an ongoing process that is never completed; such skills cannot be taught in any single book or training session" (p. 2). For additional commentary on the difficulty of defining cultural competence, readers are encouraged to consult DeAngelis (2015) and Grant, Parry, and Guerin (2013).

Logical/Conceptual Critiques

Critiques within this category identify logical problems, conceptual problems, or a combination of both in the quality of the reasoning used to support cultural competence advocacy. Logical critiques draw from the principles of formal and informal logic (Bennett, 2015; McInerny, 2004) to find cultural competence arguments to be disingenuous, illogical, or invalid. Justification for

cultural competence advocacy and training has also been critiqued on the basis of its lack of conceptual clarity. This occurs when arguments use vague and/or ill-defined concepts or fail to provide strong and/or persuasive reasons to believe the conclusions.

Narratives are the raw material of the cultural competence movement to which a logical examination can be applied. In science, knowledge claims are established through data gathering, observation, measurement, statistical analysis, replication, and independent verification (Chang, 2014). In contrast, narratives are stories that function as a "received wisdom," which (either intentionally or unintentionally) circumvents the need for objective, independent research. Narratives provide audiences with predigested answers that determine what does or does not constitute a problem, what problems are perceived as more or less important, or how issues are interpreted and framed. The ultimate purpose for narratives is to persuade audiences to think a certain way, believe in certain ideas, develop an attitude for or against something, or motivate action on behalf of an issue.

Braden and Shah (2005) review and evaluate "multicultural training" (which for all practical purposes is synonymous with cultural competence training) research in school psychology by first stating the three fundamental mini-narratives that undergird this movement. These are:

1. Students from diverse racial, ethnic, or linguistic backgrounds in the United States have specialized educational and psychological needs that in turn require school psychologists to develop multicultural competencies.
2. Most educational problems of minority students can be ultimately attributed to an inability to understand cultural differences (i.e., cultural insensitivity) on the part of European American clinicians. Therefore, students and families of color should be served by psychologists of the same racial and ethnic backgrounds so they feel most comfortable and can achieve maximum success.
3. The evidence supporting the necessity of multicultural training and services is uncontestable; those who question its value are motivated to do so by racism.

Examining Unstated Assumptions An important skill in thinking logically and critically is to examine arguments for the presence of assumptions that are implicit in the argument but are not explicitly stated (Brookfield, 2012). A large part of what causes narratives to be problematic are the unstated assumptions that, when exposed and evaluated, deflate the persuasiveness of the narrative (e.g., see Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). In the previous section, the persuasiveness of the first Braden and Shah (2005) narrative rests on the assumption that individuals from groups that differ racially and/or ethnically necessarily require different treatments in order to be effectively served (called the *Difference Doctrine*; see Frisby, 2013, pp. 18–9, 498–99). Frisby (2013) showed that (with the exception of interventions requiring non-English language modifications) school districts serving racially/ethnically diverse populations implement effective, "common sense" solutions to psychoeducational problems that have little or nothing at all in common with "multicultural" theories popularly espoused in academia.

The unstated assumption that undergirds Braden and Shah's (2005) second narrative is that problems disproportionately experienced by racial/ethnic groups must necessarily have "racial/ethnic" causes. However, Gottfredson (2004, 2005) reviews persuasive evidence suggesting that individual and group differences in general cognitive ability better explain most (but not all) difficulties faced by racial/ethnic minority groups in healthcare and education.

The assumption that undergirds Braden and Shah's (2005) third narrative is already explicit – namely, that empirical evidence irrefutably supports the validity and benefits of cultural competence – and thus any criticism of CC advocacy must stem from sinister and/or nefarious motives. Problems in the empirical soundness of

CC advocacy and research are addressed in greater detail in the next section (empirical critiques).

Frisby (2009) stated five implicit assumptions of the cultural competence movement in school psychology and then cited counterarguments for each that challenges their validity. The first implicit assumption is that *cultural differences between groups are inherently problematic for schools*. Frisby (2009) observes that some school settings experience serious problems resulting from racial/ethnic diversity, while other settings do not. He argues that the factors that influence the degree to which cultural differences pose problems for particular school settings are multifaceted, complex, and "setting-specific." These complexities and subtle nuances are completely ignored in light of aggressive advocacy in support of universal cultural competence training for all school psychologists.

A second implicit assumption is that *the nation's increasing diversity impacts all American schools, generally, and all school psychologists, specifically, in a uniform manner*. Most if not all books, book chapters, and articles written in support of cultural competency begin with a recitation of statistics documenting American's increasing racial/ethnic diversity (see "*History and Development of Cultural Competence Advocacy in Applied Psychology*" Chap. 1, this book). Frisby (2009) observes that the degree of cultural heterogeneity within America varies widely as a function of equally wide geographical differences among school settings and that racial/ethnic diversity per se has always been a common feature of American schooling throughout history (which begs the question as to why racial/ethnic diversity is popularly framed as a "serious problem" needing cultural competence training as a "solution").

A third implicit assumption is that *disproportionalities in social and educational problems among culturally diverse groups must have "cultural" explanations and "cultural" remedies*. Contrary to this assumption, it is IQ, not culture, which is the most powerful correlate of individual and group differences in school achievement outcomes (see Frisby, 2013, chapter 5). In addition, this assumption fails to explain why smaller subgroups within broad racial/ethnic groups experience different mean levels of academic achievement, or why students belonging to the same racial group experience different levels of academic achievement as a function of differences in schooling contexts (Frisby, 2009).

A fourth implicit assumption can be stated as follows: *Whatever school psychologists are doing currently in response to cultural diversity, it is inadequate for meeting the needs of culturally diverse groups absent specialized training in cultural competence*. Frisby (2009) cites research showing that school psychologists who deliver "traditional" assessment and special education decision-making services to children from racial/ethnic minority groups do not result in biased referral decisions, biased diagnostic/placement decisions, or biased assessments of cognitive test session behavior.

The fifth implicit assumption is that *there is a direct relationship between cultural competence and improved outcomes for culturally different clients in life*. This is the most central justification for CC training in all of applied psychology, yet it is the one assumption for which empirical evidence is virtually nonexistent (see section on Empirical Criticisms). Frisby (2009) argues that there are many complex factors that influence client outcomes in schools, the implication being that establishing the cultural competence/client outcome link is considerably challenging.

Syllogistic Reasoning One of the ways in which narratives can be evaluated for their logical soundness is to reduce their arguments into simpler syllogisms whenever possible. A syllogism consists of two brief premises (sometimes called a major and a minor premise), followed by a conclusion. One type of syllogism is the categorical syllogism, which has the following form:

(Major premise)	All A are B.
(Minor premise)	X is an A.
(Conclusion)	Therefore, X is a B.

Consider the statement "all racial and ethnic minority groups in the United States share experiences of oppression as a result of living in the

dominant White American culture" (Sodowsky, Kuo-Jackson, & Loya, 1997, p. 13). From this major premise, a categorical syllogism can be derived, the conclusion from which harmonizes with numerous texts and articles for training in cultural competence (e.g., see D'Andrea & Daniels, 2001; Ridley, 2005; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006):

(Major premise)	All US racial and ethnic minority groups experience oppression.
(Minor premise)	My counseling client is a member of an American racial/ethnic minority group.
(Conclusion)	Therefore, my counseling client has experienced oppression.

One way to evaluate the truth claim of this syllogism is to examine the content of the major premise, which can be shown to suffer from a variety of problems. First, clear communication requires that the term *oppression* be carefully defined, which represents a principle discussed in the previous section. Is oppression as used here comparable to the oppression experienced by the "untouchable" Dalit peoples of India, who are treated as practically subhuman, having their marriage and occupational choices rigidly dictated by their caste membership (Mogul, 2016), who are regularly denied access to basic healthcare and nutritional services, or whose children are not allowed to touch the meals of children from other castes in the state schools in some regions (Jadhav, 2005; Sarkar, 2014)? Is oppression as used here also comparable to how women are treated in some Muslim countries, which observe strict rules related to what women wear, their social relationships with men, how they are to act in public, and how far they can advance occupationally (Ali, 2015; Lichter, 2009)? If not, then does the occasional microaggression (see Sue, 2010) qualify as an American "oppression" that is equivalent with these other examples?

Second, this premise can be challenged on the grounds of being too broadly stated, in that there exists no study which documents the presumed oppression of every last human being belonging to a particular racial/ethnic group. Although one can conceivably find historical writings which document oppression (however defined) visited on nearly all racial/ethnic groups in the United States *in a general sense*, it does not logically follow that *all individuals* within a group have experienced the same degree of oppression, if they have experienced oppression at all.

Many writers have identified the logical problems that result from making inferences about individuals from knowledge of broad groups. Frisby (2005a, 2005b, 2013) calls this the "Group Identity Doctrine." Dreher and MacNaughton (2002) call this the "ecologic fallacy." Stuart (2004) calls this the logical flaw of "basing ideographic predictions on nomothetic data sets" (p. 5).

A second type of syllogism found in arguments is the propositional "if/then" syllogism, which is subject to a logical error called "affirming the consequent" (Bennett, 2015). The symbolic form of this logical error is given below:

(Major premise)	If A, then B
(Minor premise)	B
(Conclusion)	Therefore, A

The fallacy here lies in the assumption that the presence of B necessarily means the presence of A as the causal factor. Even though A leads to B, there could be numerous reasons that have nothing at all to do with A that could be responsible for the presence of B. This logical error can be brought into sharper focus with a simple example:

(Major premise)	All cats have fur.
(Minor premise)	This animal has fur.
(Conclusion)	Therefore, this animal is a cat.

Some critics have observed that cultural competence advocacy is built on this logical error, the syllogistic form for which is given below:

(Major premise)	The cultural competence of caregivers leads to positive outcomes for culturally diverse clients.
(Minor premise)	This culturally diverse client experienced a positive outcome.
(Conclusion)	Therefore, the caregiver was culturally competent.

The converse is also present in cultural competency advocacy:

(Major premise)	The lack of cultural competence in caregivers leads to negative outcomes for culturally diverse clients.
(Minor premise)	This culturally diverse client experienced a negative outcome.
(Conclusion)	Therefore, the caregiver lacked cultural competence.

It should be noted at the outset that the major premise in the positive and negative forms of these syllogisms assumes implicitly that cultural competence is an empirically validated construct that can be reliably measured (an issue that is discussed in subsequent sections of this chapter). Separate from this issue, however, is the issue of whether or not the conclusions are logically warranted.

In evaluating the cultural competence movement in school psychology, Frisby (2009) observes that many reasons exist for the success or failure of interventions for minority clients within schools that have nothing at all to do with the presence or lack of school psychologists' cultural competence (however defined). Such reasons include, but are not limited to, individual differences among schools in the quality of organizational resources used to help clients, individual differences in caregiver abilities and skills, or unanticipated random events that are outside the control of either caregiver or client (see also Individual Differences chapter of this text).

Conceptual Confusion in Distinguishing Between and Among Subgroups Tremendous subgroup diversity exists within the broad groups of European, Black, Hispanic, Asian, and Native Americans (LoConto & Francis, 2005; Lopez, Lopez, Suarez-Morales, & Castro, 2005; Michaelis, 1997; Thao, 2005; Wood, 2003; Worrell, 2005; Yoon & Cheng, 2005). Some critics argue that the practice of assigning individuals to mutually exclusive categories based on race or ethnicity (for the purpose of determining appropriate counseling methods) is problematic because cultural, language, and behavioral traits overlap in various degrees across groups as a function of "normal" individual differences within groups and acculturation processes between groups (Patterson, 2004). Thus, group boundaries are not rigid but are fluid and permeable – as numerous "cultures" exist within any one racial group and numerous races exist within any one cultural group.

According to Kirmayer (2012), a complicating issue involves the difficulty in translating the meaning of cultural differences smoothly from one country to another. He argues that efforts to understand general cultural competence principles are made more difficult due to the fact that "definitions of culture at play in the US reflect a particular history and politics of identity and therefore do not map neatly onto the distinctions among groups made in other countries" (p. 150).

Conceptual Confusion in Distinguishing CC from Other Forms of Competence In establishing the construct validity of new construct, advocates and researchers must show how the new construct differs both conceptually and empirically from similar constructs (Mackenzie, 2003; Smith, 2005). Frisby (2009) argues that the CC movement has not sufficiently established conceptually whether or not the social competence construct (Schneider, Ackerman, & Kanfer, 1996) (1) subsumes cultural competence and (2) is a necessary but not sufficient condition for cultural competence or (3) whether social competence and cultural competence are independent constructs.

Coleman (1998) designed a study to test the hypothesis that general and more specific multicultural counseling competence could be perceived as distinct constructs. Coleman had graduate students and ethnic minority social psychology undergraduates watch two videotapes depicting the same white counselor counseling an ethnic minority client. The first tape depicted the counselor displaying both general counseling competence and culturally sensitive counseling skills, and the counselor in the second tape displayed general counseling competence and culturally "neutral" cultural sensitivity. Participants rated the counselors in the two tapes on a general counseling competency scale and a multicultural competency scale. Coleman found that both groups of participants perceived the counselor in the "culture neutral" vignette to have less multi-

cultural and general counseling competence – which "raises the question of whether these are distinct constructs" (p. 153).

Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) acknowledge that serious research which attempts to answer this question (i.e., whether or not multicultural and general counseling competencies are distinct constructs) poses a threat to the fundamental political goal of multiculturalism – "which is to transform traditional psychology to make it more relevant for diverse populations" (p. 130). They write:

> [Multicultural] research seems to be at risk if results do not support any significant differences between a multiculturally competent counselor and one who is generally a competent (i.e., not multiculturally competent) counselor. (p. 130)

Empirical Critiques

The term "empirical" is defined broadly to mean any investigation that collects data and analyzes data in order to gather information, support or refute an argument, or test a hypothesis. Obviously, to review all such activities connected to the cultural competence movement is well beyond the scope of this chapter. This section more narrowly focuses on results from empirical studies that call into question one or more of the core components of cultural competence theory and advocacy.

General Shortcomings in CC Research A common theme voiced by CC advocates is the lack of empirical research to effectively support many claims in the CC movement. As an example, Sue et al. (2009) opine that cultural competence definitions pose problems in terms of empirical testing, as characteristics of culturally competent therapists or human interaction processes are difficult to specify and operationalize for research (Sue et al., 2009, pp. 529–530). According to Sue et al. (2009), the discussion of cultural competence issues for a particular ethnic minority group becomes even more challenging in view of the limited amount of empirically based information available on cultural influences in mental health treatment (p. 527). Weinrach and Thomas (2004) echo this observation and object to CC advocacy on the grounds that the relationship between race/ethnicity and mental health functioning is poorly understood, which precludes making clear predictions of cultural influences on mental health (Weinrach & Thomas, 2004). Pope-Davis, Liu, Toporek, and Brittan-Powell acknowledge that little research supports the assumption that racially/ethnically diverse clients seek out culturally competent counselors for treatment (p. 125). Sue et al. (2009) opine that it has been difficult to develop research strategies, isolate components, devise theories of cultural competency, and implement training strategies. They summarize the limitations in cultural sensitivity or competency research as being a function of the fact that these constructs (*a*) have various meanings, (*b*) include inadequate descriptors, (*c*) are not theoretically grounded, and (*d*) are restricted by a lack of measurements and research designs for evaluating their impact in treatment (Sue, Zane, Hall, & Berger, 2009, p. 530).

Even those who support cultural competency advocacy admit that the effectiveness of multicultural training has not been empirically determined conclusively and that no evidence exists showing that practitioners who adopt multicultural counseling competencies will be better counselors compared to those who do not (Braden & Shah, 2005; Neville et al., 1996; Sue, 1998; Weinrach & Thomas, 2002, 2004; for a dissenting view, see Worthington, Soth-McNett, & Moreno, 2007). The empirical and associated pedagogical problems with multicultural competencies, as applied to the mental health counseling profession, are succinctly summarized as follows from Weinrach and Thomas (2004):

> There is insufficient evidence that cultural differences account for sufficient variance in the mental health of clients from different groups to justify unique treatment protocols. And even if there were sufficient evidence, the myriad of permutations of protocols would be impossible to achieve. (p. 82)

Weinrach and Thomas (2002) articulate four specific shortcomings of empirical research that undermine the construct validity of cultural

competence: (1) lack of consistency among multiple raters as to mastery of cultural competence, (2) lack of stability in demonstrating cultural competence from one setting/situation to another, (3) lack of generalization of cultural competencies from simulated to "real-life" situations, and (4) lack of construct validity of professional organization's cultural competency documents with what counselors actually do in multicultural counseling settings.

At the conclusion of a 20 year literature review of multicultural counseling competencies research, Worthington et al. (2007) opined that multicultural competencies appear "to be more thoroughly *discussed* than they are actually *investigated* in the literature" (p. 357; see also Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005), although they expressed optimism that this trend seems to be reversing at the time of their writing.

Disparity Interpretation Errors As discussed in the chapter on the History and Development of Cultural Competence Advocacy, racial/ethnic statistical disparities in the quality of mental and physical healthcare are one among many justifications of the need for cultural competency training. In the context of analyzing health disparities in the quality of treatment received within the healthcare system, however, Klick and Satel (2006) argue that researchers can arrive at incorrect conclusions when they fail to statistically control or account for "third factors" that are correlated with race, which in turn can influence the quality of care received in the healthcare system. As examples of third factors, racial/ethnic disparities already exist in the type of insurance coverage patients hold (e.g., insured, uninsured, or underinsured; public versus private health plans; profit versus not-for-profit health plans), quality of physicians with whom patients interact (as racial groups do not visit the same population of physicians), regional variations in medical practices (as healthcare quality varies as a function of where people live – and different racial groups tend to live in different geographical areas), and individual differences in patient characteristics such as health literacy or the clinical features of the medical problems for which they are seeking treatment.

They argue that when more careful researchers control for such factors, "the magnitude of the race effect shrinks considerably, if it does not disappear altogether" (p. 4).

Results from Clinician Surveys As shown in previous chapters, cultural competence is portrayed as an urgent need for pre- and in-service clinicians who presumably lack such skills. Huey, Tilley, Jones, and Smith (2014) reviewed survey studies showing results that challenge the assumption that clinicians poorly attend to cultural issues when treating ethnic minority clients (e.g., see Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Hansen et al., 2006; Holcomb-McCoy & Myers, 1999; Lopez & Hernandez, 1986; Maxie et al., 2006). According to Huey et al. (2014), survey data collected since the middle 1980s report that the majority of therapists (who are predominantly white) "feel competent to work with ethnic minorities, discuss race/ethnicity issues when relevant to the presenting problem, feel reasonably comfortable discussing issues of ethnic difference with clients, consider race/ethnicity when constructing case formulations, and pursue additional resources when they are unfamiliar with the clients' culture" (p. 324).

CC Measurement Criticisms Measures designed to assess cultural competence have been criticized as putting too much emphasis on self-report methodology (Weinrach & Thomas, 2002). Self-report scales have been criticized for their failure to address social desirability effects (Constantine & Ladany, 2000), which can be defined as the tendency of respondents to answer questions (particular on sensitive topics) in a manner that would be viewed favorably by themselves or others. Social desirability influences respondents to over-report good attitudes/behaviors while under-reporting bad attitudes/behaviors (Fisher, 1993). As a result of these problems, later cultural competence scales (across a variety of disciplines) have incorporated items designed to measure social desirability (e.g., see Bernhard et al., 2015).

Cultural competency scale development in applied counseling has exposed a number of weaknesses cited by scholars, which include the lack of significant conceptual and/or empirical relationships among scales purporting to measure the same construct (see review in Worthington et al., 2007). Studies of the validity of self-report measures of multicultural counseling competencies have shown little correspondence among the subscales of the most frequently used measures, as well as a lack of correspondence between cultural competency self-reports and observer ratings (Constantine, 2001; Ponterotto, Fuertes, & Chen, 2000; Worthington, Mobley, Franks, & Tan, 2000).

Atkinson and Israel (2003) expressed serious reservations about the hasty acceptance of four cultural competency assessment instruments developed during the early 1990s (D'Andrea, Daniels, & Heck, 1990; LaFromboise, Coleman, & Hernandez, 1991; Ponterotto, Sanchez, & Magrids, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994) that were adopted by the counseling psychology profession but turned out to measure nothing more than "self – efficacy for [multicultural counseling competencies], not [multicultural counseling competency] itself" (p. 595). When Constantine and Ladany (2000) controlled for social desirability effects before correlating several cultural competence self-report measures and a behavioral measure of multicultural case conceptualization ability, they found no significant correlation.

Larson and Bradshaw (2017) identified 15 studies that address issues related to cultural competence scales and social desirability bias. Collectively, the studies used ten cultural competence scales taken by respondents from the disciplines of counseling, marriage/family therapy, teaching, collegiate student affairs, and nursing. Their review concluded that measured cultural competence is positively correlated with social desirability bias (as measured by a separate social desirability scale); however, the strength of this association varied as a function of the particular cultural competence scale used (for a research study that found no correlation between measured cultural competence and social desirability, see Reyna, 2014).

Methodological Rigor of CC Training Evaluation Price et al. (2005) evaluated 64 articles published between 1990 and 2003 that used cultural competence training for healthcare providers as a strategy to improve the healthcare of minorities. They concluded that the quality of evidence for the improvement of health professionals' cultural competence was poor. Specifically, less than a third of the reviewed studies provided quality criteria for describing the targeted health service providers or described CC interventions taught to healthcare providers. Few of the studies reviewed included adequate control groups necessary for accurately detecting and interpreting the effects of training. Many of the studies did not use objective evaluation procedures, which undermined study validity. Most studies reviewed measured changes in health providers' attitudes and knowledge as opposed to changes in their behaviors or patient outcomes, which the authors interpreted as being a function of studying students rather than actual practitioners. Few studies reported quantitative data that would indicate the strength of the pre- and post-test differences between groups of variability in outcomes (e.g., confidence intervals).

Bhui, Warfa, Edonya, Mckenzie, and Bhugra (2007) evaluated 109 scholarly papers published since 1985 that described and/or evaluated models of cultural competence in mental health settings in North America. Only 9 out of the 109 papers actually described implementation of a cultural competence model of mental healthcare (by psychiatrists, nurses, medical students, and multidisciplinary teams) as well as provided evaluation data for service provision or training. Of these nine studies, only three provided quantitative outcomes, published their teaching and learning methods, or actually followed up subjects to assess changes in behavior or adherence to the cultural competency model following the intervention. Huey et al. (2014) reviewed these and other studies before concluding:

> Literature reviews mostly agree that there is little in terms of rigorous evaluation to guide policy decisions about the utility of training clinicians in cultural competence …. The use of appropriate control groups is rare, client samples are analogue rather than clinical, cultural competence evaluations are based almost exclusively on therapist self-report, and evidence linking therapist cultural competencies to client outcomes is sparse. Despite several decades of research, we know very little about (a) the threshold for adequate cultural competence among clinicians, (b) which training approaches increase cultural competence in clinicians, and (c) whether cultural competence can be reliably differentiated from generic clinical competence (p. 322)

Horvat, Horey, Romios, and Kis-Rigo (2014) assessed the effects of cultural competence education for healthcare professionals on patient-related outcomes, health professional outcomes, and healthcare organization outcomes by conducting an exhaustive literature review of randomized controlled trial (RCT) up until the middle of 2014. The studies reviewed involved approximately 8400 patients, 41% of whom were from culturally and linguistically diverse backgrounds in the United States, Canada, and the Netherlands. The authors found that their review either showed support for the cultural competence education or no evidence of an effect. They concluded that the quality of evidence was insufficient to draw generalizable conclusions, largely due to heterogeneity of the interventions in content, scope, design, duration, implementation, and outcomes selected.

Benuto, Casas, and O'Donohue (2018) reviewed 17 training studies (spanning a 30 year period) that evaluated the outcomes for psychologists trained for multicultural competency. They note that 9 of the 17 studies were published prior to the publication of the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists in 2002 (American Psychological Association, 2003). Training mechanisms included lectures, discussions, utilization of case scenarios, cultural immersion activities, role-playing exercises, contacts with diverse individuals, self-reflections of interactions with clients, journaling activities, and service learning experiences. Across the studies reviewed, topics covered in the curricula included racism/discrimination, worldviews, cultural identity, general concepts about culture, and the nature of biases. The authors found that the majority of studies indicated positive changes with regard to knowledge. However, outcomes with regard to attitudes, awareness, and self-reported and objective skills were mixed, with some studies identifying positive changes after training and other studies not identifying significant changes. The authors opined that synthesizing the outcomes of cultural competency training research was a challenging task – given the limited amount of information included in the published literature about the studies themselves, the varying outcome variables assessed across studies, and the varying methodologies used across studies.

Racial/Ethnic Matching of Helpers/Clients The entire justification for cultural competence training rests on the assumption that racial/ethnic differences between helpers and clients necessitate specialized cultural competency training for helpers. The unspoken implication is that helpers and clients who come from the same racial/ethnic group enable the helper to be more effective to some unspecified degree. This enables researchers to test the hypothesis that racial/ethnic matching of helpers and clients leads to demonstrably greater effects compared to helpers and clients that are not racially/ethnically matched.

Marimba and Hall ((2002) identified and examined seven ethnic matching psychotherapy studies published between 1977 and 1999, all of which involved three dependent variables: (1) dropping out, defined as the failure of the client to return for a second session after the initial session; (2) utilization, defined as the number of sessions attended; and (3) global assessment score, which measures the degree of overall functioning on a continuum from psychiatric disturbance to psychiatric health. The authors found very small effect sizes in favor of ethnic matching

(ES = 0.01–0.04) but concluded that these effect sizes were too small to provide support for ethnic matching as a promising variable for improving client outcomes.

Cabral and Smith (2011) conducted a meta-analysis of three variables frequently used in research on racial/ethnic matching: (1) clients' preferences for a therapist of their own race/ethnicity, (2) clients' perceptions of therapists, and (3) therapeutic outcomes. Although the average effect size from analyses of the first two questions (involving 52 and 81 studies, respectively) was d = 0.63 (client preferences) and d = 0.32 (client perceptions), the effect size for therapeutic outcomes (involving 53 studies) was d = 0.09, "indicating almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists" (p. 537).

Treatment Effect Research Lau, Chang, Okazaki, and Bernal (2016) organized a review of the literature on psychological/mental health treatment outcomes for ethnic minorities around three paradigms in treatment outcome research: (1) the generalizability of treatment effects (evidence-based treatment efficacy and effectiveness), (2) the adaptation of treatment (cultural adaptations to evidence-based treatment efficacy and effectiveness), and (3) innovations in treatment development (culturally sensitive treatment efficacy and effectiveness).

Generalizability of Evidence-Based Treat ment (EBT) Effects for Racial/Ethnic Minorities Evidence within this category generally refers to treatments that have been validated on samples that are not racial/ethnic minorities but can be evaluated for their effectiveness when applied to racial/ethnic minorities.

As discussed in the History and Development of Cultural Comptence chapter, aggressive cultural competence training advocacy is often justified from the suspicion that racial/ethnic disparities in mental health indicators may be due, in full or in part, by the lack of cultural competence in clinicians. From this reasoning, it should follow that "traditional" treatments (that include no specific adaptations for the race/ethnicity of clients) should be largely ineffective or harmful when applied to nonwhite clients.

Huey et al. (2014) reviewed the literature on psychotherapy outcomes for culturally diverse youth and families, as well as summarized evidence from more than 300 randomized trials of mental health treatments that (a) included predominantly ethnic minority participants, (b) assessed how client ethnicity affects treatment outcomes, or (c) evaluated separate treatment effects for ethnic minority participants (p. 311). The majority of the literature they reviewed focused primarily on African-Americans and Latinos living in the United States, with a smaller number of trials targeting Asian-Americans, Native Hawaiians, Native Americans, and ethnic minorities living in Australia, New Zealand, and a number of other European countries. They found that the number of minority-focused randomized trails increased steadily over the 40 years prior to publication of their review (beginning in the 1970s). In particular, since the establishment of the National Institute of Mental Health (NIMH) policy requiring clinical research grantees to include women and minorities in 2001, this number increased dramatically.

Huey et al. (2014) also found that therapies which served minorities appeared to be effective across a broad range of mental health problems (including anxiety, depression, externalizing problems, schizophrenia, substance abuse, smoking, and trauma). In addition, evidence from a subset of studies showed promise in "attracting minorities into treatment, keeping them involved in therapeutic activities, improving the client-therapist relationship, and preventing minorities from terminating treatment prematurely" (p. 312).

Huey et al. (2014) investigated the extent to which treatment outcomes are similar for whites and racial/ethnic minorities or whether treatment outcomes for whites are superior to those for racial/ethnic minorities (i.e., race/ethnicity as a moderator effect). Their review of 29 meta-analyses showed 62% reporting no significant ethnicity

effects, 14% reporting outcomes favoring whites, 17% showing superior outcomes for racial/ethnic minorities, and 7% showing mixed or indeterminate outcomes (p. 314). When substance use meta-analytic studies were examined separately (N = 12), 33% showed no race/ethnicity effects, 25% showed superior outcomes for whites, and 42% reported better outcomes for ethnic minorities. When Huey et al. (2014) reviewed four meta-analyses for investigating whether some racial/ethnic groups benefit more from psychotherapy compared to others, no racial/ethnic differences in treatment outcomes were found – except for one meta-analysis (Smith, Rodríguez, & Bernal, 2011), which showed that Asian-Americans benefited more from psychotherapy than did African-Americans, Latinos, and Native Americans. From these reviews, Huey et al. (2014) conclude:

> Thus, on average, psychotherapies appear to work equally well for whites and ethnic minorities …. Overall, these results appear to support an "ethnic invariance" perspective, with the caveat that certain treatments may favor white participants under some circumstances but ethnic minorities under others. In addition, treatment outcomes across ethnic minority groups were quite similar, with one notable exception. One important limitation of these "ethnicity-as-moderator" studies is that the role of cultural competence is mostly obscured. (p. 315)

According to Lau et al. (2016), large literature reviews support the generalizability of evidence-based treatments for racial/ethnic minorities (Huey & Polo, 2008; Miranda et al., 2005). However, EBT outcomes show more mixed results as a function of the statistical design used, the clinical problem that was the focus of treatment, and the acculturation levels of clients (for details, see Lau et al., 2016).

Efficacy and Effectiveness of Cultural Adaptations to Treatment for Racial/Ethnic Minorities Evidence within this category generally refers to treatments that have been validated on samples that are not racial/ethnic minorities but have been adapted to some degree in order to provide a better fit for the cultural characteristics of racial/ethnic minority clients, and "there is a plausible threat of EBT generalization failure" (Lau et al., 2016, p. 37). Adaptations generally are made in order to accomplish one or more of two broad goals: to enhance the engagement of minority groups in the treatment and/or to contextualize the content of the treatment to better fit the needs of the target group.

Examples of cultural adaptations include the provision of treatment in the preferred language of the clients, directly addressing cultural myths about the clinical problem and/or treatment, changing the name of treatment where appropriate in order to avoid stigma, the provision of child care or transportation to ensure and permit attendance for treatment, ensuring that treatment is accessible within community sites in which clients reside, the depiction of ethnic minorities in graphic materials, or altering depictions of activities that are more culturally familiar to clients (e.g., see Graves et al., 2016).

From their review of five large meta-analyses of culturally adapted treatments (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Huey & Polo, 2008; Smith et al., 2011; van Loon, van Schaik, Dekker, & Beekman, 2013), Lau et al. (2016) report finding significant effects for cultural adaptation in four meta-analyses but nonsignificant effects for one. Lau et al. (2016) interpret this disappointing finding as due to the poorly specified or superficial nature of the adapted treatments, leading to a failure to effectively distinguish among treatments on the basis of the quality or content of the cultural adaptations (p. 42).

Huey et al. (2014) employed the overarching term "cultural tailoring" to describe aspects of studies which use the terms "culturally adapted" and "culturally sensitive" to depict treatment modifications (in addition to using the term "cultural tailoring"). These researchers summarized results from ten meta-analyses that evaluated culturally tailored interventions for ethnic minority youths and adults. They concluded that all ten meta-analyses showed culturally tailored interventions to be efficacious for racial/ethnic minorities; however, authors of the studies they reviewed differed in their conclusions regarding the specific benefits of cultural tailoring. They write:

> Overall, these findings present a mixed picture of the benefits of cultural tailoring. Although culturally adapted treatments are clearly efficacious with ethnic minorities when compared to conventional control groups, it is less evident whether culturally adapted interventions are more efficacious than un-adapted interventions. Some meta-analyses suggest that cultural tailoring may be a powerful tool for enhancing treatment effectiveness for ethnically diverse groups …. However, other meta-analytic evidence suggests that some forms of cultural tailoring may provide little added benefit to ethnic minorities compared to standard treatments and, in some cases, may even reduce treatment effectiveness …. Further research is needed to understand the effects of cultural tailoring and determine what forms are effective and for whom. (p. 320)

Huey et al. (2014) evaluate these findings as somewhat ambiguous, since the randomized controlled trials typically involve comparing a culturally tailored treatment to no treatment, a placebo, or treatment-as-usual controls. This type of design evaluates the efficacy of an overall intervention rather than the specific effects of cultural tailoring (p. 321). They nevertheless view results from studies that use moderator analyses as helpful for providing at least preliminary clues as to which types of cultural tailoring might be most efficacious. They mention six conclusions that show some helpful evidence:

1. Cultural tailoring aimed at a specific ethnocultural group is more effective than tailoring targeting a mixed group.
2. Matching clients with therapists who speak their preferred (non-English) language may improve treatment outcomes.
3. Cultural tailoring may be most effective for older, less acculturated clients.
4. Therapist/client congruence on therapeutic goals and using metaphors/symbols that match the clients' cultural worldview may strengthen treatment efficacy.
5. Myth adaptation that incorporates the clients' beliefs about symptoms, etiology, course, consequences, and appropriate treatment may improve treatment outcomes.
6. Addressing cultural factors implicitly rather than explicitly may be one promising way to capture the benefits of cultural tailoring without the risk of iatrogenic effects (i.e., illnesses caused by a medical treatment or diagnostic procedure) (pp. 320–321).

Efficacy and Effectiveness of Innovative Culturally Sensitive Treatments (CSTs) for Racial/Ethnic Minorities Evidence within this category generally refers to the efficacy of novel interventions that originate out of the cultural milieu of specific racial/ethnic minority communities. According to Lau et al. (2016), CSTs can be distinguished from culturally adapted EBTs (see previous section) in that CSTs are healing traditions, cultural practices, alternative cultural healing philosophies, or heritage folk practices that are not typically represented in the "mainstream" literature of EBTs.

In their review of a small sample of studies, Lau et al. (2016) found encouraging results for the efficacy of CSTs (e.g., Brody, Murry, Kim, & Brown, 2002; Costantino, Malgady, & Rogler, 1986; Gonzales et al., 2012; Kogan et al., 2012). However, there were not enough studies conducted in their review to definitively address whether CSTs work as well as EBTs or to clearly explicate the specific mechanisms that would explain why CSTs were effective.

Client Outcome Research Although some client outcome research (on the effects of counselor multicultural competencies) has investigated client perceptions of counselor characteristics, client attrition, and client satisfaction with counseling, no client outcome studies have investigated actual client *behavioral change* as a result of counselors' cultural competencies (Worthington et al., 2007, p. 358). In addition, those studies that demonstrated positive effects were limited by the almost exclusive use of analogue designs (i.e., using artificial conditions, settings, or subjects that simulate real-life condi-

tions, settings, or subjects; Worthington et al., 2007).

Zane, Bernal, and Leong (2016) coined the term "criterion problem" in describing "the lack of research evidence that a culturally competent therapist produces better client outcomes than a therapist who is not deemed culturally competent" (p. xiii). They explain this condition as being attributed to the CC movement focusing overwhelmingly on caregiver training rather than on actual therapeutic outcomes.

Philosophical Critiques

Objective empiricism is rooted in the time-honored axiom of "follow the data wherever it leads" – which also involves having the courage to "discard contemptuously whatever may be found [to be] untrue" (Sir Francis Galton, quoted from Pearson, 1914, p. 297). The hallmark of objective empiricism is the dogged pursuit of truth, primarily, and then finding the best evidence-based solutions for solving practical problems, secondarily (Frisby, 2013, p. 519). Ideally, there are no "sacred cows" in science, as all knowledge claims are open to evaluation, scrutiny, and debate – in the hope that more accurate knowledge will be discovered (Frisby, 2013, p. 519).

Unfortunately, as the material in the previous section has shown, the empirical evaluation of cultural competence theory and practice is extremely challenging and complex. Here, empirical findings from large literature reviews and rigorous meta-analyses include many caveats and nuances – which invite extreme caution with respect to how to interpret the implications of this literature. At the very least, the fruits of the hard work that scholars have devoted to the empirical evaluation of this literature should encourage reasonable observers to appreciate the fact that *the construct validity of cultural competence is far from settled*. Nevertheless, the existence of, and need for, cultural competence is depicted as "settled law" for many observers. Long before any of the research described in the previous section was undertaken, Ridley, Mendoza, and Kanitz (1994) asserted:

> Consequently, the issue of whether or not to include some form of [multicultural training] in graduate training is no longer open for debate. (p. 227)

This causes many critics to argue that the cultural competence movement – either in its foundational assumptions, content, research agendas, or practical/professional applications – is fueled by an aggressive *sociopolitical ideology* rather than by dispassionate science (see O'Donohue & Benuto, 2010; Paasche-Orlow, 2004; Vontress & Jackson, 2004). When this happens, critics argue that both psychological science and applied practice are subsequently corrupted to varying degrees (Frisby, 2013; Lilienfeld, 2017; Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010; Wright & Cummings, 2005).

Sociopolitical ideologies begin with a constellation of popular and persuasive *narratives*, which are easily identified by four predictable characteristics (Frisby, 2013). First, sociopolitical ideologies are framed as urgently necessary in order to fight an injustice in society. As seen in the History and Development of Cultural Competence chapter, for example, cultural competence advocacy is often justified on the basis of its perceived value in correcting "unjust" statistical disparities in psychological/health services (e.g., see Minnesota Evidence-Based Practice Center, 2016). Second, sociopolitical ideologies must oversimplify life's complexities so that moral/philosophical battle lines can be crystallized more clearly in the minds and hearts of followers. As one example, the cultural competency movement has been criticized as oversimplifying race/ethnicity as the "primordial" factor that determines the quality of psychological services (see criticisms by Satel & Forster, 1999; Weinrach & Thomas, 2002). Third, sociopolitical ideologies have their own specialized lexicon in order to communicate its ideas more parsimoniously among advocates. As examples, recipients of cultural competency training in applied psychology must be familiar with various specialized terms such as "social justice," "privilege," "oppression," "microaggressions," "othering," "marginalization," and "intersectionality" – to name a few. Fourth, sociopolitical ideologies must

enforce conformity by rewarding followers and punishing dissenters (for examples within the cultural competency movement, see Jacoby, 2017; Levitt, 2005; Rogers, 2006; Rudow, 2013; Satel & Forster, 1999; Starnes, 2016). Levitt (2005) writes:

> "Cultural competence" is, in essence, a bureaucratic weapon. "Cultural competence," or rather, your presumed lack thereof, is what you will be clobbered with if you are imprudent enough to challenge or merely to have qualms about "affirmative action," "diversity" and "multiculturalism," as those principles are now espoused by their most fervent academic advocates. Cultural competence … is something a professor is supposed to keep handy at all times … in order to dispel any suspicion of racism, sexism or Eurocentrism that might arise in the minds of the professionally suspicious

Although cultural competence advocacy is decorated by the trappings of science (i.e., databased studies, journal publications, scale development, "best practices" documents by professional guilds, conference presentations, etc.) – critics argue that the fundamental agenda of such narratives is not the disinterested search for truth. Levitt (2005) acknowledges that the original meaning and application of the term "cultural competence" was designed to assist healthcare professionals to function effectively with persons from ethnic minority and immigrant groups. Over time, however:

> [C]ast loose from its original moorings, the phrase [cultural competence] has become emphatically political …. In the context of higher education, cultural competence necessitates abject refusal to articulate or defend ideas that might make certain protected groups uncomfortable

O'Donohue and Benuto (2010) argue that "cultural sensitivity" (one of the many synonyms for "cultural competence" - see History and Development of Cultural Competence chapter, this text) in applied psychology is little more than a means by which whites can assuage their "white guilt" (Steele, 2006) – as opposed to doing anything concrete that actually helps disadvantaged minorities. In this process, the constant emphasis on the infusion of cultural competence (i.e., "sensitivity") requirements, guidelines, directives, and policies by professional organizations and institutions is an effective way for demonstrating to themselves and others that they are not racists (Steele, 2006).

According to some critics, the driving goal of sociopolitical ideologies is to *promote*, *protect*, *and sustain the ideology at all costs* – regardless of what data reveals (or does not reveal). To do this, large bodies of relevant research that are damaging to the ideology must be ignored, kept offstage, vigorously attacked, or spun in ways that ultimately reinforce the ideology (Frisby, 2013; Gottfredson, 1994; Phelps, 2009; Wright & Cummings, 2005). Although consensus exists among critics as to the palpable influence of sociopolitical ideologies in guiding the cultural competence movement, critics differ as to the names given to these ideological influences.

Redding (2001) argues that American psychology in general lacks sociopolitical diversity, which results in an overwhelming identification by both practicing and research psychologists with *political liberalism*, which is also the perspective that dominates higher education (Gross, 2013; Langbert, Quain, & Klein, 2016; Maranto, Redding, & Hess, 2009; Pew Research Center, 2016; Yancey, 2017). According to Redding, not only are politically conservative psychologists underrepresented in American psychology, but research, advocacy, and professional practice/policy positions advocated by psychology guilds are more often than not politically liberal as well. In his view, this viewpoint imbalance is what corrupts research, clinical practice, and the education of psychologists (for a more elaborated discussion, see chapter on Viewpoint Bias, this text).

Writing from the perspective of school psychology, Frisby (2013) uses the term *Quack Multiculturalism* to describe the sociopolitical ideology that misleads audiences as to what actually facilitates positive psychoeducational outcomes for racially/ethnically diverse school children. Frisby defines Quack Multiculturalism as "that subset of ideas – promoted under the banner of multiculturalism – that is aggressively sold to audiences despite having no serious research support, or in some cases is blatantly contradicted by quality research" (p. 57). Frisby

(2013) argues that Quack Multiculturalism is pervasive in writing on diversity issues within school psychology because it satisfies emotional needs in audiences for “quick fixes” in solving complex, difficult problems (p. 571).

Political correctness is a frequent term identified by critics that refers to the social pressure to self-censor or monitor one’s language in favor of only “socially approved” language, the thinking of only “socially approved” thoughts, the public endorsement of certain “socially approved” viewpoints, or taking great pains not to acknowledge certain truths or observations that have the potential of giving offense to politically organized advocacy groups (based on gender, race, ethnicity, language, sexual orientation, disability, etc.) or their designated or self-appointed spokespersons (Frisby, 2013, p. 569).

According to Cummings and O’Donohue (2005), three major characteristics signal the presence of political correctness in American psychology. First, psychologists must be scared into changing their behavior by adopting a “the sky is falling” hysteria about an aggressively advertised “crisis.” More often than not, the urgent “crisis” turns out to be a false narrative that eventually is revealed as baseless, only to be replaced by yet another “crisis” requiring immediate action. Second, politically correct thinking is noted by its easy acceptance of popular but incorrect ideas. When such ideas are challenged, however, there is no honest reexamination of the assumptions and/or evidence supporting the false idea. Third, political correctness is noted for its tendency to promote largely superficial actions that may indeed help persons to feel good about themselves, but without engaging in the difficult thinking and hard work needed to actually accomplish tangible results (Cummings & O’Donohue, 2005).

Restricted Sources of Variation in Human Behavior Some object to the cultural competency movement on the grounds that the movement encourages an overly restrictive view of the factors that influence human behavior. In the early 1950s, Kluckhohn and Murray (1953) established a robust principle for understanding similarities and differences among human beings. In their view, human similarities and differences are influenced by three sources: (1) characteristics and traits that persons share in common with all other human beings, (2) characteristics and traits that persons share in common only with smaller subgroups of which they are members (e.g., age, gender, racial, ethnic, language religious, socioeconomic, or geographic subgroups), and (3) traits that are unique to an individual that are not shared by any other person (Kluckhohn & Murray, 1953; Sue, 2001). Add to this the truism that individual and situational differences in behavior are influenced as well by the immediate context in which human beings operate (see Frisby, 2013, chapter 3).

These combined truths make the cultural competence movement vulnerable to criticisms that it exaggerates the role of racial/ethnic/language/cultural subgroup membership as the sole, the exclusive, or even the most important determinant of human psychological functioning and behavior (e.g., Frisby, 2005b; Satel & Forster, 1996; Weinrach & Thomas, 2004). Frisby (2005a, 2005b, 2013) calls this the *Difference Doctrine*, an influential assumption which holds that differences between racial, ethnic, language, and/or social class groups are so profound and mutually exclusive, that members within each group must necessarily require different assessment, counseling, and/or instructional techniques to adequately meet their psychological needs.

In short, this crit rceptions could be imagined or exaggerated (i.e., a true symptom of a psychological disorder).

Distortions of the Helper/Client Relationship Satel and Forster (1996) object to the CC movement’s assumption that the doctor/patient relationship is fundamentally vulnerable to mistrust and communication simply because of racial/ethnic group differences. Others object to the presumption of racism on the part of helpers simply because they are white (Satel & Forster, 1996).

Promotion of Racism and/or Racialism Racism is a term that has been used, misused, and defined in a wide variety of ways (see chapter

on Race, Racial Differences, and Racism, this text). If racism is defined as the practice of stereotyping all members of a group based on the actions of a few, then some have suggested that cultural competency professional recommendations are consistent with a "racist" viewpoint (Weinrach & Thomas, 2002, p. 21).

Another pejorative term that is similar to racism, but describes a slightly different problem, is the term "racialism." *Racialism* is the belief that race and racial differences are fundamental to understanding differences in cognition, personality, and behavior. In racialist thinking, all members within racial subdivisions share certain heritable traits and characteristics that are presumed to be unique to that race and are not characteristic of members belonging to different races (see Frisby, 2013, p. 571). Some writers have argued that the fundamental principles that undergird the cultural competency movement are rooted in racialism. They argue that the constant emphasis on race is outmoded and incapable of providing an adequate explanation of the wide variety of circumstances and outcomes that are present in the human condition (Weinrach & Thomas, 2002). Others argue that racialist advocacy leads to the proliferation of and comfort with *liberal racism*, defined as "a condescending and patronizing set of assumptions about nonwhite minority groups which assumes that racial differences are so profound, and the social disadvantages and grievances associated with these differences to be so inevitable, that nonwhite groups cannot be expected to adhere to basic standards of morality and behavior assumed to be fundamental to a shared civic culture" (Frisby, 2013, p. 561; see also Sleeper, 1997).

Pedagogical Critiques

Critiques within this category object to the manner in which cultural competency is taught to pre- and in-service psychologists and counselors. A sampling of these critiques is discussed below:

Lack of Consensus on How to Train for Cultural Competence The lack of consensus as to how best to train for cultural competence appears to parallel the lack of consensus as to how it is defined. Bhui et al. (2007) write:

> There is considerable confusion about what constitutes cultural competence …. Despite a growing body of health and educational policies that prioritise cultural competency in health care provision, there is surprisingly little agreement on the meaning of cultural competence training or knowledge about its effectiveness. (p. 2)

Superficiality of Cultural Competence Training Some criticize cultural competence training as being somewhat superficial and cursory, which, in their view, potentially gives students a false sense of cross-cultural competency (Vontress & Jackson, 2004). Others have criticized training for cultural competence on the grounds that exercises designed to help students develop understanding, sensitivity, and/or empathy for groups different than themselves are "invasive," "synthetic," and "hollow" – as the "nuances of culture are too complex to absorb as a part-time observer" (Weinrach & Thomas, 2002, p. 30). Frisby (2013) has called the mindset that spawns such practices as "Light-and-Fluffy Multiculturalism" (see pp. 11–12).

O'Donohue and Benuto (2010) label this issue the "amateur anthropologist" problem (p. 35). They note that anthropologists spend years, decades, and even lifetimes studying specific cultural groups and even then express a degree of humility in acknowledging the limits of their understanding about such groups. Paradoxically, applied psychologists are presumed to possess "competence" about cultural groups from being exposed to brief units within what are often one-time courses.

Distorted Views of Clients Some object to cultural competence training on the grounds that it tends to perceive culturally diverse clients according to a "deficit model" (Weinrach & Thomas, 2004, p. 89). That is, clients from nonwhite, non-English-speaking groups are seen as automatic "victims" of society (in general) or of white psychological service providers (in particular) – solely on the basis of their group member-

ship (Ridley, 2005; Sue, 2010; Sue & Sue, 2016). These critics argue for a strengths-based model of mental health counseling that, in their view, is the only acceptable path for facilitating positive client growth (Weinrach & Thomas, 2004).

Content Imbalances Some object to cultural competence advocacy on the grounds that the cultural competency movement overemphasizes issues involving race yet overlooks and/or underemphasizes issues involving age, disability status, gender, and sexual orientation (Weinrach and Thomas, 2002). Even with this exclusively racial emphasis, multicultural competency standards have been criticized on the grounds that they overemphasize differences between groups to the near exclusion of similarities across groups or wide differences within groups (Frisby, 2013; Jackson, 1998; Weinrach & Thomas, 2002).

The Impossibility of Training for All Diversity Obviously, psychological/mental health treatments must be delivered to clients in a language that they can clearly understand. Other than this language matching issue, a fundamental justification for cultural competence training is the promise that students will learn specialized knowledge, awareness, and skills that will enable them to be uniquely effective with clients who are racially or ethnically different than themselves. Frisby (2013) coined the term *culture x treatment interaction* in referring to the idea that there exist unique treatments that are particularly effective for racial/ethnic minority clients but are not effective for nonminority clients (on the basis of some unspecified "cultural" modifications). This idea raises doubt among some critics, who argue that attempts to find methods that would be effective for every conceivable racial, ethnic, language, religious, socioeconomic, and cultural group (as well as accounting for seemingly endless permutations and combinations of these groups within individuals) constitutes a near-impossible task (Braden & Shah, 2005; O'Donohue & Benuto, 2010; Patterson, 2004). This is based on the argument that "everyone is a member of a class of one" (Patterson, 2004, p. 67) and that no mental health counselor can be prepared in preservice training to counsel every conceivable type of client.

Those who voice these criticisms argue for counseling methods based upon the common nature of all human beings (Patterson, 2004). As examples, some critics have argued that the quality of universal caregiver skills (e.g., rapport, warm, genuineness, good listening skills, empathy) is more beneficial than "culture-specific" caregiver skills or decontextualized information and knowledge (Fischer, Jerome, & Atkinson, 1998; Patterson, 2004; Pope-Davis et al., 2002).

Failure to Promote Critical Thinking Braden and Shah (2005) argue that "multicultural training is valid only if the assumptions underlying it are valid" (p. 1025). While critical thinking is obviously a fundamental requirement of case conceptualization training in applied psychology (John & Segal, 2015), some training programs make little to no sustained effort to help students develop thinking skills to critically evaluate the many implicit assumptions that underlie cultural competence advocacy (Frisby, 2013, 2015; see also Lilienfeld, Ammirati, & David, 2012). When this becomes habitual and long-standing, students and practitioners develop a general attitude of intellectual laziness toward multicultural issues (Frisby, 2013).

As examples, some critics object to cultural competence training on the grounds that the content of such training consists of vague platitudes and bromides that merely reflect common sense principles for understanding any client (Satel and Forster, 1996). A different criticism holds that race-/ethnicity-specific teaching curricula for developing cultural competence promote silly and/or lazy stereotypes – most of which are subjectively determined, not based on rigorous empirical evidence, and are descriptive of only small subsets of the groups for whom they broadly describe (Frisby, 2013; Satel & Forster, 1996, p. 14). To combat this problem, Frisby (2013, pp. 502–509) demonstrated how readers can apply simple critical thinking skills (e.g., defining terms, asking for evidence/data, examining hidden assumptions, identifying faulty reasoning) to textbook passages about

multicultural issues. O'Donohue and Benuto (2010) provide a series of critical questions that must be asked if clinicians are to critically sift through the numerous issues implicit in understanding what it means to be culturally sensitive to clients.

Promotion of Sociopolitical Advocacy Some critics object to the notion that training for proficiency in cultural competence requires sympathy (at the very least) or actual participation (at best) in activist sociopolitical causes (Satel & Forster, 1996; Weinrach & Thomas, 2004) – on the grounds that such activities have a dubious relationship to the *actual* job requirements of mental health services to individual clients.

Student Resistance to Perceived Indoctrination Criticisms within this category observe that the constant emphasis on race, racial identity, and morality plays involving narratives of "white wickedness/minority victimhood" alienates and upsets both white and nonwhite students, resulting in a variety of negative reactions and coping styles in cultural competency training (e.g., anger, silence, avoidance, and/or passivity; see Jackson, 1998; Reynolds, 2011; Sue & Sue, 2016; Sue et al., 2009). Such observations are not unique to cultural competency classes for psychologists and counselors, but have been reported to occur in higher education situations outside of these contexts (e.g., Flaherty, 2013; Smallwood, 2005).

Disconnect Between Suggested Practices and Real-World Realities When trainers attempt to give concrete examples of how to apply cultural competency principles, some have argued that the exemplars used violate empirical reality and/or a basic understanding of common sense (see discussion in Weinrach & Thomas, 2002, pp. 28–9). As an example, Jones (2013) discusses a task within cultural competence training that teaches students how to enact social advocacy in the workplace. The task involves assessing a school district's racial disproportionality rates (presumed to apply to special education enrollment), implementing a school-wide pre-referral intervention program (designed to reduce disproportionalities), and then assessing improved outcomes (i.e., defined as reductions in disproportionalities).

Such a task assumes that disproportionalities are reflective of defective pre-referral intervention practices, which constitute an "injustice needing correction." The reality, however, is that state racial/ethnic disproportionalities in special education enrollment have always been pervasive nationwide (e.g., Office of Special Education and Rehabilitative Services, 2016) – with federal policy, generally, and school psychology, specifically, having found no successful methods or programs that have eliminated them (Skiba, Albrecht & Losen, 2013).

Professional Best Practices Critiques

Observations within this category focus criticisms on mandates, position papers, and "best practices" guidelines issued by professional organizations for psychologists and counselors.

Advocacy Driven by a "Vocal Minority" Weinrach and Thomas (2002) cite one writer with many years of teaching experience in counseling who opines that multicultural competencies are based only on the views of a select group of highly vocal professionals – the intent of whom is to "impose a social activist political agenda" that "express[es] a specific point of view rooted in the racial hostilities of the 1960s" (pp. 24, 29). Satel and Forster (1996) opine that "radical multicultural therapy is not concerned with the integration of racial groups but with discrediting traditional therapy as an oppressive manifestation of a white-dominated culture" (p. 5).

Weinrach and Thomas (2002) have argued that the professional work group that developed multicultural standards for the counseling profession (at the time of their writing) did not use an established procedure such as the Delphi method (Garson, 2014) that could have been applied to the varied responses of a broad pool of academicians, practitioners, administrators, and clients (which could potentially have had a stronger impact on the counseling field). They

argue that this oversight has the potential to engender resistance from the field that can be easily avoided if more appropriate and democratic methods had been used. Support for using the Delphi technique has also been echoed at the conclusion of literature reviews on caregiver cultural competence in the healthcare professions (see Alizadeh & Chavan, 2016, p. e126).

Hasty Mandates Absent Consensus or Sufficient Research Some argue that a professional organization's acceptance and promotion of multicultural competencies (in guild best practices and ethics documents) are fundamentally inappropriate due to "a lack of consensus regarding their need, a paucity of research to support the efficacy of their use in improving the practice of [applied psychology], and a dearth of information about how to implement them, either in the classroom or in the field" (Weinrach & Thomas, 2002, p. 32). In addition, they argue (although speculatively) that malpractice claims against mental health professionals are likely to increase once clients are made acutely aware of the existence of cultural competence best practices/ethics documents within applied psychology.

Commenting on the multicultural counseling competencies identified by Sue et al. (1982), Sue, Arredondo, and McDavis (1992), Atkinson and Israel (2003) opined that the competencies are little more than aspirational statements that quickly and successfully captured the enthusiasm of the counseling psychology profession but nevertheless have not witnessed any serious efforts to empirically validate the competencies (for a rare exception, see Pope-Davis et al., 2002). They express serious reservations about the hasty acceptance of four cultural competency assessment instruments for counseling psychology developed during the early 1990s (D'Andrea et al., 1990; LaFromboise et al., 1991; Ponterotto et al., 1991; Sodowsky et al., 1994) that were adopted by the profession but turned out to measure nothing more than "self – efficacy for [multicultural counseling competencies], not [multicultural counseling competency] itself " (p. 595). Once social desirability is accounted for, no relationship was discovered between self-efficacy scores on these instruments and case multicultural case conceptualization ability (Constantine & Ladany, 2000; Ladany, Inman Constantine, & Hofheinz, 1997). Furthermore, they opined that policy initiatives on behalf of the CC movement have jumped far ahead of its research base, and "the reality is that very little research actually supports either the policy changes that have been implemented by the APA and other professional organizations of the MCC training models that have been an important feature of the movement" (pp. 593–594).

Critiques Related to Practice

Critiques within this category relate to perceived problems in the application of cultural competence to actual work with clients.

Questioning the Need for Multicultural Competencies Some scholars argue that the underlying conditions necessary to facilitate healing are universal regardless of whether or not the counseling involves multicultural issues (Fischer, Jerome, & Atkinson, 1998).

Qualitative research studies, in which participants give their unfiltered opinions within the context of individual or group interviews, provide actual data where practitioner views often *contradict* pronouncements from high-profile leaders in applied psychology professional guilds and organizations on the topic of cultural competency. As an example, Granello, Wheaton, and Miranda (1998) interviewed three focus groups consisting of African-American only, European American only, and a mixed-race group of state-agency rehabilitation counselors on the topic of multicultural competency skills, knowledge, and awareness. Among other findings, some interviewees rejected the practice of lumping all whites together into a homogeneous group that lacks ethnic diversity (when using skin color as the sole criterion for determining cultural identity). Particularly damaging for the

cultural competency movement were (1) their perception that good listening skills constituted the most important counseling competency for all cultural groups; (2) their skepticism about the usefulness of multicultural knowledge to counseling competency, particularly given its potential for stereotyping; and (3) their doubt about the existence of culturally specific skills and interventions that were uniquely effective for particular groups.

Potential for Ethical Violations Some have cautioned that it would be both ethnically and professionally unwise for practitioners to make clinical practice decisions on the basis of a perceived cultural competency mandate from one's professional organization – when that practice violates professional ethics or a given standard of personal morality (Paasche-Orlow, 2004; Weinrach & Thomas, 2004). These critics argue that the problems for which persons seek help may have nothing at all to do with a person's racial/ethnic/cultural group membership. Thus, for psychologists and counselors to automatically assume that they do (and to behave accordingly) would be to commit "a serious error in diagnosis and treatment" as well as behave in an "unprofessional" and "unethical" manner (Weinrach & Thomas, 2004, p. 83).

Sometimes critics will argue that ethics guidelines provide little to no insight for clinicians striving to be culturally competent in practice. O'Donohue and Engle (2013) cite a section of the American Psychological Association (APA) Ethics Code (American Psychological Association, 2010) which requires psychologists to obtain the training and expertise necessary to ensure "competence" of services that involve an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status. They argue that since no well-validated empirically supported treatments for specific cultural groups exist (at least at the time of their writing):

> [G]aining an appropriate level of competency as a prerequisite to working with certain groups, as required in the Ethics Code, is a complicated feat to accomplish and must depend on some other form of "professional knowledge." Given that there is no agreement in the field about what requisite knowledge entails, the field is left open to nearly any and every idea about how one might first identify a deficit of requisite knowledge, and then develop and maintain a level of competence sufficient to provide care …. This standard broadens the opportunity for psychologists who are attempting to be "culturally sensitive" to instead categorize and conceptualize a client from a perspective that could possibly cause harm. (p. 319)

To illustrate this problem, the authors give a hypothetical example of a Native American client from the Cherokee tribe, who suffers from a panic disorder. A "culturally sensitive" therapist, following the dictates for adhering to "culturally sensitive treatments" (see previous section on Empirical Critiques), may suggest that the client submit to a tribal healing ritual practiced for centuries. However, due to the dynamics inherent in the client's presenting problem, this treatment may do harm. In this hypothetical scenario, administering a treatment based on the client's cultural/ethnic affiliation would not be professionally "ethical" or even wise. In partial support for this possibility, Huey et al. (2014) report findings from an unpublished meta-analysis of culturally tailored versus generic treatments which concluded that tailoring effects resulted in negative effects nearly as often as they resulted in positive effects (Huey, 2013).

Living with Ambiguity Due to these inherent difficulties in applying cultural competence theory to practice, some have argued that applied psychologists must learn to live with a certain degree of "felt ambiguity" (p. 33) in their professional work, as mandating a uniform code of behavior based on cultural competency theory is little more than an exercise in futility (Weinrach & Thomas, 2002).

Critiques Offered as a Catalyst for Improving Cultural Competence Theory and Research

"Back to the Drawing Board"

Stuart opines that "[a]lthough it is easy to endorse the principle of culturally sensitive practice, it is often much harder to make it a reality" (p. 3). Even its most ardent supporters recognize that significant conceptual problems undermine cultural competence research. For example, Dr. Derald Wing Sue – who is generally credited with spearheading the aggressive introduction and subsequent development of cultural competency in American psychology – has remarked:

> In general, it has been difficult to develop research strategies, isolate components, devise theories of cultural competency, and implement training strategies. Some limitations in cultural sensitivity or competency are that it (a) has various meanings, (b) includes inadequate descriptors, (c) is not theoretically grounded, and (d) is restricted by a lack of measurements and research designs for evaluating its impact in treatment (Sue et al., 2009, p. 530)

Improving Theory Gallegos, Tindall, and Gallegos (2008) articulate a fundamental criticism of the cultural competence concept that raises serious doubts as to its legitimacy as a scientific construct. They argue:

> The concept of cultural competence has become ubiquitous in human services language and settings. Though the literature from various disciplines is replete with discussions on the topic, there still exists much disagreement regarding the definition of cultural competence as well as how to operationalize, test, and apply concepts related to cultural competence in social service settings. A related issue stems from debate regarding whether cultural competence is a theory, model, paradigm, framework, or perspective. Though cultural competence has been referred to as a theory by some scholars from different disciplines … there is still disagreement about whether the concepts related to cultural competence actually meet the criteria for a theory and, consequently, whether they can be used to generate hypotheses and allow for independent observations that can be used to continue building theory, conduct empirical research, and provide evidenced-based practice implications. (p. 51)

Material within the previous section has highlighted critics' contention that cultural competence advocacy is inextricably intertwined with sociopolitical ideology (Frisby, 2015; Levitt, 2005; Satel, 2000; Satel & Forster, 1999; Thomas & Wubbolding, 2009; Weinrach & Thomas, 1996, 2004). If cultural competence is to be viewed as a "legitimate" and nonpoliticized theoretical construct in science, then it must adhere to rules for what constitutes a "good theory." Theories are always subject to revision, testing, and refinement as scientific inquiry advances. Therefore, scientific theories are not portrayed as facts but are more accurately understood as statements of likelihood. The academic literature offers many definitions for what a theory is (see Gay & Weaver, 2011). Theories can be distinguished, in part, by adhering to the elements that distinguish good theories from merely "any theories" or at worse "bad theories." Wacker (2008) defines a "good theory" as "a fully explained set of conceptual relationships used for empirical testing" (p. 7). By pursuing criteria for good theories, researchers are better able to develop empirical studies that will have a lasting impact on their academic field (Wacker, 2008, p. 5). According to Wacker (2008), the following criteria (in part) characterize good theory in science:

Definitions Science can only advance as rapidly as the language that expresses its concepts (Wacker, 2008, p. 8). When researchers use ill-defined concepts, or assume that previously used concepts are adequate when in fact they are not, then researchers have little idea what they are measuring, testing, or discussing. Good theories adhere to the following criteria when using definitions for terms:

Conservation Property Good theories are careful to carefully distinguish terms from highly similar terms that may have been used in the past. This ensures that "new" words do not simply reflect the same concepts called by different names. As can be seen in the History and Development of Cultural Competence Advocacy chapter, words that comprise the term "cultural

competence" (CC) overlap considerably with at least a dozen similar terms found in a wide variety of disciplines both within and outside of the social sciences. A complicating matter is the fact that the cultural competence construct – as it has been used in applied psychology – has not been adequately differentiated from earlier concepts such as "social competence" (e.g., see Schneider et al., 1996). Specifically, researchers have not done the necessary empirical work to address questions of whether or not social competence subsumes cultural competence, if social competence is a necessary but not sufficient condition for cultural competence, or whether social competence and cultural competence are entirely independent constructs (see Frisby, 2009).

Uniqueness Property When terms used in one construct are similar to terms used in other constructs, then it increases the difficulty with which the uniqueness of the construct can be discerned. As shown in the History and Development of Cultural Competence chapter, terms such as "cross-cultural competence," "intercultural competence," "cultural sensitivity," and "cultural humility" are often used interchangeably, even by scholars within the same disciplines.

Parsimony Shorter, more concise definitions are preferred to longer definitions in order to reduce the risk of terms becoming too broad conceptually, which risks confusion with other terms. As shown in Table 2.1 from the History and Development of Cultural Competence chapter, definitions for cultural competence can be quite lengthy.

Theory Domain All other things being equal, better theories can be applied at more times and in more places than lesser theories. The wider the existing populations to which the theory can apply, the more generalizable the theory is. In addition, the degree to which a theory is independent of time and physical space requirements, the more abstract the theory is. Wacker (2008) calls the abstractness criterion "the ideal goal of theory [development]," because "the theory applies to all times and all places" (p. 10). Paradoxically, good theories must also "tell you what it cannot tell you." That is to say, a good theory outlines its own limitations as to what can or cannot be investigated, as some topics lie outside of the scope and parameters of the theory.

At the time of this writing, the scope and application of the cultural competence construct remain unclear. Frisby (2009) articulates this ambiguity as follows:

> Is [cultural competence] a nominal dichotomous variable, which clearly categorizes practitioners into those [who] are culturally competent versus those who are not? Or, are there degrees of cultural competence? If there are degrees of [cultural competence], how does the field characterize persons who have "more" [cultural competence] from those who have less? Is cultural competence a generalized continuous variable analogous to having a "cultural competence IQ"? Or, is cultural competence simply the accumulation of discrete uncorrelated skills? Can a person be culturally competent only in certain settings with certain groups, but also be culturally incompetent in other settings with different groups? (p. 869)

Explanation of Statistical Results When statistical analyses are applied to a research data, the manner in which statistical results are interpreted in support of a theory is another criterion that distinguishes among the quality of theories. The following key requirements are necessary for "good" theories (Wacker, 2008):

Fecundity In addition to explaining existing phenomena, good theories offer new areas for potential research. This quality causes good theories to be superior to existing theories that can only explain a limited pool of issues. By integrating more and more concepts into larger theories (that can explain more events), science is advanced.

Internal Consistency Good theories are logically consistent. As theories are composed of interrelated statements, all statements comprising the theory must be true at the same time in order for the theory to be internally consistent.

Parsimony The principle of Occam's razor holds that when deciding among competing hypotheses or theories for observations, the hypothesis or

theory with the fewest assumptions is preferred because it is the most testable (Sober, 2015). The tendency is for overly complex theories to incorporate ad hoc explanations for explaining inconvenient findings, whereas simpler and more parsimonious theories are better able to be falsified.

Predictability As stated earlier, good theories are able to be falsified (Popper, 2002). That is, good theories clearly state the conditions under which the theory can be refuted by independent researchers. Bad theories are theories that are designed in a manner that negates their ability to be disproved by independent researchers. Wacker (2008) argues that a bad theory can never be disproved because there are so many conceptual loopholes that would never allow the theory to be disproved (p. 7). If a bad theory is not disproved because of faulty construction, then this can lead to the equally faulty conclusion that the theory must be true. This then leads to the observation that, even if a theory promotes itself as "scientific," it is not scientific if it does not (or cannot) incorporate the potential for falsification.

In applying this principle, therefore, it is incumbent on cultural competence theorists to specify in sufficient detail the conditions that would falsify the validity of the cultural competence construct as a useful explanatory variable in applied psychological outcomes. For example, are there conditions for which a clinician possesses no skills that can be deemed "culturally competent," yet clients experience positive outcomes? Similarly, are there conditions for which a clinician possesses exemplary cultural competence, yet clients experience negative outcomes? As an example, how would cultural competence theory explain why clinicians and clients belonging to the same racial/ethnic group experience negative client outcomes?

Improving Measurement Depending on the field of study, the definition for a construct and the measurement of the construct are intimately intertwined. In the history of human intelligence research, rapid progress in the study of intelligence did not occur until the definition of intelligence was empirically operationalized as the *g* factor or the common factor responsible for positive nonzero correlations among all mental tests (Jensen, 1998). Before then, verbal definitions of intelligence given by experts did not yield anything coming close to a consensus. Jensen (1998) writes:

> No other term in psychology has proved harder to define than "intelligence." Not that psychologists haven't tried. Though they have been attempting to define "intelligence" for at least a century, even the experts in this field still cannot agree on a definition. In fact, there are nearly as many different definitions of "intelligence" as there are experts .... Therefore, the term "intelligence" should be discarded altogether in scientific psychology ... [it] will continue, only because it can mean anything the user intends, and where a precise and operational definition is not important .... To put the study of mental ability on a firm scientific footing, we must begin by using theoretically neutral, objective, operational definitions. (pp. 46, 48, 49)

Objective observers can easily see the same conditions surrounding the term "cultural competence." Nevertheless, the cultural competence movement continues in its attempt to develop measurements of cultural competence despite having no commonly accepted consensus on its definition. As the content in Table 2.1 (see "*History and Development of Cultural Competence Advocacy*" Chap. 1, this book) indicates, definitions for cultural competence vary considerably. Here, the construct of cultural competence is not measured directly but instead consists of caregivers' subjective assessment of their own attitudes related to cultural competence or client ratings of the extent to which they feel that their counselor is culturally competent.

This leads to Wacker's (2008) second point, namely, that researchers cannot precisely measure what they cannot define precisely (p. 9). If terms used in a theory are vague, ambiguous, and ill-defined, then this leads to a plethora of measures that may yield contradictory results that are difficult to integrate into a clear conceptual whole. Furthermore, this disconnect between conceptual clarity and measurement leads to situ-

ations in which the use of measurements may lead to statistically significant results that are practically meaningless.

Worthington et al. (2007) opine:

> [I]t is impossible to measure actual multicultural counseling performance or skills via paper-and-pencil self-reports. Instead, measurement of skills should be based on observations of actual performance and should be highly contextualized – meaning that a counselor's score should be specific to each discrete performance, rather than based on global ratings assumed to generalize to future performances (p. 359)

Worthington et al. (2007) opine "we should be working toward the development of instruments that will assess knowledge, awareness, and skills that range from very broad and basic to very focused and complex" (i.e., that assess narrower segments of target populations, as in Latinos to Chicanos/Chicanas – see p. 360).

In a concise summary of a number of these criticisms, Gallegos et al. (2008) argue that "cultural competence" is not a scientifically useful theory because (1) what may be observed as culturally competent is given to value judgments, (2) cultural competence does not lend itself to prediction or measurement, (3) cultural competence lacks discernable or agreed-upon attributes, (4) cultural competence does not predict behavior, and (5) cultural competence lacks a dynamic relationship among (independent and dependent) variables (p. 56).

"Open Exploration into Previously Neglected Areas"

Some writers criticize cultural competence on the grounds that its current application is to some degree "too narrow," which in their view requires an expansion of advocacy efforts into new or under-researched areas.

Expand Pool of Groups for Study Many critics have argued that the cultural competency movement in mental health counseling, healthcare, and closely related fields has focused on only a few minority groups and in doing so has failed to be sufficiently inclusive in its attention to other minority groups. These critics mention women (Pieterse, Todd, Neville, & Carter, 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the disabled (Eddey & Robey, 2005; Pieterse et al., 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the elderly (Pieterse et al., 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the overweight (Pieterse et al., 2012; Weinrach & Thomas, 1996), and the religious (Pieterse et al., 2012; Priester et al., 2008; Vieten et al., 2013) as groups deserving of increased attention.

Expand Areas of New Competencies Vieten et al. (2013) argue that, although religion and spirituality are important areas that define individual identity and living, religion/spirituality is not often discussed in psychotherapy, nor included in assessment or treatment planning, nor included in cultural competence training.

Expand Focus Outside of White Trainees Negy (1999) criticizes cultural competence training for its exclusive orientation to the training of white students, particularly as this relates to the assumption that racism and prejudice are unique to only whites (while failing to address bias of nonwhites against whites; Negy, 1999). In their comments on the topic of multicultural counseling training, Sue and Sue (2016) opine:

> "[S]ome students of color come to believe that multicultural training is only for White students; the implicit assumption is that they know the material already and are the experts on the subject … such a perspective prevents self-exploration and constitutes a form or resistance … people of color … are not immune from prejudice, bias, and discrimination …. Multicultural training is more than [dyads involving Whites vs. Non-Whites]. It is also about African American-Asian American, Asian American-Native American, and Latino/a-Native American relationships …. Race, culture, ethnicity, gender, and sexual orientation/identity are about everyone; it is not just a 'minority thing'." (p. 19)

Ongoing/Unresolved Controversies

As stated earlier, many scholars believe deeply in the construct validity of cultural competence and devote considerable effort conducting research in

hopes that they can improve on its shortcomings. Among those who hold this view, they identify key areas of controversy that remain unresolved to this day, which are briefly discussed below:

Controversies Over CC Definitions/Measurement In the first half of this chapter, readers were exposed to analyses that made explicit the hidden assumptions that often are unstated in CC theory, for the purpose of showing them to be in error (which implies that cultural competency itself is a flawed construct). Kumaş-Tan et al. (2007) use the same analytic tools; however, their ultimate purpose is to argue that cultural competence theory and practice – while presently flawed – can be ultimately improved if audiences are willing to think more critically about its implicit assumptions. These authors identified the ten most frequently used cultural competence measures (at the time of their writing) used in counseling psychology, mental health counseling, nursing, and medicine. From a close examination of these measures, they identified six implicit assumptions that they regard as flawed and/or highly problematic:

1. *Culture is a matter of ethnicity and race.*
2. *Culture is possessed by the Other; the Other is/has the problem.*
3. *The problem of cultural incompetence lies in practitioners' lack of familiarity with the Other. Practitioners should be aware of, knowledgeable about, and seek contact with the Other.*
4. *The problem of cultural incompetence lies in practitioners' discriminatory attitudes toward the Other.*
5. *Cross-cultural healthcare is about Caucasian practitioners working with patients from ethnic and racialized minority groups.*
6. *Cultural competence is about being confident in oneself and comfortable with others.*

The authors advocate challenges to the underlying worldview that they see these assumptions as representing. They write:

> [W]e might reconsider a definition of culture that encompasses not only ethnicity and race, but also (at least) gender, age, income, education, sexual orientation, ability, and faith …. [W]e may need to … shift and expand what it is that we measure when evaluating cultural competence, … measure constructs above and beyond cultural competence in the traditional sense … develop more theoretically informed measures of effective practice across cultures, and/or … explore alternate methods for evaluating cultural competence, namely, qualitative and mixed methods. (p. 555)

Huey et al. (2014) propose a novel approach to rethinking how cultural competence is conceptualized and defined. This novel approach arises from the atheoretical "dust bowl empiricist" tradition (Nugent, 2013), which uses an inductive rather than deductive process to explicate important relationships in data. Here, they advocate defining cultural competence by first researching the factors that determine what makes some therapists effective with minority clients vs. those factors that cause therapists to be ineffective with minority clients. Survey and treatment process research would identify the personal characteristics and clinical skills that empirically differentiate these two groups. Writing about the relationship between caregiver cultural competence and patient outcomes within the healthcare field, Alizadeh and Chavan (2016) identify seven categories of outcomes that can serve as indicators of a clinician's cultural competence effectiveness: (1) increased numbers of patients seeking treatment, (2) lower rates of morbidity and mortality, (3) increased adherence to treatment, (4) higher levels of trust, (5) increased feelings of self-esteem, (6) improved health status, and (7) greater satisfaction with care.

Controversies in Research Pope-Davis et al. (2001) advocate for more research on culturally diverse clients' experiences with counselors. They argue that such research needs to "investigate the experiences of actual clients who have gone through therapy with a perceived multicultural counselor … to examine potential patterns in experiences" (p. 132). Pope-Davis et al. (2001) also advocate for more research in counselors' perceptions of their supervisor's cultural competence and how this may qualitatively impact the client/counselor relationship.

They argue in favor of using qualitative research methods, which would allow clients to describe their experiences in their own language. Qualitative research has the added advantage of allowing researchers to avoid the limitations of survey research (i.e., researcher biases, inability of surveys to capture key variables of interest to multicultural counseling).

Huey et al. (2014) offer the following suggestions for improving the design of research to better isolate and evaluate the specific effects of culturally competent practice. First, they recommend designing studies that would enable the researcher to clearly observe that the "culturally tailored" treatment leads to a significantly greater symptom reduction (or treatment engagement) than a generic treatment. The generic treatment should include the same core features as the culturally tailored treatment, yet not differ substantially in length or intensity.

Second, randomized controlled trials should have appropriate statistical power to detect effects from the cultural tailoring treatment. Third, the mechanisms hypothesized to account for cultural tailoring effects should be specified, tested, and confirmed by research. They justify this on the grounds that "cultural tailoring may enhance treatment effects, but not necessarily for the reasons theorized by investigators" (p. 322). Fourth, the authors argue that cultural adaptations and/or processes culled from research literatures outside of counseling and clinical psychology "could expand the range of treatment options for ethnic minorities" (p. 324).

Controversies in Training As observed in the History and Development of Cultural Competence Advocacy chapter, cultural competence self-report scales are an established fixture in much CC research. However, Jones, Sander, and Booker (2013) advise *against* using MCC self-report scales for evaluating trainee skills (p. 18). They state:

> Instead, we encourage the use of them for facilitating discussion, engaging in the process of self-reflection, and as an opportunity to learn more about your students to inform instruction or overall program development. In general, it is recommended that students be evaluated using a combination of evaluation methods for broad areas of professional development like cultural competence. (pp. 18–9)

Patterson (2004) argues that simple knowledge of different subgroups learned within a classroom setting is a necessary but insufficient method for developing cultural competence. Instead, it is argued that the best way to attain knowledge of a cultural group is to actually live within a community comprised of the kinds of clients with whom one expects to work.

Controversies Over Practice If the issue of cultural competence is set aside only momentarily, there exists a general agreement about the dearth of psychotherapy efficacy research with racial/ethnic minority clients (Lau et al., 2016). Nevertheless, there is a clear difference of opinion that can be identified in the literature as to the implications of this observation. One side opposes the practice of generalizing treatments to racial/ethnic minority populations in the absence of sufficient data. Those holding this view argue that this suggests a form of "cultural imperialism," in which the administration of treatments not validated on nonwhite groups should be accompanied by "warning labels" of limited external validity (Bernal & Scharrón-del-Río, 2001). Some have voiced concern that generalization of treatments that have not been sufficient validated on racial/ethnic minority groups may have the unwanted effect of reducing commitment to conduct necessary validation research on these groups (Sue & Zane, 2006).

In contrast, others argue that it would constitute a more serious error if insufficiently validated treatments were withheld from minority groups that could be helpful. Those who advocate for this position base this assertion on the following observations: (1) clinical evidence that evidence-based treatments can be used effectively with racial/ethnic minorities, (2) a small international literature on treatment outcomes, (3) a lack of evidence that evidence-based treatments are not effective for ethnic minorities, and (4) emerging findings that evidence-based treatments are effective for diverse samples (Lau et al., 2016; Miranda et al., 2003).

Returning to the issue of cultural competence, Stuart (2004) discusses 12 suggestions that, in his view, would help caregivers to "avoid stereotypes and identify the multiple cultural influences that often operate unconsciously in the mixed identities of most clients" (p. 6). These suggestions, coupled with a brief highlights within each, are adapted and outlined below:

1. *Develop skill in discovering each person's unique cultural outlook*. Here, clinicians are encouraged to develop ethnographic interviewing skills that would enable them to understand which specific aspects of clients' backgrounds are relevant to their own specific worldview.
2. *Acknowledge and control personal biases by articulating your worldview and evaluating its sources and validity*. Here, clinicians are encouraged to periodically evaluate their personal experiences about persons from a given racial/ethnic group with the research literature.
3. *Develop sensitivity to cultural differences without overemphasizing them*. The observation of a few stark differences between groups (however defined) should not be the basis for the gratuitous assumption that all other aspects about groups should be different as well.
4. *Uncouple theory from culture*. In understanding individuals, replace the broad category of "culture" with measurable psychological variables along which individuals differ.
5. *Develop a sufficiently complex set of cultural categories*. Since persons reflect far more diversity than is reflected in the language used by (academic) multiculturalists, it is more advisable to describe rather than categorize clients' identities.
6. *Critically evaluate the methods used to collect culturally relevant data before applying the findings in psychological services*. Researchers must define the population to which test/survey results will be generalized and make sure that the samples used to generalize are adequate in both size and representativeness.
7. *Develop a means of determining a person's acceptance of relevant cultural themes*. Clinicians are encouraged to use nuanced interviewing techniques to ascertain the extent to which specific "cultural" beliefs/practices are accepted, how strongly each is accepted, or whether or not particular beliefs are situation specific.
8. *Develop a means of determining the salience of ethnic identity for each client*. Demographic racial/ethnic categories may dominate, merely influence, or be utterly inconsequential with respect to a client's felt identity. "Sensitive" assessment involves asking clients to articulate the sources of their values/perspectives – which may involve many other factors related to developmental stage, gender, sexual orientation, religion, or nationality.
9. *Match psychological tests to client characteristics*. Great care must be taken to evaluate the appropriateness of instruments used in clinician/client interactions, and written reports must acknowledge any possible cultural bias that may impact findings.
10. *Contextualize all assessments*. Identify common environmental stresses experienced by members of racial/ethnic/cultural groups, and then consider the extent to which individual "traits" can or cannot be relabeled as coping responses.
11. *Consider clients' ethnic and worldviews in selecting therapists, intervention goals, and methods*. Intervention is not likely to succeed when it is offered by providers who do not earn clients' trust, use language or concepts that are not understood, or require behavioral or cognitive skills that clients lack. Careful matching of service providers and methods to clients' preferences and expectations helps to remove unnecessary obstacles to effective therapy, as well as enhances outcome.
12. *Respect clients' beliefs, but attempt to change them when necessary*. Empathetic caregivers see the world from the clients' perspective, but do not necessarily accept everything in the

client's view as healthy. There may be instances in which it is appropriate and/or ethical to change certain beliefs and/or behaviors.

In what is perhaps the most practical suggestion for improving cultural competence in practice, Huey et al. (2014) suggest that once culturally competent behaviors are reliably identified, researchers would do well to avoid requiring clinicians to use cultural competence protocols that involve "considerable training, complex protocols, extensive monitoring, substantial costs, and applicability only to narrow demographics" (p. 331). Instead, they advise the development and use of inexpensive, easy-to-adapt cultural competence protocols that "create minimal burden to mental health professionals" (p. 331).

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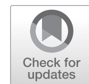

4 Conceptual and Empirical Issues in Training Culturally Competent Psychologists

Craig L. Frisby, William O'Donohue, Lorraine T. Benuto, and Jena B. Casas

The current zeitgeist in applied psychology training portrays the development of cultural competence as a necessary and highly valued component of clinical training (DeAngelis, 2015; Mena & Rogers, 2017). This has prompted the American Psychological Association (APA) to create guidelines for multicultural education, training, research, practice, and organizational change for psychologists (APA, 2002), as well as mandate culturally competent behavior in its Ethical Principles of Psychologists and Code of Conduct (APA, 2017). If students attending applied psychology training programs are expected to develop cultural competencies, then they must be exposed to structured experiences designed to assist them in this goal. Such experiences include, but certainly are not limited to, didactic classroom instruction. It is also not clear whether practicing professionals require additional training as they face new situations (e.g., their caseload includes a minority group for which they have little experience), or need "refresher" courses because either their skills might decay, or because the field may advance. Interestingly, professional scholarly opinion as to the feasibility of teaching cultural competence training (across a variety of sources both within and outside of applied psychology) tends to vary considerably. These differences of opinion can be subdivided into three broad categories, which acknowledges that subcategories within each of these broad categories also exist.

The first category includes writers who support commonly given justifications as to the need for cultural competence, accept implicitly how the construct has been defined, and support the urgency for developing cultural competence as a permanent and ongoing professional trait in future practitioners. Some advocates within this first category see the construct of cultural competence in strictly *moral terms* – believing that the teaching of cultural competence is necessary in order to help learners understand the impact of social structures on power, privilege, and oppression (e.g., see Cultural Competence Training in the Context of Civil Liberties chapter, this text; Robinson, Cross-Denny, Lee, Rozas, & Yamada, 2015) – or rid learners of conscious or unconscious moral evils (e.g., "racism"). According to Torino (2015), for example, cultural competence is increased when White counseling trainees develop a "non-racist White racial identity" through teaching that helps them to examine their biases and explore their White privilege.

Other writers believe implicitly that cultural differences result in chasms of misunderstanding between individuals that are so difficult to bridge,

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that intensive special training is needed to bridge the gap. Priya (2017) opined that "all psychotherapy is cross-cultural, as even a clinician and a patient from similar socio-demographic backgrounds may have widely differing constructs of mental health, relationships, and indeed of the psychotherapeutic process itself" (p. 55).

She argues that a culturally competent supervisor provides teaching strategies for supervisees that enables them to "navigate . . . intersecting cultural forces" in psychotherapy (p. 55). Leonard and Plotnikoff (2000) assert that "although knowledge of many cultures is impossible, [the] willingness to learn about, respect, and work with persons from different backgrounds is critical to providing culturally competent care" (p. 51).

Although these writers opine that "correct attitudes" are the fundamental ingredient for developing cultural competence, other writers believe that cultural competence is fully attainable with the right "toolkit." The toolkit approach essentially argues that if consumers are provided with explicit and concrete step-by-step procedures to implement in practical settings, a comprehensive array of hands-on materials that can be used in practice (e.g., treatment guides for specific cultural populations [Benuto, 2017; Benuto & Leany, 2017], assessment guides [Benuto, 2013a, 2013b], etc.), reproducible instruments to use for evaluation of training outcomes, easy access to outside informational resources for networking/partnership opportunities and continuing education, appropriate case study materials that explore a wide variety of diversity issues (e.g., Benuto & Bennett, 2015), and links to published studies which presumably provide research support for an intervention – that cultural competence is fully achievable. As one example of this approach, Jeffreys (2015) describes the benefits of a recent textbook for developing cultural competence in nursing and health-care professionals:

> These hands-on, user-friendly resources reveal a systematic seven-step approach that takes nurses, educators, administrators, professional association leaders, managers . . . students, and other health care providers from their own starting points toward the pinnacle – optimal cultural competence. (p. xv)

In short, trainers whose views most closely align with this first category seem relatively unconcerned about questioning the legitimacy and validity of the cultural competence construct. What seems most important to these advocates is for audiences to (1) recognize its importance and (2) do whatever is necessary for practitioners to "get it." In addition, they seem to adhere to what Kiesler (1971) has classically called "client uniformity myths." The problematic idea in this is that trainees are so uniform that some standard training will result in the same positive effects for all. Of course, this is more than a little ironic given the general diversity ideology of this training. Important empirical questions remain regarding the extent to which these cultural trainings are effective at producing cultural competence (whatever this may mean) and the extent to which trainee variables interact with trainings to produce differential outcomes.

A sizable number of writers, while asserting that cultural competence is widely considered to be an important component of practitioner training – also concede that cultural competence remains challenging, if not difficult, to operationalize clearly (Frisby, 2009; O'Donohue & Benuto, 2010; Priya, 2017; Sue, Zane, Hall, & Berger, 2009). Other writers are bothered by what is perceived to be an overly simplistic manner in which the term is defined and understood conceptually (Kleinman & Benson, 2006), its tendency to occasionally lead audiences into faulty assumptions about clients that should be avoided in practice (Stuart, 2004), the observation that cultural competence has not been adequately differentiated from similar psychological constructs (Frisby, 2009), the perception that cultural competence is more *discussed* than it is *empirically investigated* in the professional literature (Worthington, Soth-McNett, & Moreno, 2007), and the lack of evidence of its predictive validity in real-life contexts – especially if it is positively correlated with client outcomes (Braden & Shah, 2005).

These and other writers comprise a second category, which sees value in pursuing the positive features of the cultural competence construct that are conceptually and empirically

defensible – while at the same time recognizing (and seeking to correct) its conceptual and empirical shortcomings. It is reasonable to assume that these scholars would include important caveats and safeguards in the teaching of cultural competence.

A third category of scholars have serious concerns about the cultural competence construct – and by extension its ability to be successfully taught to students. These concerns focus on the ideological, definitional, and/or empirical problems that are deeply intertwined within the cultural competence construct. Some writers essentially argue that the biased sociopolitical and ideological roots of cultural competence advocacy have poisoned the scientific and professional integrity of the movement. For example, Weinrach and Thomas (2004) opine that the Association for Multicultural Counseling and Development's (AMCD) multicultural counseling competencies are essentially "political . . . in nature," and their tone and style are more consistent with a "manifesto" designed to establish a "political identity to the groups that issue them" (p. 85). They observe that anyone who disagrees with any aspect of how cultural competence is defined is routinely demeaned by militant cultural competence advocates (at least within the counseling psychology profession) as "racist," "ethnocentric," "Eurocentric," and suffering from "White privilege" or "White supremacy."

Other scholars essentially argue that audiences are prone to overlook significant difficulties in the cultural competence movement's fundamental definitional and conceptual assumptions. For example, O'Donohue and Benuto (2010) point out serious problems with the lack of clarity in defining "culture" and "sensitivity," as well as problems in defining what elements of a treatment need to be culturally tailored for a particular cultural group (Benuto & O'Donohue, 2015). Patterson (2004) argued that there is a faulty assumption in the literature whereby counseling or psychotherapy is a simple matter comprised solely of information, knowledge, practices, skills, or techniques. Patterson also questioned the assumption that differences between the clinician and the client outweigh the importance of similarities. Patterson suggested that a focus on similarities between the client and clinician could lead to improved rapport.

Finally, many writers argue that the cultural competence movement is lacking a solid empirical base that justifies specific practice recommendations. At the time of their writing, for example, Atkinson and Israel (2003) argued that very little research supported the validity of multicultural counseling competencies promoted by professional organizations or policy changes that have been implemented by the APA and other professional organizations related to the promotion of multicultural counseling competencies. Patterson (2004) concluded that there is no evidence for the appropriateness or effectiveness of specific methods, techniques, or skills for working with multicultural clients. Moreover, research findings indicate that little professional consensus exists among experts as to the nature of cultural competence and its components (Cunningham, Foster, & Henggeler, 2002), and clients do not rate therapists with specialized training superior to those without (Stanhope et al., 2008). As a result of disappointing findings from a study designed to identify consensus among family caregivers, family advocates, administrators, and community stakeholders in the children's mental health system, Davis (2004) concluded:

> . . . the dearth of empirical support for culturally related concepts and practice models raises troubling questions about the foundations upon which social work students are being educated about culturally responsive practice. (p. 220)

Reviews of Cultural Competency Training

Using meta-analytic techniques, Smith, Constantine, Dunn, Dinehart, and Montoya (2006) concluded that multicultural education interventions were typically associated with increased cultural competency largely assessed through the administration of self-reported

questionnaires across a wide variety of participants and study characteristics. In addition, they found that multicultural education interventions which were explicitly founded on research-based principles of multicultural competence (and included theory-based curricula) yielded outcomes nearly twice as beneficial as those that were not.

However, Smith et al. (2006) failed to define what exactly was meant by "research-based principles" and "theory-based curricula," in addition to noting other problems in the studies they reviewed (e.g., see Benuto, Casas, & O'Donohue, 2018 for additional details). Lie, Lee-Rey, Gomez, Bereknyei, and Braddock (2011) reviewed seven studies involving health professionals that focused specifically on the positive relationship between cultural competency and patient outcomes but did not expressly focus on mental health professionals. Most recently, Smith and Trimble (2016) conducted a meta-analysis of surveys and outcome studies with the aim of assessing the extent to which multicultural training improved therapists' ability to effectively serve diverse clients. Unfortunately, their review was not published in a peer-reviewed journal, and as such the review did not undergo a peer-reviewed evaluation process. In addition, a substantial proportion of studies they reviewed included samples of undergraduate students (i.e., not professional therapists), and there is a large degree of variability across helping professions with respect to the types of services delivered and the type of training that is mandated by the associated professional organization (e.g., the American Psychological Association vs. American Association for Marriage and Family Therapists).

Mills et al. (2016) used a pre- vs. posttest questionnaire to assess the effects of a 1 h didactic teaching session on the DSM-V cultural formulation interview with psychiatry residents and found that mean scores changed significantly (in a positive direction) as a result of the intervention. Although they noted important limitations in these results, they concluded that "psychiatry residents' cultural competence scores improved" (p. 829) as a result of the training. This conclusion stays close to the data; however, the overall title of the research article does not – which reads, in part: *Training on the DSM-5 Cultural Formulation Interview Improves Cultural Competence in General Psychiatry Residents.* Here, increases in scores on a self-report paper and pencil instrument do not necessarily reflect actual changes in cultural competence as generally demonstrated in an actual work setting (Frisby, 2009).

Current Review of Cultural Competency Training Goals Benuto et al. (2018) conducted a systematic review of how psychologists are trained for cultural competence. They addressed the following specific questions:

1. What research methodologies are employed to examine the effects of cultural competency training?
2. How are psychologists trained to be culturally competent, including what are the specific goals of cultural competency training?
3. How are training outcomes assessed (i.e., what are the expected outcomes of cultural competency trainings)?
4. What are the outcomes of cultural competency training?

Benuto et al. (2018) searched several different databases (PsycARTICLES, PsycCRITIQUES, PsycINFO, Social Work Abstracts) through March 15, 2017, using different combinations of the following key terms: "cultural competence," "cultural sensitivity," "training," "psychology," "mental health," "multicultural," "education," "psychotherapy," "psychotherapists," and "psychologists." After omitting duplicates, book chapters, and nonempirical dissertations and peer-reviewed manuscripts, the final pool for analysis consisted of 563 dissertations and peer-reviewed manuscripts.

These 563 abstracts were reviewed by two independent raters to determine which sources examined cultural competency training outcomes using clinical or counseling psychologists/trainees in the United States or Canada. From the abstracts that were reviewed, a total of

17 training outcome studies (published between 1984 and 2014) ultimately met the inclusion criteria.

According to Benuto et al. (2018), 82% of the outcome studies used a between-group design with a control group, with graduate students (including interns) constituting the majority of participants. The majority of the studies reviewed provided little or extremely limited information about curricular content. Of the information that was provided, the following subset of topics were covered: racism and discrimination, worldviews, cultural identity, general concepts about culture, biases, information about specific cultural groups, and information about the clinical/client interaction as it related to cultural competency or diversity. Even when attempts were made to describe curricular content, Benuto et al. (2018) opined that descriptions of curricular content were often vague (e.g., the amount of time spent on each topic was unclear; topic material covered was unclear; and particular cultural groups covered was often not clearly specified) and trainings were not manualized (for details as to curricular methods used, see Benuto et al., 2018).

The majority of studies reviewed by Benuto et al. (2018) used questionnaires to assess knowledge and awareness rather than actual concrete skill development relevant for professional practice (for details of instruments used, see Benuto et al., 2018). The majority of the studies reviewed by Benuto et al. (2018) indicated positive changes with regard to knowledge; however, outcomes related to attitudes, awareness, and self-report of skills were mixed (i.e., some studies indicated positive changes after training and other studies resulting in no significant changes). For a more detailed explanation of findings, see Benuto et al. (2018). However, again, it is still unclear whether such positive knowledge gains reach some cutoff for "cultural competence." Again, it is also unclear if such a generic construct make sense or whether cultural competence is tied to a specific cultural group, e.g., cultural competence in treating African-Americans or cultural competence is assessing Latinos.

According to Benuto et al. (2018), 9 of the 17 studies that were identified in this systemic review of the literature also employed qualitative methodologies including 6 studies that employed mixed methodology and an additional 3 studies that employed exclusively qualitative methodology. Results from the studies that examined qualitative data as a mechanism for assessing training outcomes included studies that evaluated feedback from trainees. One study reviewed used course evaluations which revealed that trainers should consider the cultural background of the trainees [when preparing training material]. According to Benuto et al. (2018), this was consistent with Klausner's (1997) finding that instructor characteristics are important to training experiences. Specifically, instructor characteristics that were rated positive included those who fostered personal safety in the classroom for sharing life experiences, feelings, and beliefs; were open and receptive to students' comments, questions, and concerns; were provocative and challenging; and appropriately shared relevant, personal experiences. According to Benuto et al. (2018), results from Tomlinson-Clarke's (2000) study indicated that trainees felt that the diversity of the trainees and the interactions among trainees were a strength of the training and enhanced multicultural learning.

Benuto et al. (2018) summarized trainees' comments as to aspects of cultural competence training that they found most useful. Their review revealed the following trainee observations: course readings were useful, but additional discussion regarding the readings would have been helpful; students did not find presenting about their own culture or keeping a journal during the course to be particularly useful, but indicated a desire to learn factual information about different cultural groups; guest speaker presentations, cultural exploration, and cross-cultural contact were found to be most important; and exposure to different people, readings, films, lectures, and panels helped to develop multicultural awareness (see Benuto et al., 2018 for additional details). However, again, it must be noted that trainees finding material useful is not the same as data indicating that such trainings actually produced culturally competent practice.

Benuto et al. (2018) discussed three studies that used service learning (i.e., multicultural training that allows trainees to learn about culture in context through various types of community service activities) as a training platform. One study (Roysircar, Ortega, Hubbell, & Gard, 2005) had trainees mentor ESL students as part of the training. When trainees' narrative reflections were analyzed, trainees identified concepts of relationship and alliance building (i.e., differences being integrated, cultural empathy, affective empathy), intra- and interpersonal dynamics (i.e., counselor self-disclosure and self-reflection), and cultural norms, values, and practices (i.e., unintegrated differences, stereotypes, and overgeneralization of similarities). Benuto et al. discussed one study that had trainees write reflections about their experience with service learning (Lee, Rosen, & McWhirter, 2014). When reflections were analyzed for themes, trainees appreciated the importance of building rapport and connecting with others (in this case the students that they were working with). Benuto et al. (2018) discussed one study that examined the experiences and outcomes (via interviews) of trainees after they completed a service-learning course based on social justice principles in Belize (Koch, Ross, Wendell, & Aleksandrova-Howell, 2014). Findings indicated that trainees experienced a change in diversity attitudes; growth in their self-rated multicultural counseling competence, counseling skills, and leadership skills; an increased awareness of the need for multicultural competency; increased knowledge; and an increased appreciation of individuals who are different.

Benuto et al. (2018) concluded that the training studies had many methodological flaws, lacked information regarding the specifics of training, the implications for trainee benefits were unclear, and there has been no demonstration that cultural competency trainings resulted in improvements for clients. The authors give recommendations for future research as a result of their findings. In their view, future research needs to (1) employ more rigorous methodology (i.e., RCTs, dismantling designs) to move the field toward developing evidence-based training practices; (2) authors should provide their training manual as online supplemental material as a way to promote accessibility to training materials (and allow for replication); and (3) develop an improved understanding of what elements (i.e., trainer characteristics, training methods, etc.) are related to the outcomes of cultural competency trainings.

While the APA (2002) created guidelines for multicultural education and training (and research, practice, and organizational change) for psychologists, these guidelines provide information regarding the necessity of multicultural education and training for psychologists but do not provide specifics regarding how this training should be delivered. As such, it is not surprising that the existing research on training psychologists to be culturally competent practitioners is sparse, varies substantially, and comes with many methodological flaws. As suggested by Benuto et al. (2018):

> Because there is not sufficient information to suggest that specific curricular methods or content produce strong outcomes, the field should reconsider the foundation of cultural competency training using psychological science as a basis. This may include an examination of the empirical literature regarding what clinician characteristics and behaviors are linked to poor or positive client outcomes [for diverse clients] and a review of the strategies that have documented success in changing problematic clinician characteristics (i.e., attitudes, biases, and stereotypes) and behaviors. With this behavioral focus, evaluating skills (and possibly client outcomes) would be appropriate.

The field as it stands is ripe for the development of evidence-based trainings, which as suggested above, can be developed using a clinical science model.

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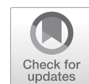

5 Cultural Competence and Sensitivity in Applied Psychology: Ethical and Scientific Problems

William O'Donohue

This chapter explicates and then clarifies several interrelated claims associated with the conceptual structure of the cultural sensitivity (CS) movement in applied psychology (the terms "cultural sensitivity" and "cultural competence" will be viewed as interchangeable). For the purposes of this chapter, the CS movement can be broadly understood as the set of claims indicating that knowledge about culture is an instrumentally and even ethically necessary component for competency in professional psychological services. Calls for CS can be found in a diverse set of central aspects of professional functioning: i.e., in mandates for curriculum content necessary for accreditation in many professional training programs, in ethical mandates in professional ethical codes, in competence requirements mandated for professional licensing, in requirements in continuing education training, in various employment requirements, in requirements in grant applications, as well as in many other facets of professional life (American Psychological Association, 2002). As such, it is one of the most central constructs – if not the most influential construct – expected of professionals, especially professionals in the human service professions.

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The prominent philosopher of science Larry Laudan (1978) has argued that science has both empirical and conceptual problems. It is the thesis of this chapter that all too often the central claims of the CS movement have been imprecisely stated, what kinds of claims these have been poorly understood, key concepts contained in these statements poorly defined, the interrelationships between the claims poorly explicated, and, finally, the evidence or arguments for these claims insufficiently examined. Because of these gaps, the very rationality of the cultural sensitivity program is undermined or at least can be called into serious question.

This chapter will conclude that these claims have often been treated as not requiring the normal evaluation regarding evidence and arguments as many other claims found in scientific psychology (see Frisby, 2013; O'Donohue & Benuto, 2010). This situation, it will be argued, can be partly explained by the fact that the core claim in this movement is actually an ethical/normative claim and not an empirical one. However, the normative correctness of this value claim is unclear and rarely explicitly argued for – it is often asserted somewhat dogmatically and in an ex cathedra manner – as if it is a mandate from on high. (It is important to note that there is a long tradition in ethics and philosophy of using the word "normative" to describe claims involving ethical, aesthetic, or value content – which is distinct from the use of the term "norms" in psychology to

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describe some sort of group averages or measure of this and variance around these averages.)

The fact that these central claims of the CS movement have had minimal critical scrutiny will also be examined in terms of describing possible harm done by treating these claims as dogmatically beliefs instead of rationally appraised assertions. Thus this chapter will explore further the normative quality of this movement. In doing the above, the chapter will show there is much work that needs to be done before these assertions associated with CS can be properly regarded as warranted knowledge claims – whether empirical knowledge claims or ethical ones.

One reason to undertake these tasks is to decrease the likelihood that dilettantish, or even cartoonish, versions of CS escape standard scrutiny because rational standards are set so low or completely neglected. Part of the reason for this low standard might be the apparent "obviousness" of the ethical claim itself – it can appear, to some at least – that a claim that one should be sensitive and appropriate to a person's culture is apodictic, so obvious on its face that one needs no argument for it. And therefore in this view, any disagreement or criticism has to be wrongheaded and even worse – based on a position that must be immoral, mean-spirited, or irrational.

However these claims associated with CS movement when uncritically and dogmatically advanced can then be used in applied settings with largely unknown effects – especially unknown effects on some clients who may not be in the best position to experience unknown and possible iatrogenic effects of these claims. There is too little concern and thus too little empirical evaluation to ensure that these views are indeed doing more good than harm or more good than alternative views. As Thomas Sowell (1996) has stated: "In their zeal for particular kinds of decisions to be made, those with the vision of the anointed seldom consider the nature of the process by which decisions are made. Often what they propose amounts to third-party decision making by people who pay no cost for being wrong--surely one of the least promising ways of reaching decisions satisfactory to those who must live with the consequences" (p. 129).

To illustrate some of the unknown effects that ill-defined and poorly researched claims can have, Frisby (2013), although focusing on the somewhat related problems of multiculturalism in school psychology, has suggested superficial concepts are often mistaken for scientific or conceptually substantive concepts:

Boutique cultural sensitivity: that consists of "superficial cultural displays of ethnic restaurants and weekend festivals." Thus a taco bar on a university campus during Cinco de Mayo might qualify as this sort of "boutique" cultural sensitivity. The effects of treating a complex and sensitive phenomena associated with culture in such a superficial way are unknown but of obvious concern.

Kumbayah cultural sensitivity: that tries to create a world where every group's values are respected by every other group to achieve the goal that all can live in harmony. Here the lifestyles promoted in gangsta rap would be seen as having as much value and validity as the lifestyle of women living under Sharia law, as would the lifestyle of professional women in progressive Western cultures. The negative effects of such false moral equivalence are unknown.

Light and fluffy cultural sensitivity: in this approach, cultural sensitivity is viewed as not requiring the empirical and conceptual analysis of other beliefs but rather because it is so noble it can be immediately disseminated often by simplistic catch phrases ("Celebrate Diversity"). No effort is made to grapple with the rather demanding sociological research agenda needed to actually uncover and document a variety of group norms and behaviors and no discussion occurs of harsh realities that may be upsetting to those embracing this philosophy (e.g., the misogyny of some rap music).

Bean counting cultural sensitivity: in this view if, for example, some number of course credits or some hours of exposure to some group (often alarmingly few) or if a one can enumerate different demographic or cultural identities within some group for it to be considered sufficiently diverse, then multiculturalism or CS is considered achieved. Thus, a white individual going to a black church service or even a Cinco de Mayo parade would be considered as more "culturally competent" than before. Again, the caution embodied in the adage "a little knowledge can be dangerous" is unheeded.

However a major problem in this field is that the substance of CS has been quite vague. Much ink has been spilt on generalities along the lines: "It is important to be culturally sensitive"; "More cultural sensitivity is needed"; "Bad results will occur if some intervention is not culturally sensitive." However, exactly what is meant by these claims and exactly what cultural tailoring ought to occur is often much more vague.

It might be useful to explore some specific professional scenarios where CS concerns arise as some of the complexities can be seen in the particular. Imagine the following scenarios:

1. Mental health professional P offers therapy for a wide range of problems but only to women. A potential client C not of that gender contacts P, and P politely but firmly indicates that they will not be willing to see C because they are not of the gender P treats. A referral is made to a professional of the same gender. Is this gender discrimination and is this allowed by the CS program? Is the treatment of discrimination by the CS movement problematically selective?
2. A person of culture Q presents to P for treatment of depression and is interested in cognitive therapy, a specialty of P. The P states, "I am not a member of Q and therefore I am not able to treat you" and refers C to another therapist who is a member of Q but who generally does not practice evidence-based therapies. Is this in the potential client's best interest? How does one appraise the necessity of such cultural matching or its value relative with respect to other possible trade-offs such as evidence-based practice? This also speaks to the point of how to apply research on groups to situations involving individuals.
3. During treatment P says things to C who is a member of Q like "I know you belong to the culture Q and I have an understanding that people who belong to culture Q tend to have characteristics, x, y, z (perhaps learned in a required CS class). P assumes C in that way and factors these alleged properties into P's assessment and treatment plan. Is this sufficient or necessary for the professional interaction to be "culturally sensitive?" Suppose further that possessing properties x, y, z is a probabilistic relationship for members of culture C, how much error can be associated with such CS moves?
4. During treatment P says things to C who is a member of Q like "I know you belong to the culture Q and I have an understanding that people who belong to culture Q tend to have properties, x, y, z." P does not assume C actually has these properties and does not factor this into the assessment and treatment plan. Suppose further that P conducts an idiographic assessment to understand what characteristics C actually has. Finally, suppose that C does not in fact hold any of these properties. This seems prima facie reasonable but seems to be a less culturally sensitive and more generic case formulation. Is this strategy sufficiently culturally sensitive?
5. C, who is an African-American, comes into therapy and, in the course of therapy, says things like "All whites are prejudiced." "White people never treat me fairly." "White people hate black people." "My university has systemic racism which partly explains my poor grades." Suppose the therapist is a cognitive therapist – are these beliefs of C rational or irrational? If irrational ought they be targeted in therapy? How does the construct of CS enter into this appraisal of rationality? What would a culturally tailored therapy look like for this person? Suppose further that the therapist is white, should the therapist continue to see this client? Finally, replace all references to "whites" in the above to "blacks." How does this change the analysis and are there any disquieting features of this change?
6. C enters therapy and, in the course of therapy, says things like "I like my ho's hot" and "I have many tight bitches who give me good loving" and "Bros before ho's." P considers these utterances may come about because C is a member of a culture that may be described as "gangsta" which occurs at some frequency among young urban Black male so says nothing critical about these utterances and beliefs. Is this culturally sensitive? Is this problematic from a social justice perspective in its obvious misogyny? Is there a "cultural clash" involved here between two minority cultures and if so, what ought to be done to resolve this?

It is to these kinds of specific situations that CS has some relevance. However, exactly what CS would suggest about these situations is both somewhat unclear and at times somewhat problematic. It is this lack of clarity and even lack of validity that is the concern of this chapter.

The Relationship Between CS and Prejudice and Discrimination

It is also important to note at the outset that a critical examination of calls for CS must not be misconstrued in any way to condone racism, sexism, or any other unethical bias, prejudicial view, or discriminatory practice. It is important not to conflate these issues. One must recognize that holding negative views toward prejudice and discrimination does not automatically entail one holding positive views toward the CS movement. Criticism of the CS movement is neither to deny that prejudice and discrimination exist, nor that these can have a multitude of pernicious effects, nor that these ought to have a high priority to be remedied. These types of problems are too seldom *directly* examined in the academic literature (see Benuto, Casas, & O'Donohue, 2018) – promoting CS in training and practice has been somewhat of a (unsatisfactory) proxy for directly addressing these important social problems because CS has somewhat of an oblique relationship with prejudice and discrimination.

Certainly, as we will see, "being sensitive" to a culture would prima facie seem to be inconsistent with prejudice toward members of that culture. However, the actual situation is more complex: CS can be enacted in a way in which problematic stereotypes are employed (e.g., "All Latinos are macho" or "All Asian-Americans are collectivist" or even "All Asian-Americans come from the same culture" – as Woody Allen in *Annie Hall* famously states, "I'm a bigot but a bigot of the Left"). In addition, certain people are problematically not treated as individuals but as a member – more precisely as a token – of some group, because perhaps some observer (correctly or incorrectly) identifies them as belonging to some minority culture. CS can be taken quite superficially as Frisby (2013) noted above and not really reduce prejudice or discrimination in any substantive ways and paradoxically may serve to increase these.

Importantly, one needs to admit that there are other vastly different approaches and other ways to address the vitally important problems of prejudice and discrimination. For example, Dr. Martin Luther King (1963) in his famous "I Have a Dream" speech states:

> I have a dream that one day on the red hills of Georgia, the sons of former slaves and the sons of former slave owners will be able to sit down together at the table of brotherhood.
> I have a dream that one day even the state of Mississippi, a state sweltering with the heat of injustice, sweltering with the heat of oppression, will be transformed into an oasis of freedom and justice.
> I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin but by the content of their character.

The key question raised in this different vision of ending bigotry and discrimination is: Is Dr. King's dream of "brotherhood" (and sisterhood) as well as the dream of all being judged by the content of character rather than the color of the skin best achieved by a CS movement that attempts to explicate and prioritize these demographic differences and to suggest that these differences cause schisms that require separate treatment? The logical connection between cultural sensitivity and identity politics with all its possible attendant problems such as divisiveness and use of stereotypes must be recognized as well as the potential advantages of Dr. King's alternate vision.

As previously mentioned, it is also possible that CS program can allow "reverse prejudice," i.e., *negative stereotypes and prejudgments toward individuals in other groups – not only toward members of the majority culture but also to members of minority cultures when they are defined as the Other*. There has been too little concern that the CS movement paradoxically condones prejudicial behavior toward the Other, that stereotypes are employed; hasty generalizations are asserted (e.g., when a radical feminist

describes the "male rape culture" and states that "all males are rapists" (see MacKinnon, 1987) – that logically would include not only white males but also Black, Hispanic, and gay males – they are making crude, hasty, and pernicious generalizations, and generalizations that feed into the pernicious stereotypes of some minority groups). There are also concerns raised by Jussim (see chapter in this volume) that there can be an element of empirical truth behind many stereotypes? Does the CS movement demand that we bury our heads in the sand about this? In specific cases, this may result in situations where claims of mistreatment by minority culture members are accepted as true without any due process or even much critical examination (see the Duke Lacrosse case 2005 where an African-American stripper made false claims of rape against several white males). In a rush to judgment based on stereotypes, the majority Other (males, whites, heterosexuals, Christians) are illegitimately punished or lose their employment because of claims of "insensitivity" or making others feel "uncomfortable" (see, e.g., the resignation of Harvard's president Larry Summer's case at Harvard after his speech exploring why women are underrepresented in science) or even more recently cases involving allegations with the use of the new construct "microaggressions." One wonders if the rhetoric of this movement in which the majority culture is demonized bears some responsibility of the recent murders of white policeman. Is the Other in the CS movement automatically guilty of insensitivity (or worse) until proven innocent? Is it true to view the Other as always experiencing "privilege" that needs to be remedied because at a minimum this privilege will result in biased and problematic treatment of every minority member this person interacts with? What sort of reasonable due process ought to be used to arbitrate contrary claims concerning allegations of "insensitivity?" What are reasonable kinds of steps to take to remediate this problematic states of affairs – education? psychotherapy? loss of employment? jail? Does this analysis and practical action in any way abrogate this individual's basic freedoms – such as freedom of speech? However, at this point, it is important to note that criticisms of CSM are not either a denial of the existence of prejudice or discrimination, a denial of the importance of these, or by any means an attempt to justify or promote prejudice.

Another important set of questions concerns whether there is a hierarchy of importance here relating to the various social injustice situations of these diverse cultures. Are some culture's grievances or past or current injuries or need for rectification more important than others? (see Frisby in this volume where he summarizes the view expressed by a prominent researcher in the field where the scholar mentions seven groups that you have to "walk on eggshells" when talking about). Suppose, for example, there is one faculty opening in a department where not all professors are white, male, heterosexual, nondisabled, and Christian. Suppose five equally qualified candidates are the finalists for the job:

An African-American male, heterosexual
A white, female, heterosexual, Christian
A white, female, gay, Christian, who speaks Spanish
A white female gay Jewish-American
A wheelchair-bound, African-American, male, gay, Muslim
A poor white heterosexual male from Appalachia who is a first-generation college graduate

From a social justice perspective, are there any considerations from cultural status regarding who should be hired? How do we understand priorities of claims when there are constraints (normally found in real situations) that require a prioritization of these sorts of cultural injustices?

Finally, another concern is to what extent cultural sensitivity allows any criticisms and creates a chilling effect on what might in fact be constructive criticism of a subculture. There is a bit of a logical paradox here: the CS movement seems to be logically inconsistent. It is not purely relativistic: i.e., it does not involve a meta-claim that would allow no culture to be evaluated because there are no objective norms or superordinate evaluative criteria that apply to all cultures. One can see this because the CS movement is founded on manifold and severe critiques of the majority

cultures: e.g., males are sexist; whites are racist; heterosexuals are homophobic; and Christians perhaps are all three. So obviously such nonrelativistic criticisms can be made and indeed are made. (Similar claims can be said about the movement's inconsistent embrace of postmodernism and social constructionism – "gender" and "sexuality" might be socially constructed, but key concepts internal to the movement such as "patriarchy" and "oppression" seem for them to have much more of a nonrelativistic, objective status.)

Moreover, these critiques are often leveled without any direct criticism of minority cultures, as if these were beyond constructive criticism or that any critique would be inconsistent with insensitivity or worse a sign of prejudice. So here, paradoxically, the CS movement is strangely quiet. If according to the CS movement Hispanic-American males are indeed macho, is this characteristic good or problematic? From a feminist point of view wouldn't this be a psychological characteristic that could be (and is, see, e.g., Zaitchik & Mosher, 1993) related to the mistreatment of women – including sexual and physical assault – that needed to be critiqued and be regarded as problematic? Again, if according to the CS movement Asians-Americans are indeed collectivistic, is this good or bad? Is this problematic in terms of Asian-American women being independent and assertive – a feminist ideal? If male gays have many more lifetime sexual partners, is this good or bad? From a public health perspective, clearly, sexually promiscuous behavior is related to the spread of venereal disease including HIV. (Some recently have even claimed that part of belonging to the gay culture is to be HIV positive.) This is called "bugchasing" (see, e.g., Gonzalez, 2010).

This sort of inconsistent evaluation is most starkly present and most problematic when two minority cultures clash, for example, women and the "gangsta" culture as in the example of the misogynistic lyrics of some rap. For example:

> Bitches ain't sh*t but hoes and tricks/Lick on these nuts and suck the d*ck. (Snoop Dogg)

> My little sister's birthday/She'll remember me/For a gift I had ten of my boys take her virginity. (Bizarre)

> Slut, you think I won't choke no whore/ 'Til the vocal cords don't work in her throat no more?!/ Shut up slut, you're causin' too much chaos. (Eminem, "Kill You")

> Punch your bitch in her mouth just for talkin' shit/ You lurkin' bitch? Well, I see that wrist/Because if you do, I might blind you bitch. (Jasper Dolphin, "Bitch Suck Dick" by Tyler, The Creator)

These lyrics are extreme but not atypical: one analysis shows that approximately 30% of rap lyrics contain some sort of misogyny depending on the sub-genre (Armstrong, 2001). These and other lyrics pose a real problem for the CS movement: by what transcultural (and "culturally sensitive") evaluative criteria are these to be judged? Would these judgments be in any way "insensitive" to the black urban male culture? If these are not strongly condemned, is the CS movement silent on some of the most egregious examples of misogyny? If these lyrics were instead part of white country music, would then it be more permissible to critique these – and if so why? Finally it is important to note that this problem is not just restricted to this one example: Are there "tiger mothers" a legitimate part of Chinese-American cultures and what is the evaluation of these? Do some Hispanic cultures sexualize females at too early of an age? These mirror larger questions about some cultures: Is fundamental Islam and Sharia laws necessary to criticize regarding their treatment of women?

Finally, what has reasonably received more attention recently, and appropriately, is some of the impact of the CS on free speech. This is a complex issue that will be dealt with later in this chapter. Thus, the question also needs to be raised to what extent are the claims associated with CS consistent or inconsistent with free speech as defined by the Constitution? (see The Foundation for Individual Rights in Education, thefire.org).

As a preliminary conclusion, it is important to note that a proper evaluation of CS movement is complex – it requires a rather complex weighing of multiple kinds of evidence – and ought not to be treated as obviously good. We turn now to an explication of some of this complexity.

The Major Hypotheses Associated with the Cultural Sensitivity Movement

The first issue that will be examined is: What exactly are the central claims of CS program? Is the movement simply to be characterized by something along the lines of "Everyone must be culturally sensitive to everyone all the time?" It seems that exegetically this is not correct. This claim is simplistic. It seems that more precisely a central claim might be called the *CS descriptive hypothesis* and can be more precisely stated as the following:

CS Descriptive Hypothesis
When Professional P interacts with a certain type of Person A, P's behavior can be evaluated with respect to the degree to which it is ***culturally sensitive*** *with respect to culture(s) A belongs to/or identifies with, if and only if A belongs to certain cultures x, y, z (a minority and perhaps discriminated against culture) and if and only if A is not sufficiently acculturated into the majority culture*.

Now this claim is somewhat complicated – but the argument is that it more faithfully explicates the complexity and nuances of the underlying situation. The complications arise because there are important *boundary conditions for CS descriptive hypothesis*: this hypothesis does not apply to all persons A (although it does apply to all persons P).

(a) *Not all cultures are relevant*. One important boundary condition is that the CS descriptive hypothesis is not taken to apply to all cultures. For example, if A is an Asian-American, then this hypothesis is generally thought to be relevant; however, if A is a member of many, many other cultures – indeed a vast majority of other cultures – then the descriptive hypothesis simply does not apply – for example, Irish-Americans, Italian-Americans, Jewish-Americans (somewhat paradoxically), Mormons, and an American who is a member of the military, as well as thousands of other cultures. These cultures simply are thought not to be relevant and thus fall outside the boundary of this claim (look, e.g., at what cultures are described in textbooks on CS). It is somewhat paradoxical that the phrase "cultural sensitivity" does NOT in fact apply to the vast majority of cultures and thus must be taken as some sort of "weak" version of cultural sensitivity. A decided advantage to this view is that it makes this descriptive hypothesis more practical to implement because if it were to apply to the thousands of cultures that exist, it would simply be unworkable – no one could obtain all this knowledge and skill. Anthropologists often spend years of study to specialize in one subculture – and no one can really know dozens let alone thousands of cultures (see chapters on culture in this volume). Typically the extension of the concept of "culture" is thought to apply to only a handful of cultures, the general candidates seem to be African-Americans, Asian-Americans, Hispanic-Americans, Native-Americans, Pacific Islanders, and GLBTQ individuals and sometimes disabled individuals (see also Haidt, 2015), and these might comprise the universe of cultures that this hypothesis pertains to. However, one possible reason why this boundary is not clear is that to draw a clear demarcation would inevitably be controversial and be subject to claims of "insensitivity" – as inevitably many cultures/minority groups would be excluded. However, it is also important to note that the American Psychological Association's Ethical Code (2002) complicates this: in a few key places, the Ethical Code uses the following list to describe what psychologists must be sensitive to: *age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status*. This greatly complicates matter – many more "cultures" are (vaguely) created. Let's, for example, briefly examine the first category listed in the Code – age. What cultures does age create? There is certainly prejudice against the old (ageism) – so is just one culture

created – the aged (however this is defined) vs. non-aged? Or are there other age-related cultures – teens?, millennials?, middle aged?, and so on?. Interestingly, there really have been no principles stated by the proponents of the CS by which those cultures that are relevant to the CS program can be clearly demarcated from those cultures that are not. Perhaps "are stereotypically seen as experiencing prejudice by typical majority culture Americans" might be the best candidate (this seems to be somewhat common to these cultures, although the magnitude and kinds of prejudice and discrimination may differ significantly). However, this principle does not work all that well as, for example, there has been and still is significant anti-Semitism. However, Jewish-American culture is not typically seen as being involved as a cultural category in the mainstream CS movement. Some (e.g., Cummings, O'Donohue, & Cummings, 2009) have argued that particularly among psychologists, there is significant and unfortunately rather accepted prejudice against the religious – particularly Christians. These targeted religious cultures (e.g., Jews, Catholics, Mormons, Evangelical Protestants) typically are not included in the CSM descriptive hypothesis. Perhaps, unfortunately, the best candidate for a principle of cultural inclusion is "cultures that are discriminated against that are of typical concern to the political Left." That is, the political Left seems more concerned with the prejudice expressed against the first group of cultures than the prejudice expressed against the second group of cultures.

(b) Another important boundary condition to the CS descriptive claim is that *A needs to actually belong to or at least identify with culture x, y, or z*. If A does not identify with the culture (perhaps due to upbringing) or identifies with another culture, or is "in the closet" with respect to the culture, then this hypothesis does not apply. Cultural identification is a complex construct and process, and it is not as simplistic as if one has heritage x or has consistently displayed sexual behavior y, then one automatically can be regarded as x or y. There are cases where individuals who are Hispanic in many ways (parents are Hispanic, they speak Spanish, etc.) identify as African-Americans. It would seem that P needs to explore this with A although this may be a fairly complex process and fraught with a number of obvious pitfalls, and no clear validity data exist to be shown that this can be accurately accomplished.

(c) Another boundary condition is *acculturation*. Acculturation over an individual's lifetime or in a family over generations can reduce minority cultural identification and idiosyncratic cultural behaviors to the extent that this individual essentially becomes a member of the majority culture. For example, it is rare that the third generation is only fluent in the language of the home country. This descriptive hypothesis also places a burden on P to gain some sort of gauge of the degree of acculturation of A. Again, this raises the question of whether there are validity data to show the accuracy of these judgments. Making this even more complex, some cultural dimensions seem more affected by acculturation than others: for example, ethnicity seems to be more amenable to acculturation than say, gender or sexual orientation (Frisby Individual Differences chapter, this volume).

(d) The CSM descriptive hypothesis also may not even apply to all times: if P is not interacting with a member of a relevant culture x, y, z, it seems to be the case that P's behavior cannot be described as culturally sensitive or not. That is, if P is of the majority culture and interacting with another P who is also of the majority culture, then this hypothesis seems not to apply.

(e) Note that the descriptor "culturally sensitive" is essentially relative, i.e., it is relative to Person A and his or her culture. For example, if Person A is Mexican-American, a different set of descriptors regarding cultural sensitivity applies than if Person A is Chinese-American or gay. As such, even members of cultural minority groups can be evaluated

with respect to the degree they are culturally sensitive to other minority groups. This issue is rarely directly confronted. For example, there seems to be less concern if a gay individual is culturally sensitive to African-Americans than if a heterosexual is. Minority status seems to have some sort of protective status regarding judgments of insensitivity. It also can present thorny intellectual issues that have been mostly avoided: What if, for example, one wants to be sensitive to a culture (e.g., African-American or Latino), and let's assume that members of this culture are also fairly religious (let's say Mexican-Americans and Catholicism or African-Americans and the AME Church), and then let's further stipulate that these religions view homosexual behavior as a sin. What becomes culturally sensitive in this situation? – to simply say "African-Americans and Latinos are homophobic," or to say "It is culturally sensitive to understand that for this minority culture an accepted norm in certain religious segments of the African-American and Latino cultures that homosexuality is morally wrong – and these individuals are not homophobic but must be respected as practicing their cultural choice of religion." These are two very different views dealing with a very sensitive and complex issue (see also Frisby, 2013, table 2.1, pp. 58–59).

(f) Note also that the term "culture" as used here is a bit vague. The APA Ethical Code (see below) seems to suggest that there may be 12 dimensions that can define culture (*age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status*), making the construct of culture fairly complex (see O'Donohue and Benuto (2010) for a more extended critique).

(g) Note also that for P to actually be culturally sensitive, P needs to accurately identify what culture(s) A belongs to/identifies with. However, it is not clear how this is supposed to occur for P as cultural identity or membership may not be readily apparent. For example, for sexual cultures (LGBTQ), P might need to directly ask A, which may also raise other issues such as this behavior being considered an invasion of A's privacy, or also difficult because one can wonder what stimuli occasion P's inquiry ("I didn't ask because he didn't "seem" gay") can be problematic.

(h) Note also that cultural sensitivity is presented as a categorical dichotomous judgment – one is either culturally sensitive or not. However, what is also unclear is the how to make this distinction. Does one have a clear "test" where there is an obvious "cut" between sensitive and insensitive (or "competent" and "incompetent")? What exactly is examined – verbalizations about scientific regularities? Verbalizations about values? Actual therapy skills? Can there be a paper and pencil test? Language competence? The demographics of the individual being evaluated are all African-Americans automatically culturally sensitive toward all other African-Americans – if not could a white person judge an African-American as culturally insensitive toward other African-Americans?. Is the evaluative model in any way compensatory – although the performance of Person A was problematic on x items or dimensions, their performance of the remainder of the items or dimensions overrode these deficits in such a matter that they are now deemed "competent." Can a person regress – one was competent, but due to forgetting or some new advance or some new (problematic) attitude, can one become incompetent? And finally, is it really a dichotomous construct – can one have degrees of cultural sensitivity? – and if so how much does one need to escape moral or professional punishment?

CS Functional Hypothesis

We next turn to the general question of the rationale for the CS descriptive hypothesis: Why is this claim made? Again, it is too vague to simply say, "because it is the right thing to care about" or because "better outcomes will inevitably occur." Thus, a second major claim associated with the

CSM is the *CS functional hypothesis* that might be stated along the lines of:

> *Professional Person P will be* ***more professionally effective*** *with A if P's behavior is consistently culturally sensitive.*

Of course, the dimension of "effective" depends on some desired goal or outcome as "effective" implies some specific end or ends. There can be various outcomes in the context of professional psychology and a variety of range of values on these dimensions. Outcomes within clinical psychology can include (1) accurate assessment, (2) quicker or a higher magnitude of clinical change, (3) more readily overcoming a barrier to initiate treatment, (4) completing treatment, (5) liking treatment, (6) improved education, and so on. Thus, it is hypothesized then when P is culturally sensitive, one of more of these kinds of outcomes has a greater probability of occurring or occurs at a greater magnitude. This again is a complex matter that can't be covered by any simplistic statements. It seems to be related to Gordon Paul's (1969) "ultimate question" (with slight paraphrasing) which is relevant: "How does cultural sensitivity relate to what treatment, by whom, is most effective for this individual, with that specific problem, under which set of circumstances, and how does it come about?" It would seem prima facie that CS may have a host of different effects on values for each of these dimensions. Only extensive empirical evaluation will be able to tease all this out. The research agenda here is daunting, and there has not been an abundance of literature showing robust high magnitude effects on, for example, treatment outcomes (Benuto, Casas, & O'Donohue, 2018; Huey, this volume).

Another assumption in this functional hypothesis is that the cultural categorization is fairly homogenous – it "cuts nature at its joints." However, this assumption is clearly false. The alleged cultural construct of Asian-American actually covers diverse cultures such as Indian, Japanese, Thai, Chinese, Filipino, and so on. The same claims can be made about Native-Americans (hundreds of diverse tribes) as well as Hispanic-Americans (dozens of diverse countries and cultures). These cultures are not homogenous and thus their status on arrange of variables can differ. Such heterogeneity can interfere with any orderly functional relationships and may itself show a profound cultural insensitivity.

Psychological Effects Hypothesis

The next major claim involved in the CS program is again often not explicitly stated but is concerned with the psychological states produced by either culturally sensitive or insensitive behavior:

> *When Professional P interacts with a certain type of Person A in a culturally sensitive manner, P will experience a combination of increases in positive psychological states such feeling respected, understood,* etc.*, as well as a decrease of negative psychological states such as feeling uncomfortable, alienated, misunderstood, judged, traumatized, etc.*

These psychological states of course can be important to psychologists – especially as these can either be ends in themselves (psychologists often attempt in their professional pursuits to produce positive psychological states as ends in themselves or because these positive states can be important means to other ends – e.g., rapport and other nonspecific are commonly thought to be central to successful outcomes in psychotherapy). In addition, roughly all the professionals agree with the adage "at least do no harm," and avoiding the production of negative psychological states would seem to be a positive outcome.

However, the empirical support for these claims is none too clear. It is not clear exactly what psychological effects, of what strength, in what percentage of some group, are produced by either behavior that is culturally sensitive as opposed to culturally insensitive? For example, some professionals not knowing that some Asian-American "belongs to a collectivist culture" thus ask him or her what he or she wants to do in some situation. A perhaps "individualistic approach" produces exactly what psychological effects of what magnitude and of what duration? Can these negative effects outweighed by other important

variables related to professional behavior such as not delivering an evidence-based treatment? Are there any negative psychological effects of alleged “culturally sensitive behavior” such as the individual wondering if they are being treated as a token of some group as opposed to an individual? Or that the person sees group stereotypes being used (e.g., “Latinos are macho”)? Or that the person sees the cultural sensitivity as a relatively superficial and inadequate attempt to deal with much deeper societal problems? Or that the person sees the professional’s attempts at cultural sensitivity to be much more about the professional’s need to be seen positively than about the client’s situation?

There also are seven related issues: (1) important constitutional rights guarantee free speech – and it is commonly recognized that this free speech can cause negative psychological states in the listener. Constitutionally protected proabortion speech might cause significant psychological discomfort and distress in a pro-life listener as the pro-life listener can hear this as promoting the killing of babies. On the other hand, constitutionally protected pro-life speech can cause a variety of negative reactions in the pro-choice listener as he or she can hear these as violating the legitimate rights of women. But both are constitutionally protected despite these negative psychological reactions – and particularly despite the possible gender issues associated with pro-life views. And the same can be said for many other issues, gun rights, views on wars, views on the Middle East, school choice, and so on. It seems though that issues associated with cultural sensitivity are beginning to be seen by some as having a special status akin to hate speech, i.e., any negative psychological reactions to certain kinds of statements about gender, race, or sexuality are viewed as due to illegitimate behavior on the part of the speaker due to the reactions of the listener – and also as behavior that can be sanctioned – and perhaps seriously so because of these negative psychological reactions.

However, the first major question is to what extent do constitutional freedoms protect even speech and behavior that produce negative psychological stress in some and which might be regarded as “culturally insensitive?” (2) Many other kinds of speech result in negative psychological reactions in others (e.g., disagreeing with someone, denying someone’s ardent request, misinterpreting someone) – why isn’t some level of negative reaction just regarded as part of the normal “rough and tumble” nature of human interactions and reactions? Certainly, some “hate speech” can be proscribed – but can one legislate all human interactions to be free of conflict? (3) These reports are necessarily self-reports – these are reports of private psychological states and as such can be exaggerated, distorted, and even falsified (e.g., due to malingering) – and it is well known among health-care professionals that certain individuals can distort due either to secondary gain (getting attention or special treatment) or due to the psychopathology of the listener (e.g., histrionic personality disorder). How can one ensure that possible claims of psychological negative states can’t in turn be used for illegitimate purposes such as silencing views that someone finds disagreeable, e.g., seeking attention, or harming an individual or group for some reason? (4) It is also well known particularly to mental health professionals that all psychological reactions are not legitimate – some are pathological. Being extremely afraid of dogs or spiders is called a simple phobia because according to the DSM5, the emotional reactions are irrational. Becoming depressed due to a poor grade in a class is also regarded as irrational and targeted in cognitive behavior therapy. Some individuals suffer from mental disorders such as personality disorders in which they are too easily emotionally deregulated. To what extent then are the reported reactions of individuals to cultural insensitive behavior rational or irrational or caused by an underlying pathological condition? All too often this question is not examined – rather the assertion that it made someone feel uncomfortable is sufficient for a problem to be defined. (5) Exactly what kind of emotions and what magnitude and what duration are considered problematic? Any negative emotion of any magnitude in any listener for any period of time? Is “uncomfortable” sufficient, as in “What you just said made me

feel uncomfortable?" or something of higher magnitude? (6) Is the concern about negative psychological reactions a bit hypocritical or one-sided? Being called culturally insensitive, or homophobic, or sexist or a member of the patriarchy could also result in significant negative psychological reactions in this listener – but there seems to be little or no concern about these kinds of negative psychological reactions. Is there some sort of rationale that those enjoying some alleged "privilege" are fair targets for negative psychological states?

Finally, one wonders to what extent these reactions are partly related to power and the allocation of interpersonal power. Claiming victimhood by assertions (even correct ones) of negative psychological reactions can be a move that has implications for power realignment. These negative psychological reactions can be seen as grounds for a variety of special measures to be taken – the person who uttered these can be fired, or asked to apologize, or special accommodations made. For example, recently at the University of Missouri, black students asserted that they didn't feel safe and felt a variety of other negative psychological states due both to the events that occurred at Ferguson, Missouri, and their perceptions of the university's problematic reactions to these. Among their demands were:

> *I. We demand that the University of Missouri System President, Tim Wolfe, writes a handwritten apology to the Concerned Student 1-9-5-0 demonstrators and holds a press conference in the Mizzou Student Center reading the letter. In the letter and at the press conference, Tim Wolfe must acknowledge his white male privilege, recognize that systems of oppression exist, and provide a verbal commitment to fulfilling Concerned Student 1-9-5-0 demands. We want Tim Wolfe to admit to his gross negligence, allowing his driver to hit one of the demonstrators, consenting to the physical violence of bystanders, and lastly refusing to intervene when Columbia Police Department used excessive force with demonstrators.*
> *II. We demand the immediate removal of Tim Wolfe as UM system president. After his removal a new amendment to UM system policies must be established to have all future UM system president and Chancellor positions be selected by a collective of students, staff, and faculty of diverse backgrounds.*
> *III. We demand that the University of Missouri meets the Legion of Black Collegians' demands that were presented in 1969 for the betterment of the black community.*
> *IV. We demand that the University of Missouri creates and enforces comprehensive racial awareness and inclusion curriculum throughout all campus departments and units, mandatory for all students, faculty, staff, and administration. This curriculum must be vetted, maintained, and overseen by a board comprised of students, staff, and faculty of color.*
> *V. We demand that by the academic year 2017–2018, the University of Missouri increases the percentage of black faculty and staff campus-wide to 10%.*
> *VIII. We demand that the University of Missouri increases funding, resources, and personnel for the social justices centers on campus for the purpose of hiring additional professionals, particularly those of color, boosting outreach and programming across campus, and increasing campus-wide awareness and visibility.*

The president of the university eventually resigned. It is not the point here to argue about the correctness or incorrectness of these demands or to sort out the complex issues that gave rise to these but simply to argue that this clearly involves strategies to change power relations between entities – which again can have fairly obvious psychological reactions. It is also of concern to what extent university administrators can show personal and intellectual courage around issues concerning CS as these incidents might serve as object lessons for subsequent intellectual cowardice.

The Culturally Sensitive Ethical Hypothesis: Culturally Insensitive Behavior Is Ethically Wrong and Culturally Sensitive Behavior Is Ethically Obligatory

It also seems to be the case that the culturally descriptive hypothesis is not only advanced because of its hypothesized impact on outcomes but also due to a moral imperative: it is seen as an ethically mandatory act. Kant (1993) distinguished between counsels of prudence – practical behaviors aimed at achieving positive outcomes – but activities that in themselves were not moral or

immoral; for example, it is prudent, although not moral or immoral, to brush one's teeth to produce healthy gums and teeth. Kant suggested that these needed to be distinguished from moral matters. Thus, a fourth major claim of the CSM is the *CS ethical hypothesis* that might be roughly along the lines of:

> *Person P can be said to engage in* ***ethically problematic*** *behavior if his or her treatment of A is not sufficiently* ***culturally sensitive***. This can also be stated in a positive way: *A necessary condition for Person P's behavior to be ethical is that it be culturally sensitive with respect to A*. (see for example, the APA's Ethical Code of Psychologists, 2002)

Some might also claim a stronger version of this claim:

> *A sufficient condition for Person P's behavior to be ethical is that it be culturally sensitive with respect to A.*

This is an important claim because it is often the grounds for the actions taken for presumed violations of cultural sensitivity. Individuals can be wrong, and these kinds of events are processed differently than when individuals make moral errors. In serious moral errors, people can receive much more serious consequences – fired, or fined, or licenses revoked.

This kind of ethical pronouncement is embodied in the APA's (2002) Code of Ethics. As one example, in the aspirational section of the Code:

> **Principle E: Respect for People's Rights and Dignity** Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making. Psychologists are aware of and respect cultural, individual and role differences, including those based *on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status* and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (Italics added)

However, this phrase also occurs in the binding, enforceable sections of the Ethical Code. Its second appearance in the Code is in Principle 2.01, Boundaries of Competence:

> (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with *age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status* is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies. (Italics added)

And finally, it appears in the Code in two sections dealing with prohibitions against discrimination and harassment:

> **3.01 Unfair Discrimination** In their work-related activities, psychologists do not engage in unfair discrimination based on *age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status* or any basis proscribed by law. (Italics added)

However, O'Donohue (2016) has recently criticized the inclusion of this phrase (*age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status*) in the APA's Ethical Code for the following reasons:

1. Problems in its clarity.
2. Its failure to describe the oppression, prejudice, and privilege making these kinds of categories important but perhaps also distinctive.
3. It fails to include some important dimensions related to prejudice such as mental health status.
4. It is not used consistently.
5. Its reliance on scientific and professional epistemologies may render it internally inconsistent as this ignores critiques of these epistemologies as being biased.
6. It is impossible to adhere to.

7. It surprisingly picks out "autonomous decision-making" as a key property but ignores other important properties associated with prejudice and oppression.
8. It may use an inappropriate standard of "established knowledge."
9. It relies on an inadequate and impoverished understanding of the reputed empirical regularities regarding these dimensions.
10. Its use of "professional knowledge" adds vagueness.
11. It may blame the victim.
12. It is unclear how a psychologist can validly engage in self-assessment regarding his or her own biases and prejudices.
13. It may entail privacy violations in order to adhere to it.
14. It ignores important questions regarding the moral status of these differences among groups.
15. It ignores other rival and plausible interpretations of solutions for these problems.

Note also that this phrase containing 14 dimensions dramatically broadens the notion of "culture" – as mentioned before age can become a culture – and apparently there can be a teenage culture and a culture of folks in their 80s. So can linguistic abilities: all speaking Urdu form a culture as well as those speaking French. And because these can interact with one another, an 80-year-old French speaker can perhaps be considered to be a separate culture than an 80-year-old Urdu speaker. If one assumes that each of the 14 variables has only two values (and many such as language has more), there are over one million permutations of possible culture groupings – which would make the epistemic task of understanding each culture impossible. And it is important to remember that these are ethical distinctions – these have moral force. Thus they point (vaguely) to a host of moral obligations the professional must meet.

Other Key Definitional Matters in These Claims

There also are some important ancillary hypotheses. Importantly, there needs to be a definition of what is meant by "cultural sensitivity" or "cultural competence." See Table 5.1 that illustrates a wide variety of proposed definitions. Many of these definitions seem to center around this central notion:

1. P's behavior is *culturally sensitive* if P's behavior consistently embodies certain knowledge, attitudes, and skills relevant to A's culture.

However, this definition is vague – how consistent? Exactly what knowledge, attitudes, and skills – and who determines what these are? How good is the evidence in support of the claim – does it in fact meet the normal conditions to be considered "knowledge such as well-designed sociological studies?" Does one "mistake" offset other culturally competent behavior rendering the ultimate evaluation as "insensitive?" Others have also criticized the CS program because it has failed to specify these knowledge, attitudes, and skills or have given heterogeneous accounts of these (see, e.g., Benuto and O'Donohue, 2001). For example, after three or four decades of the CS program, what has it revealed about the facts of the Hispanic culture? (Benuto, Casas, & O'Donohue, 2018). This also raises the question of how are these cultural facts be determined: Are cultural members authorities? One simply has to ask one or a few. Or does one need to carefully consider scientific sociological and anthropological research? Is this clear, up to date? How are these cultural facts be seen in the context of human universals?

Another candidate for this definition that avoids some of these problems might be along the lines of:

2. If P's behavior is not prejudicial or discriminatory or if P's behavior does not embody any bias, stereotypes, prejudice, hostility (maybe even more recently "microaggressions," or "privilege") toward A as a member of culture x,y, z, then P's behavior is *culturally sensitive.*

Admittedly sometimes only definition (1) is emphasized, and sometimes both seem to be emphasized. Notice that these are quite different

Table 5.1 A variety of definitions of cultural sensitivity and competence

1.	Sensitivity is the capacity of a person to respond psychologically to changes in his/her interpersonal relationships. The component parts of the terms are embedded in definitions and uses of the terms when cultural is added; Orlandi (1992) defines cultural competence as "a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups" (p. vii). He continues by drawing attention to one's willingness and ability to draw on community based values, traditions and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other supports (p. vii). The key words in his definition are skills, understanding, appreciation, willingness, and ability; perhaps the most salient of these is willingness for without a conscious intent and desire, the achievement and realization of cultural competence are not likely to occur. Trimble, Joseph E. (2013). *The Portable Mentor: Expert Guide to a successful career in Psychology.* Springer. **58**, 57–80
2.	Moritsugu (1999) offers a more general definition where he maintains that it is "the knowledge and understanding of a specific culture that enables an individual to effectively communicate and function within that culture. This usually entails details regarding language and metalanguage, values and customs, symbols and worldviews" (p. 62). The emphasis here is on knowledge and understanding. Trimble, Joseph E. (2013). *The Portable Mentor: Expert Guide to a successful career in Psychology.* Springer. **58,** 57–80
3.	Sue, Arendondo, and McDavis (1992) maintain that cultural competence is generally defined as the development of a counselor's awareness of his or her cultural identity and belief systems and the knowledge and skills to work with diverse populations (p. 136) Trimble, Joseph E. (2013). *The Portable Mentor: Expert Guide to a successful career in Psychology.* Springer. **58,** 57–80
4.	American Counseling Association (Erford, 2009). Franklin (2012) points out that "cultural competence… is having awareness of and a working knowledge of the development and socialization that is the source of people's beliefs, values and spirituality and informs the way we think about, respond to, and interpret what is meaningful to them. When I think of cultural competence it is integrated with counseling experience, for it is only another element of many skills required in effective counseling" (p 65) Trimble, Joseph E. (2013) *The Portable Mentor: Expert Guide to a successful career in Psychology.* Springer. **58,** 57–80
5.	An awareness of diversity among human beings, an ability to care for individuals, nonjudgmental openness for all individuals, and enhancing of cultural competence as a lifelong continuous process have been identified as common themes in the cultural competence frameworks (Jirwe et al., 2006). Jirwe M., Gerrish, K., Emami A. (2006) The theoretical framework of cultural competence. *Journal of Multicultural Nursing and Health*, **12**, 6–16
6.	Cultural competence is defined in this model as "the capacity to provide effective health care taking into consideration people's cultural beliefs, behaviors, and needs" and is seen both as a lifelong developmental process and as an output. Papadopoulos I. (2006) *Transcultural health and social care: Development of culturally competent practitioners.* London, England: Churchill Livingstone, p. 10
7.	Cultural competency at the person level involves several therapist characteristics: (a) cultural awareness and beliefs, including sensitivity to the impact of one's values and biases on perceptions of the client, presenting problems, and the therapeutic relationship; (b) knowledge of the client's cultural background, worldview, and therapy expectations; and (c) cultural skills, encompassing the ability to provide culturally relevant and sensitive treatment (Sue, Arredondo, & McDavis, 1992). Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*, 64–89
8.	Intercultural sensitivity is a component of cross-cultural communication skills and is defined as an "...active willingness to generate their own motivation for understanding, accepting and appreciating intercultural differences." It indicates that people feel effective and comfortable when interacting with persons of different cultural backgrounds. P (3401) Uzun, Özge, Çetin Emeçmah. Olimpiyat köy, Balçova/İzmir-Türkiye, Turkey Sevinç, Sibel, Kilis 7 Aralık University, Yusuf Şerefoğlu School of Health, Kilis, Turkey (2015) The relationship between cultural sensitivity and perceived stress among nurses working with foreign patients. *Journal of Clinical Nursing*, p. 3401. Publisher: United Kingdom, Wiley-Blackwell Publishing Ltd.
9.	The challenge in the successful integration of cultural issues into the curriculum lies in the achievement of a balance between enhancing knowledge of specific cultural groups and the acknowledgment and respect for individuals as individuals [19], so as to reduce the danger of developing or reinforcing stereotypes [20]. Loue, Sana S. *Journal of immigrant and minority health* (2015) pp. 1412–1419 Loue, Sana; Wilson-Delfosse, Amy; Limbach, Kristen; Journal of Immigrant and Minority Health, Vol 17(5), Oct, 2015 pp. 1412–1419. Publisher: Springer; [Journal Article]

(continued)

Table 5.1 (continued)

10.	Few authors define cultural sensitivity in a simple, unitary fashion. Indeed, many authors present several definitional components, including awareness, knowledge, cognitive abilities, and skills. Further complicating the picture, each of these general categories of cultural sensitivity breaks down into subcomponents: awareness (e.g., consciousness-raising, cultural self-awareness, and perceptions of cultural differences and similarities), knowledge (e.g., understandings of the values, beliefs, norms, developmental patterns, and adaptive behaviors of specific cultural groups), cognitive abilities (e.g., the balance of emic and etic perspectives, recognition of diversity, cognizance of individual differences, and accommodation of new cultural information), and skills (e.g., integration of cultural considerations into intervention planning, goal setting, diagnosing, and treatment selection). RIDLEY, CR; et al. Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology*. US, 41, 2, **127,** 125–136, Apr. 1994. ISSN: 0022-0167
11.	Cultural sensitivity depends on an idiographic understanding of the personal meaning clients derive from cultural group membership. Nomothetic, normative information about particular cultural groups may or may not fit a particular client. Clients are not merely representatives of a single culture. They participate in aspects of different cultural groups, with each cultural facet overlapping in a unique way to create a blend that is unique to the individual. In fact, it has been estimated that people may have over 1000 roles or cultures to which they belong at any given time (Pedersen, 1990). Ridley, CR; et al. Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology*. US, 41, 2, **128,**125–136, Apr. 1994. ISSN: 0022-0167
12.	Cultural sensitivity is defined as the ability of counselors to acquire, develop, and actively use an accurate cultural perceptual schema in the course of multicultural counseling. Such a schema must be realistic, plastic, and receptive of many modes of stimulus input. There are three steps involved in information processing with cultural perceptual schema. (1) Counselors remain alert to cultural stimuli relevant to the perceptual schema. (2) Counselors organize information within the schema to improve their understanding of cultural variables in counseling. They structure and restructure schemata in accordance with changing or emerging therapeutic goals, which enables counselors to use cultural information to the maximal benefit of the client throughout each phase of counseling. (3) Counselors use schemata to organize information so that it is relevant to treatment goals and culturally responsive interventions. RIDLEY, CR; et al. Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology*. US, 41, 2, **130,** 125–136, Apr. 1994. ISSN: 0022-0167

clauses: the second – at least when what is in the parenthesis is ignored – is widely accepted to be important and pernicious: essentially one, particularly when functioning as a professional, has a duty to not be bigoted. However, the first definition places a requirement on P to have a range of knowledge that often is not regarded as having the same ethical status – knowing that, for example, the pub is a key source of social activities for the Irish is generally thought as less important than not being prejudice against the Irish.

Note also that there is an important issue of how serious a moral violation any transgression of CS actually is. In general violations tend to be regarded more of a "mortal sin" than a "venial sin." For example, Larry Summers' alleged violations seemed for many to call for his dismissal. However, it is not clear how much damage in a utilitarian calculus these violations actually cause in others. Moreover, in some quarters, these kinds of violations seem to be inescapable. If majority culture privilege is seen as institutional, or implicit (beneath awareness), or if microaggressions are seen as highly frequent, then such violations become inescapable or nearly inescapable. This construal might explain some of the high magnitude demands of the students at the University of Missouri.

Note also that this definition requires accurate measurement. One would have to gather a sample of P's behavior (or misbehavior); accurately apply some standard relative to cultural skills, knowledge, or attitudes or alternatively to prejudice, bias, and discrimination to this sample; and accurately come to some sort of conclusion regarding the extent to which P's behavior is "culturally sensitive." This critical measurement issue usually has been given short shrift in the CS

movement. Sometimes others make claims about this for P's behavior, and sometimes P may evaluate their own behavior. It has been somewhat strange that these claims have generally been taken uncritically: If P claims they are culturally sensitive, then they generally are taken to be; or if A claims that P is not culturally sensitive, then ipso facto P's behavior is considered culturally insensitive, which leads us to:

CSS Sanction and Presumed Reason for Violation If Person P's behavior is culturally insensitive and thus ethically problematic, this may be an ethical violation of a high magnitude probably because it may represent prejudice (e.g., racism, homophobia) and thus may necessitate serious penalties such as losing one's job or professional license.

For example, such sensitivity has become an ethical imperative in the APA's Ethics Code, as such violations can result in the full range of sanctions allowed by the Code. However, it is important to note that this seems to be erratically enforced. There have been few if any violations prosecuted by the APA regarding this (the APA did not respond to two queries asking them how many ethical violations were adjudicated regarding these). And yet there are also egregious examples of individuals losing their jobs because of this. Finally, it is also sporadically reinforced because some majority cultures are seen as being unable to make any valid claims regarding this.

Interrelationships Between These Four Key Claims: Which Is Most Important?

We turn next to an examination of the relationships between these claims of the CS program. Is anyone predominate? I will argue that the ethical one is predominated as well as for the implications of this.

Certainly it is the case that many of the arguments for cultural sensitivity and competence are pragmatic ones – i.e., highly related to the CS functional hypothesis – that is, being culturally sensitive (allegedly) produces positive pragmatic outcomes such as improved willingness for individuals of minority cultures to use professional psychological services or when used they can gain increased benefits from these. This is what Kant (1993) called a "counsel of prudence" – something that makes practical sense to do because of positive practical outcomes like flossing one's teeth, but something that falls short of being an ethical matter. However, there are many functional claims that have not had nearly the attention, commitment, and serious consequences attached to them – functional hypotheses like "use evidence-based assessments and treatments," or "use an electronic health record," or "integrate and coordinate mental and behavior health." None of these functional claims has reached a level of attention or centrality as concerns regarding cultural sensitivity. Certainly, none of these claims have attained the ethical status of CS.

As noted above, probably the strongest argument is that the APA has placed several ethical proscriptions regarding cultural sensitivity (problematically as O'Donohue (2016) has argued) in its Ethical Code. With this institutional decision, CS clearly has institutional ethical force. However, this is not to say it did not have this before this institutional decision. It is my contention that the APA simply codified what was the professional status of the claim: being CS was always viewed by its proponents as an ethical duty.

That the CS ethical hypothesis is most fundamental can also explain some initially puzzling facts about the cultural sensitivity movement. As pointed out, there is a paucity of research regarding many of the hypotheses, but this fact can be partially explained by the predominance of the CS ethical hypothesis. Ethical claims usually don't need empirical testing or support: for example, it is an ethical claim that it is morally wrong to spontaneously hit someone for no reason. Scientific research is not needed to establish the truth of this claim. This is the case for several reasons:

(1) research is simply irrelevant for some ethical theories: duty-based (deontic) ethical theories as well as virtue ethics simply don't make empirical claims. If it is simply a moral duty not to hit others, then this is not a matter of empirical consequences: these are irrelevant. Only in utilitarian ethics are empirical consequences relevant (the net of negative vs. positive consequences), but even according to this ethical theory, actual empirical research is generally regarded as irrelevant as these consequences are considered "obvious."

The perceived ethical status of the key claim in the CS project is a possible explanation of the small amount of empirical study associated with this movement in the past several decades. One simply does not need to empirically study the advantages of behaving morally. The matter is settled by its alleged status: it is simply the right thing to do.

But if indeed the core claim of the CS movement is a moral one, it can still be evaluated whether in fact it is a correct moral claim. First, it is important to note that there is relatively little moral argument by CS proponents. Unfortunately the APA's Ethical Code is presented ex cathedra: the APA simply asserts these to be ethical duties for professionals. O'Donohue and Levensky (1992) have noted the fundamentally authoritarian, irrational aspect of such edicts. In addition, many of the concerns of O'Donohue (2016) apply.

However, here's a sketch of a rational appraisal of the CS ethical hypothesis:

1. What kind of ethical claim is it?: Is it a utilitarian one (due to the sum of its positive and negative consequences as compared to alternatives – if so let us actually calculate these)? Is it a deontic one – one simply has a duty to do so – if so how can the obligatory nature of this alleged duty be argued for? Is it based on virtue ethics – the virtuous professional acts in this manner – if so again where is the argument?
2. There are no arguments presented that this is the best ethical response to the underlying problems – e.g., is Dr. Martin Luther King's approach in which cultural markers are minimized over other variables such as "content of character" inconsistent and inferior? The alternative ethical claim would be something along the lines, "It is ethical to treat people according to their individual actions, psychological and moral makeup, rather than upon their group membership?" This has the decided advantage as applying to all as opposed to only individuals of some particular cultures as the CS descriptive hypothesis does.
3. There is no consideration of the attendant ethical matters that may outweigh or at least moderate the ethical claim of the CS ethical hypothesis. The CS movement is seen as a response to a problem – a problem with the majority culture(s). The majority culture is actually a morphing construct – when an African-American uses this term, the concern can denote all whites – including white women and white LGBTQ members; when a gay individual uses this term, it can mean all heterosexuals, including Native-American and African-American heterosexuals. Membership in the majority culture is an important dimension that varies in the CS movement. There sometimes are fairly extreme and radical positions ("all men are rapists" (McKinnon, 1987); "all whites are racist"; "the English language is oppressively privileged"; "there are no safe spaces at the university because of racism, sexism, and homophobia," etc.) At other times, there are much more moderate positions "the majority culture is not knowledgeable about Mexican culture"; "much progress has been made over the past century, but there is still some residual racism," etc. Of course these positions can reflect political ideologies rather than a careful analysis of empirical studies.
4. More worrisome is whether these can also reflect a reverse racism, problematic ethical behavior that is an ethical violation because of its own sexism, heterosexism targeting members of the majority culture, etc. Perhaps the fundamental ethical principles of fairness and

justice are also being violated by any exaggerations of claims against the majority culture or in the cavalier application of any generalization to specific individual members. Part of the reason for this is definitions of key terms are themselves partly ideological: Are the NBA's higher salaries (interestingly mainly to African-Americans) than the WBA's a reflection of sexism or a reasonable consequence of market forces that may be responding to the differential quality of basketball contained in the two leagues?

This also matters because this is a serious indictment of others – if true these sorts of claims do reflect deep societal problems that need remediation – but if exaggerated or if inappropriately leveled, these can do harm. It simply is not fair for anyone to make a claim of impropriety against anyone else – and this holds true of individuals of any race, gender, sexual orientation, or cultural heritage.

How are unfair attitudes or behaviors (prejudice, discrimination, bias, etc.) be precisely defined? Much work needs to be done here.

One possibility is that many use a Roschian prototype to understand, for example, racism: that the prototype racist is the 1930s Southern Sheriff – and because they feel their own attitudes and behavior different significantly from his – then they are not racist. But this is clearly problematic. The field needs more current, more nuanced, and more relevant definitions of prejudice and bias.

For example, psychologist Derald Wing Sue (Sue et al. 2007) has recently defined microaggressions as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership." Sue describes microaggressions as generally happening below awareness of even well-intentioned members of the dominant culture. Microaggressions, according to Sue, are distinct from overt, deliberate acts of racism or bigotry, such as the use of racist epithets, because the people perpetrating microaggressions often intend no offense and are always unaware they are causing harm. Sue further describes microaggressions as including statements that repeat or affirm stereotypes about the minority group or subtly demean a minority group or member that position the majority culture as normal and the minority one as aberrant or problematic; that express disapproval of, or discomfort with, the minority group; that assume all minority group members are the same; and that minimize the existence of discrimination against the minority group, and seek to deny, or minimize, real conflict between the minority group and the dominant culture.

According to Sue et al., microaggressions appear in three forms:

1. *Microassault*: an explicit racial derogation, verbal/nonverbal, e.g., name-calling, avoidant behavior, and purposeful discriminatory actions
2. *Microinsult*: communications that convey rudeness and insensitivity and demean a person's racial heritage or identity, subtle snubs, unknown to the perpetrator, and hidden insulting message to the recipient of color
3. *Microinvalidation*: communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person belonging to a particular group.

It would be interesting to measure the extent to which typical CS training may (inadvertently) contain these.

Conclusions: Epistemic Standards Regarding These Hypotheses

Criticism and the Growth of Knowledge

If we are to treat these claims as rational, then an appraisal of their truth requires a careful and critical examination of evidence, particularly scientific evidence, and argument for their truth. Such a scholarly rational examination would seem to have three aspects:

1. If any of these central claims regarding CS movement are regarded as empirical assertions, then empirical evidence would be

needed for such a rational appraisal of their truth status. For example, what cultural regularities regarding culture C have been discovered thus far according to what methodologies and what evidence?

2. If any of these claims involve empirical causal claims, then appropriate research methodologies and scrutiny of results need to be conducted to look at the causal nature of these claims. For example, if increased CS is claimed to result in improve therapy outcomes, then this putative causal relationship needs to be examined.
3. If any of these claims are regarded as ethical assertions, then sound ethical arguments need to be presented and evaluated for their truth status.

This chapter attempts to demonstrate some of the complexities concerning these epistemic pursuits. In addition, it provides a caution against some of the more severe usage of CS which when used carelessly can cause problematic conflicts with constitutional rights as well as be used harshly to deprive individuals of their livelihoods as well as their psychological well-being. This is obviously contrary to any salutary aims associated with justice and improved conditions associated with many of the advocates of the CS program.

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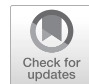

6 A Critique of Cultural Competence: Assumptions, Limitations, and Alternatives

Brenda L. Beagan

In the past two decades, there has been a rising tide of attention to cultural competence within all of the health and social service professions. While this has been a welcome recognition of both the rapidly increasing diversity that accompanies global migration and the limits of professional practices historically rooted in specific sociocultural realities, there are also important limitations to this way of framing responses to diversity. This chapter will explore the meanings of cultural competence, which dominates professional approaches to diversity, as well as critically examine some of the assumptions that undermine this approach. It will briefly explore an alternative, cultural humility and critical reflexivity, noting their potential contributions toward greater equity in health and health care.

Cultural Competence: The Dominant Approach for Working with Diversity and Inequities

In medicine, cultural competence has been taken up as a core competency for improving the quality of care across social differences, and is now required in all North American medical schools to meet accreditation standards (Kutob et al., 2013; see also Accreditation Council for Graduate Medical Education, n.d.; Committee on Accreditation of Canadian Medical Schools, 2015). It has also come to dominate discourse and professional education in other fields, such as nursing, pharmacy, occupational therapy, and physiotherapy (American College of Clinical Pharmacy, O'Connell, Korner, Rickles, & Sias, 2007; American Nurses Association, 2009; American Occupational Therapy Association, n.d.; American Physical Therapy Association, n.d.; Chartered Society of Physiotherapy, n.d.). In psychology, the American Psychological Association (APA) approved *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* in 2003, emphasizing cultural sensitivity regarding race and ethnicity. This was followed with a task force report 4 years later on implementing the guidelines (APA, 2008), which focused on recommendations for groups accountable to APA rather than for individual psychologists.

Whether the language used is cultural competence or its derivatives multicultural competence, transcultural competence, cultural sensitivity, cultural relevance, or cultural responsiveness, the definitions and approaches contain important consistencies. They all concern developing greater ability to work effectively with patients or clients unlike oneself in sociocultural terms.

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For example, culturally competent health professionals are able to "understand and appreciate differences in health beliefs and behaviours, recognise and respect variations that occur within cultural groups, and are able to adjust their practice to provide effective interventions for people from various cultures" (Balcazar, Suarez-Balcazar, & Taylor-Ritzler, 2009, p. 1153). Writing for the European Psychiatry Association, Schouler-Ocak and colleagues define cultural competence as "good clinical practice with the goal that all patients, especially those from minority groups, feel acknowledged and supported" (Schouler-Ocak et al., 2015, p. 431).

As typically framed, cultural competence centers on the development of awareness, knowledge, and skills (e.g., Bassey & Melluish, 2013; Betancourt, 2003; Campinha-Bacote, 2002; Lee & Khawaja, 2013; Schouler-Ocak et al., 2015; Tummala-Narra, 2015). Awareness is understood as developing insight into one's own cultural values, attitudes, and biases, as well as developing awareness of and sensitivity to the potentially distinct values, beliefs, and attitudes of clients unlike oneself. Knowledge entails learning about other cultures, in particular in relation to health and illness. Openness and curiosity are thought to be key. Synthesizing across the literature, skills for cultural competence are considered to include effective communication, rapport building across differences, respect, active listening, advocacy, use of open-ended inquiry, use of culturally appropriate assessments and interventions, and working with interpreters (Balcazar et al., 2009; Bassey & Melluish, 2013; Betancourt, 2003; Campinha-Bacote, 2002; Lee & Khawaja, 2013; Schouler-Ocak et al., 2015). Often cross-cultural encounters are identified as the means for improving awareness, knowledge, and skills "through repetitive engagements with diverse groups" (Balcazar et al., 2009, p. 1153).

As typically framed, cultural competence discourse and approaches contain numerous problematic assumptions and limitations. Below I will explore these limits and assumptions through a series of critical questions: What is attended to, and what is rendered invisible? Who is spoken *to*, and who is spoken *of*? How might greater cultural competence be attained? What does achieving competence mean?

What Is Attended to, and What Is Rendered Invisible?

Virtually all of the cultural competence literature gives a nod to the idea that relevant aspects of diversity that affect health and health care are broader than simply race and ethnicity. Often there is even acknowledgment that the term "culture" applies to a wide spectrum of social identities, yet immediately afterward, the focus is almost always reduced to race and ethnicity (Seedall, Holtrop, & Parra-Cardona, 2014). For example, in writing about the APA *Multicultural Guidelines* (2003), the implementation task force wrote:

> The *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (*Multicultural Guidelines*) recognizes that there are multiple identity factors such as language, gender, biracial/multiracial heritage, spiritual/religious orientations, sexual orientation, age, disability, socioeconomic situation, and historical life experience (e.g., immigration and refugee status) that have an impact on the socialization process. (APA, 2008, p. 4)

They then go on to say that the guidelines focused on "individuals and groups historically marginalized or disenfranchised within and by psychology based on their ethnic/racial heritage," and in keeping with this, the implementation task force also "limited the focus of its recommendations to ethnic/racial minorities" (APA, 2008, p. 4).

To its credit, psychology – unlike other professions – has offered a rationale for narrowing the focus to race and ethnicity. In a landmark paper proposing multicultural counseling competencies, Sue, Arredondo, and McDavis (1992, pp. 477–478) argued that while culture could be understood broadly as including "race, ethnicity, class, affectional orientation, religion, sex, age and so forth," this risks diluting the focus on race and ethnicity – and racism. While there are exceptions (e.g., see Dunn & Andrews, 2015, for insightful attention to disability), the majority of

the literature on cultural competence addresses only race and ethnicity (Seedall et al., 2014). While attention to single aspects of social identity is important, and can be appropriate, if the literature rarely or never addresses intersectional analyses, nuanced understandings of even race and ethnicity are difficult. None of us experience any social identities in isolation; our race and ethnicity are always tempered by our gender, social class, sexual orientation, citizenship status, and so on. A working-class lesbian born in the USA may experience her Iranian heritage very differently from an upper-class, heterosexual man recently migrated from Iran. To not engage in intersectional analysis helps to construct narrow, overly static understandings of race and ethnicity (Owiti et al., 2014; Seedall et al., 2014; Wear, Kumagai, Varley, & Varconi, 2012). It ignores the ways in which the political salience of multiple social identities changes constantly with context.

So, despite the fact that culture is usually defined broadly, cultural competence typically has a very narrow focus. At the same time, even *within* the social categories of race and ethnicity, the focus narrows to the racialized and/or ethnic "Other"; the experiences of the dominant group, the majority group, are rendered invisible, devoid of culture, thus both naturalized and normalized (Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Those who are "minority" – possibly in numbers but always in power – are seen as marked by race and ethnicity, while the dominant group remains unmarked, neutral. Even the definitions of cultural competence, with their emphasis on working effectively across cultural differences, draw implicitly on an unnamed and unmarked social location, the "us" from which racialized and ethnic Others are cast as "them":

> "Different" assumes a *location* from which one is looking at the Other; it also assumes that *something* or *someone* is normative, usually the one doing the observing. Understanding that the perspective that defines "normal" is often localized to a position of privilege or power reveals how efforts in cultural competency may actually reinforce the "Otherness" and marginalization of disenfranchised groups and individuals. (Wear et al., 2012, p. 753)

As Hollinsworth (2013) points out, in texts with chapters devoted to cultural knowledge about specific ethnic groups, there is rarely a chapter on the dominant group(s). This leaves the normative status that accompanies social privilege intact. Moreover, the culture of the profession itself is rendered invisible, immune from questioning.

With this emphasis on the Other, at their worst, cultural competence training and texts can become a kind of "laundry list" of cultural attributes pertaining to specific ethnic groups (Haltiwanger, 2010; Laher, 2014; Qureshi, 2004). This blunt approach has definitely fallen out of favor over the past decade; nonetheless, it is routine to encourage clinicians to gain more knowledge of ethnic and racialized minority groups (APA, 2008). In seeking to elucidate the beliefs and practices of specific cultural groups regarding health and illness, such approaches convey static, narrow versions of culture. Culture is presented as fixed and unchanging, determining rather than interactional and fluid, and grounded in differences presumed to be core to the essence of specific groups (Carpenter-Song, Schwallie, & Longhofer, 2007). Change over time and diversity within are ignored.

Moreover, the role of culture in shaping beliefs, values, and practices tends to be overemphasized with reference to the Other and underemphasized with reference to ourselves:

> Significantly, "we" (those positioned as dominant racially or culturally) often do not experience our own cultural backgrounds as so powerful in determining our own decisions and thoughts. In reflecting on our behaviour we refer to our individual autonomy and choices supposedly based on rational theories and factual information… This idea that cultures are extremely powerful in shaping, even controlling, (others') lives is called culturalism. (Hollinsworth, 2013, pp. 1051–52)

Not only does this approach reify culture (for some groups), but it also circumvents important intersectional analysis, casting health issues as the result of cultural eccentricities, instead of the result of poverty, working conditions, living conditions, stigma, racism-related stress, and so on (Garneau & Pepin, 2015).

In relegating all aspects of diversity and inequities in health and health care to culture, this approach renders invisible existing social power relations, particularly issues of power and privilege. Some have critiqued the "3D approach" to multiculturalism as "one that celebrates dance, dress, and dining, but fails to take into account the multiple dimensions of racial and social inequality" (Srivastava, 2007, p. 291). Similarly, an emphasis on the quaint, mysterious, and slightly exotic cultural beliefs and practices of ethnic and racial minority cultures – even in the interest of better understanding health-related beliefs – may well fail to grasp factors that have the most far-reaching and immediate impact on people's health and wellness, such as migration history, citizenship status, employment discrimination, linguistic isolation, and the structural, institutional, and everyday forms of racism and ethnocentrism.

Who Is Spoken to, and Who Is Spoken of?

Too often the research and literature on cultural competence leaves the impression of a group of well-intended, caring, white, Anglo, upper-middle-class, heterosexual, cisgender, Christian-heritage, able-bodied citizens, gathered together in a heartfelt, impassioned conversation about better understanding and doing better work with "those people." If the racialized, ethnic minority patient or client is cast as the Other, the health professional in cultural competence is virtually always positioned as a member of socially dominant groups (Hollinsworth, 2013; Kumaş-Tan et al., 2007; Paul, Ewan, & Jones, 2014). For example, many cultural competence assessment tools include items that ask about knowledge of or contact with members of ethnic minority groups (Kumaş-Tan et al., 2007), which assumes the professionals are not, themselves, members of ethnic minority groups.

In implicitly speaking to members of dominant groups, culture is rendered solely as something in or possessed by ethnic and racialized minority Others; the health professional is depicted as culture neutral, as is the profession itself (Paul et al., 2014). To the extent that cultural competence is intended as a response to address practice problems, clients and patients from ethnic and racialized minority groups have/are the "problem." They pose problems for practice as usual, which is understood as culturally neutral. As Schouler-Ocak et al. write in the European context, "Cultural competency is about skills that a clinician can employ to understand the cultural values, attitudes and behaviors of patients, especially those whose cultural background differs from that of the mental health professional" (2015, p. 432).

When professional socialization is effective, students – new members being inducted into the profession – learn almost seamlessly the values, norms, beliefs, language, and accepted forms of knowledge and discourse that will allow them to move smoothly within the social field of their profession. What counts as relevant and worth knowing, what matters and warrants action, and how to analyze and depict a situation are cultural aspects of professions learned through the formal, informal, and hidden curricula (Hafferty, 1998). Yet the cultural aspects unique to a profession are gradually rendered virtually invisible. In medicine, Taylor calls this a "culture of no culture" (2003, p. 556) in which profession-specific knowledge, beliefs, and values become cast as neutral, objective, true, and real. The emphasis in cultural competence approaches is inevitably on teaching ("neutral") professionals to work effectively with the (challenging) cultural beliefs and practices of their patients or clients, rarely on teaching professionals to recognize how *they* are operating out of, and imposing on others, a very narrow profession-specific cultural worldview (Murray-García & García, 2008; Paul et al., 2014).

How Might It Be Resolved?

If cultural competence centers on awareness, knowledge, and skills, then cultural *in*competence can be understood to center on *lack* of awareness, knowledge, or skills. Culturally

incompetent practice, doing a "bad" job working with diversity, happens because the practitioner does not know enough, has "bad" attitudes, or is unskilled. Training programs to improve cultural competence always focus heavily on knowledge. Practitioners should be aware of, knowledgeable about, and seek contact with the Other. Cultural incompetence arises, at least in part, from practitioners' lack of familiarity with the Other (Balcazar et al., 2009). As noted above, engagement with diverse Others is then identified as a key way of developing cultural competence.

The long-standing "contact hypothesis" (Allport, 1954) suggests that increased contact with members of cultural groups reduces prejudice by challenging generalizations, oversimplified understandings, and categorical thinking about all members of a group. A meta-analysis of 515 intergroup contact studies found a small to moderate effect on reducing prejudice; the impact was more impressive among women than men and among children than adults (Pettigrew & Tropp, 2006). To be clear, Allport's original formulation suggested contact can reduce prejudice when that contact involves equal status between the groups, cooperation, common goals, and structured external support. Those features – notably equal status and common goals – are absent when cultural competence training entails rotating health professions students through placements in impoverished or racialized neighborhoods or attending workshops provided by members of ethnic or racialized minority groups. Intergroup contact certainly does not always reduce negative attitudes or beliefs; in fact, it could be seen to have given rise to apartheid, Nazi extermination policies, and effective colonization of Indigenous peoples. One study with rehabilitation counselors found the more "minority clients" on their caseloads, the *less* culturally competent counselors were (Cumming-McCann & Accordino, 2005).

The awareness, knowledge, and skills formulation additionally suggests that the problem of cultural *in*competence may lie in practitioners' discriminatory attitudes toward the Other. Prejudice, bias, discriminatory beliefs, and attitudes are assessed at the individual level, and training is intended to alter them at the individual level, largely through knowledge. As Ben-Ari and Strier (2010) note:

> Widely existing conceptions of cultural competence and the ways in which they relate to the "Other" assume that the "Other" is knowable and that this knowledge is a prerequisite for being culturally competent. Basically, the more we learn about others the better skilled we are to meet their needs. That is, knowledge about the "Other" is a precondition for cultural competence. Additionally, it is assumed that cultural competence is a capability that can be attained through learning and training. (p. 2158)

The cultural competence approach tends to assume that any issues that arise regarding diversity are because practitioners are ignorant, prejudiced, or bigoted. This assumption individualizes something that is much more complex than individual "failings." In this approach, the sociopolitical context of power relations and privilege tends to disappear.

Yet sociocultural diversity is utterly entwined with historical and contemporary power relations. In contemporary North America, having white skin means I benefit from significant privileges and advantages that darker-skinned people do not. That has to do with a history of colonization and moving Indigenous peoples off their lands, plus government policies to wipe out their cultures in residential schools. It has to do with the ongoing impacts of colonization. My white-skinned privilege today has to do with a racism that was present in slavery, followed by racial segregation that is still a de facto geographic reality, and a multitude of ongoing effects of racism. Whether I like it or not, white skin continues to privilege me in relation to employment, education, health care, the legal system, the media, politics, and the economy. I do not have to be individually prejudiced to nonetheless experience white privilege. The cultural competence approach individualizes something that is inherently social, structural, and shaped by complex histories.

Because the social world operates most smoothly for members of dominant social groups, we rarely have to think about why things work the way they do. We can take a lot for granted

when our cultural reality is depicted all around us, as the only way to be, or the best way to be, or both. Those of us in socially dominant groups develop worldviews shaped by living with an "unmarked" status. If we have white skin, our race is usually unnoticed and unremarked. Heterosexual sexual orientation is unnoticed and unmentioned. The gender identity of cisgender people (those whose biology and gender identity are in alignment) is unmarked, unnamed, and unnoticed. If I am treated poorly in an institutional setting, I can assume it is individual and personal – I virtually never have to question if it is due to being cisgender or white.

The everyday operation of privilege and disadvantage and of power and subordination – these are not individual failings to be corrected through greater contact with or knowledge of the ethnic or racialized Other. Though individual actions and inactions, words, and silences certainly help to perpetuate or undermine racism, classism, ableism, heterosexism, and so on, individuals are not responsible for these social power relations. They are the air that we breathe; they are the fabric of society surrounding us. We cannot simply opt out because we learn better. To position cultural competence as if it were an individual skill, and cultural incompetence as an individual failing, avoids grappling with broader sociopolitical realities of racism, ethnocentrism, colonialism, classism, ableism, heterosexism, gender binarism, sexism, ageism, and religious exclusivism or intolerance.

Even when cultural competence directives address the effects of social power relations, it is usually by emphasizing the value of knowing about the potential effects of stigma and discrimination – again with a focus on the Other, not on the dominant groups. Rarely do authors emphasize the importance of developing awareness not only of one's own cultural "baggage" but also of one's own privilege and unearned advantages and the attendant failures to see and comprehend.

What Does Achieving Competence Mean?

In recent years, most discussions of cultural competence emphasize that it is not an end state that can be achieved but rather a constant learning process (e.g., Bassey & Melluish, 2013). This emphasis on process, rather than on achieving a state of competence, is undermined by reliance on models (such as Bennett's [1993] Developmental Model of Intercultural Sensitivity) that suggest cultural competence is an "advanced" state relative to other approaches (e.g., Boggis, 2012). For example, those who draw on the developmental continuum of Cross, Bazron, Dennis, and Isaacs (1989) hierarchically order a developmental continuum as "(1) cultural destructiveness, (2) cultural incapacity, (3) cultural blindness, (4) cultural pre-competence, (5) cultural competency, and (6) cultural proficiency" (Haltiwanger, 2010, p. 9). Despite the insistence on process, most writing in the cultural competence approach assumes a state of competence can be achieved (Balcazar et al., 2009; Keyser, Gamst, Meyers, Der-Karabetian, & Morrow, 2014; Matsumoto & Hwang, 2013).

For example, the European Psychiatric Association guidelines state, "Attaining a level of cultural proficiency indicates a level of cultural competence but this is not absolute and will need ongoing development" (Schouler-Ocak et al., 2015, p. 436). Despite the fact that the same guidelines emphasize that "cultural competence is best understood as a process or even a sort of meta-theory rather than a specific attainable skill set" (p. 432) and qualify that cultural competence "is not absolute and will need ongoing development" (p. 436), the notion of "attaining proficiency" is difficult to imagine as other than a state of competence. As one critic suggests, "the language of competence implies a kind of mastery and control that belies the vulnerability and uncertainty of the clinical encounter in which empathy must sometimes fail" (Kirmayer, 2008, p. 469).

Writing in medicine, Delese Wear (2008) has commented that the current emphasis on cultural competence is strikingly in line with a move throughout medicine – and I would add throughout the health and social service professions – toward competency-based education. This makes the notion of cultural competence especially tempting, because it fits so well with broader trends in professional education and evaluation. Wear (2008) questions:

> How have we arrived at a place where competence has seemingly leaked into every area of academic life? It makes perfect sense in areas where we expect trainees to achieve a desired level of skill, information, or technique, but when we apply the same reasoning to habits of thought and feeling beyond the operational and instrumental, we make a wrong turn, drawn by our lust for assessment. (p. 625)

Trainees are taught profession-specific knowledge and skills and then tested on their manifestation of appropriate knowledge and behaviors. If competence is demonstrated, they move on to the next set of knowledge and skills to be mastered. In this context, when advocates of cultural competence insist they do not intend a measureable end point, but rather engagement in an ongoing process, the term "competence" seems strikingly out of step with the rest of competency-based education.

Moreover the notion of a testable, measurable outcome belies the claim that cultural competence is not expected to result in mastery. Almost 20 years ago, Melanie Tervalon and Jann Murray-García warned those in medical education to avoid the pitfall of casting cultural competence as "an easily demonstrable mastery of a finite body of knowledge, an endpoint evidenced largely by comparative quantitative assessments" (1998, p. 118). Since then, quantitative cultural competence measures have proliferated (see Gamst, Liang, & Der-Karabetian, 2011). Kumaş-Tan et al. (2007) identified 54 such instruments and critically analyzed the ten most commonly used. Suarez-Balcazar et al. (2011) reviewed 13 cultural competence assessment instruments and developed their own tool. Matsumoto and Hwang (2013) recently assessed ten assessment tools for cross-cultural psychology.[1]

The focus of such measures is almost always on awareness (or attitudes), knowledge, and skills (or ability to adapt practice as needed) (Keyser et al., 2014; Kumaş-Tan et al., 2007; Matsumoto & Hwang, 2013). They are almost all self-reports of learners' or clinicians' perceptions of their own competence; there has been surprisingly little attention to capturing client or patient assessments of practitioner competence.[2] Assessment tools frequently measure respondents' self-perception of their own ability on various aspects of awareness, knowledge, and skills, assessing degree of agreement with items that open with "I have an excellent ability to…" or "I am highly effective in…." Even more common are assessments based on self-reports of comfort and confidence, with items such as "I am confident in my ability to…" and "I am comfortable working with…."

[1]Among the tools addressed in these three articles alone are Behavioral Assessment Scale for Intercultural Communication (BASIC) effectiveness, Cross-Cultural Adaptability Inventory (CCAI), Cross-Cultural Counselling Inventory (CCCI), Cross-Cultural Sensitivity Scale (CCSS), Cultural Competence Assessment Tool (CCAT), Cultural Competence Assessment Instrument (CCAI), Cultural Competence Self-Assessment Questionnaire (CCSAQ), Cultural Intelligence Scale (CQ), Cultural Self-Efficacy Scale (CSES), Intercultural Adjustment Potential Scale (ICAPS), Intercultural Behavioral Assessment (IBA), intercultural communication competence (ICC), Intercultural Development Inventory (IDI), Intercultural Sensitivity Inventory (ICSI), Intercultural Sensitivity Scale (ISS), Inventory for Assessing the Process of Cultural Competence (IAPCC), Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS), Multicultural Counseling Knowledge and Awareness Scale (MCKAS), Multicultural Counselling Awareness Scale (MCAS), Multicultural Counselling Inventory (MCI), Multicultural Mental Health Awareness Scale (MMHAS), Multicultural Personality Inventory (MPQ), and Multicultural School Psychology Competency Scale (MSPCS).

[2]Though see Cole, Piercy, Wolfe, and West (2014) for the development of the Multicultural Therapy Competency Inventory-Client Version (MTCI-CV) which asks clients to assess their therapists on six domains: therapist awareness of their own cultural values and biases, awareness of client worldviews, use of culturally appropriate intervention strategies, respectful curiosity, naiveté (openness and receptivity), and therapeutic relationship building skills.

The ubiquitous assumption that greater confidence and comfort (and perhaps self-declared excellence) among practitioners signifies improved work across sociocultural differences is intriguing. In my experience, learners often become *less* comfortable and confident as they learn more about diversity, as they begin to see the limits of their experience, knowledge, and worldviews and as they begin to recognize entrenched biases and assumptions. In the context of working across differences, in challenging one's own privilege, comfort and confidence may indicate arrogance and lack of insight rather than competence. As Joshua Hook writes, "It is dangerous to think we have somehow *arrived* in regard to understanding individuals and groups who are different from us" (Hook, 2014, p. 278).

In a training program for 90 primary care physicians, Kutob et al. (2013) found participant scores declined on self-awareness; they suggest that as physicians worked through complex paper cases, they became more aware of complexities surrounding culture, including their own cultural identities: "This, in turn, may have resulted in an appropriate lowering of confidence in their abilities to assess a patient's culture without input from the actual patient…It is possible that the course promoted an increased sense of 'cultural humility' by encouraging continuous self-evaluation and self-critique" (Kutob et al., 2013, p. 171). Similarly in a small mixed-methods study with nursing students, Isaacson (2014) found scores on a pre-test indicated cultural competence prior to immersion in a cross-cultural clinical placement, yet journal reflections were rife with stigmatizing stereotypes. Post-immersion, student scores tended to decline, while journal reflections showed heightened awareness. It seems possible that not only is greater confidence and comfort *not* a sign of improvement, but in fact *dis*comfort may be a step in the right direction (see Harbin, Beagan, & Goldberg, 2012; Hollinsworth, 2013).

An Alternative: Cultural Humility

The concept of cultural humility was first described by Tervalon and Murray-García (1998) as a challenge to the rising tide of cultural competence; it is finally beginning to gain some traction in the health professions. Rather than seeing cultural difference as something that resides in the "diverse client," they cast it as inherent in the relationship between two equally valid worldviews, the therapist's and the client's. They urge health professionals to be "flexible and humble enough" to avoid the complacency of stereotyping, to assess the cultural narratives of each new patient/client, to admit when they lack knowledge, and to be willing to seek out appropriate resources (Tervalon & Murray-García, 1998, p. 119). Cultural humility requires lifelong commitment to ongoing, courageous, honest self-evaluation and self-critique, examining how one is implicated in patterns of intentional and unintentional advantage and disadvantage by ethnicity, race, class, ability, gender, and sexual identity. It demands systematic reflection on enactments of professional power, challenging professional authority through recognition of client expertise, and advocacy guided by community. Humility is a prerequisite in challenging professional authority (and sociocultural privilege).

Though there has been far less written about cultural humility than about cultural competence, clarity is beginning to emerge about what it means and how one enacts it (see Hook, 2014; Kirmayer, 2013; Kutob et al., 2013). Rather than a finite set of knowledge and skills to be mastered, it is described more as a disposition or orientation (Hook, Davis, Owen, Worthington, & Utsey, 2013, p. 354). It involves respectful openness to the Other and an absence of superiority when cultural values and beliefs differ from one's own:

> For a therapist to develop a strong working relationship and conduct effective counseling with a client who is culturally different, the therapist must be able to overcome the natural tendency to view one's own beliefs, values, and worldview as superior, and instead be open to the beliefs, values, and worldview of the diverse client. (Hook et al., 2013, p. 354)

For health professionals, humility arises from (and leads to) constantly acknowledging that they know less about the Other than they had thought (Kutob et al., 2013).

Drawing on the philosophy of Emmanuel Levinas (1999) stress that the emphasis on knowledge in cultural competence is misplaced, assuming as it does that the Other is ever fully knowable. "Differences," they argue, "are infinitive and cannot be known" (2010, p. 2163). Instead they recommend "the adoption of a position of complete openness in working with difference and diversity" (p. 2164). This complete openness entails "recognition and commitment that the 'Other' is infinitely unconquerable and radically different from me" (p. 2164). This is echoed by Hook and colleagues who say therapists should "cultivate a growing awareness that they are inevitably limited in their knowledge and understanding of a client's cultural background" (Hook et al., 2013, p. 354). In working with diversity, it is far more helpful to ask good questions than to have the right answers – a reversal of the competence notion of mastery.

Characterized by respectful openness and the absence of superiority, cultural humility has been described as an ethical stance (Ben-Ari & Strier, 2010). Kirmayer (2013) suggests that if the Other is infinitely unknowable, it is essential to develop a stance that welcomes uncertainty:

> The overarching values of this ethos include the recognition and valorization of difference or alterity and the tolerance, or active embrace, of uncertainty. Tolerance of uncertainty reflects the epistemic limits of clinical ways of knowledge but also serves an ethics of relatedness that allows the patient autonomy and room for self-fashioning. (p. 369)

Ben-Ari and Strier (2010) similarly advocate "an ethical relation to difference…Our recognition that differences cannot be fully known means that we are aware that they are always more than what we grasp" (p. 2163). This "ethics of relation" can help to counter the violence of domination that accompanies an authoritative stance (Kirmayer, 2013).

Embracing uncertainty is a direct challenge to the emphasis on knowing in cultural competence. Cultural humility emphasizes responsibility rather than knowledge, seeing knowing as in fact a form of domination and appropriation, of reductionism and subordination, and of objectification (Dean, 2001). To know the Other is to capture the Other, to assert control through reduction to an assumed essence:

> Knowledge does not necessarily lead to the right actions, or even to a more ethical action. It is not only that knowledge is not enough, but that under certain conditions, it can even be harmful. It is because when we think we know the "Other," when we, based on our knowledge, think we understand the "Other," there is a risk that we are totalising or reducing the "Other" according to the partiality of our previous understandings. (Ben-Ari & Strier, 2010, p. 2164)

Embracing uncertainty, however, is highly troubling for most health professionals. Learners are taught early and well to hide any uncertainty, any lack of knowing, under a cloak of professional expertise and authority (Beagan, 2001; Kirmayer, 2013). The displays of expertise, certainty, and mastery demanded in competency-based education may in fact be dangerous when it comes to working with differences.

Awareness and Knowledge in Cultural Humility

This is not to say there is no place for awareness or knowledge in cultural humility; it simply shifts focus. Rather than knowledge of the Other, the focus is knowledge and awareness of the self. In this it is not markedly divergent from the best of the cultural competence literature, especially in psychology. One of the 2003 APA guidelines for multicultural practice asked psychologists to "recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (APA, 2008, p. 3). As Bassey and Melluish (2013) summarize, in the counseling literature, cultural competence is understood to include awareness of the self (own cultural biases, assumptions, beliefs, personal

and professional values) and awareness of the Other (client relationship to their cultural identity, as well as individual beliefs and values).

The best literature goes further, calling for awareness of and knowledge regarding historical and current sociopolitical realities that give rise to the kinds of social and health inequities at the heart of cultural competence concerns (Bassey & Melluish, 2013). As Kirmayer (2008) writes, "Cultural competence begins with the clinician's self-knowledge, and an appreciation of how historical circumstances situate the encounter with the patient. The history of colonialism, slavery, racism, and discrimination precede the clinical encounter and give each word and gesture added meaning" (p. 469). Awareness and knowledge of socially structured power relations are critical to begin to understand one's own power and privilege and where those may intersect with experiences of disadvantage and subordination, producing distinct assumptions, biases, and worldviews on *both* sides of power divides.

In this, cultural humility overlaps with a term that emerged from Maori nurses in New Zealand, "cultural safety" (Papps & Ramsden, 1996; Ramsden, 1990, 1993). The rationale behind it was a "belief that the significant health disparities experienced by the Maori people of New Zealand were a direct outcome of over a century of colonialism and chronic cycles of poverty, which were misconstrued by many as being synonymous with Maori culture" (Gerlach, 2012, p. 152). Most common in New Zealand and Australia, especially in nursing, cultural safety holds central a focus on power relations, particularly a critical recognition of colonialism and its ongoing effects on the social, economic, political, and health inequities faced by Indigenous peoples (Gerlach, 2012; Nursing Council of New Zealand, 2011). Cultural safety moves beyond sensitivity to and awareness of cultural difference to analyzing power imbalances, discrimination, and the lasting effects of colonization. Rather than attending to cultural practices and reducing diversity and inequities to cultural "difference," it emphasizes the social, economic, and political relations that shape and determine experiences and outcomes. This perspective moves away from casting "minority groups" as a problem for practice as usual to understanding the (largely unconscious) wielding of power and privilege by members of dominant groups as the problem (Gerlach, 2012).

At the same time, cultural safety recognizes that power and authority are also embedded in the policies, practices, and everyday procedures of heath care (Garneau & Pepin, 2015; Gerlach, 2012). There is explicit recognition that healthcare providers wield professional power; it demands that health professionals critically examine their professional assumptions and beliefs, as well as their own personal cultural and colonial heritages, motivated by and directed toward health equity and social justice. This self-reflection helps practitioners to avoid imposing their cultural values and avoid reproducing inequitable social relations. As with cultural competence, cultural safety requires awareness and knowledge – particularly about historical and current social inequities – but these are as much about advantage as disadvantage, as much about power as oppression, and as much about privilege as discrimination.

Self-awareness and self-knowledge are common elements of most approaches to work with diversity; the work of unlearning our socially constructed biases and assumptions is less often discussed:

> Acquiring knowledge and skills related to cultural competency pales in comparison to the difficult, complicated, never-ending process each of us faces in identifying, confronting, *and* attempting to unlearn such biases and stereotypes. When we stop at merely identifying our biases, most of the work still lies ahead of us. Recognizing that one has a bias is not an end point but the beginning of a larger process of awareness. (Wear et al., 2012, p. 755)

That larger process connects to an ethical commitment to challenging oppression and working to reduce inequities (Ben-Ari and Strier, 2010), what Wear and colleagues refers to as tackling "the really difficult issues of privilege, justice, witnessing, and responsibility" (Wear et al., 2012, p. 757). They warn that there are no comfortable places on that journey; as noted earlier, comfort is not necessarily an avenue to improved

work with diversity. Unfortunately, discomfort too often leads us to step back from the challenging work of engaging with power and privilege, oppression, and disadvantage (Hook, 2014, p. 278).

In cultural humility, then, self-awareness and self-knowledge are motivated by challenging oppression, which means constant – often painful – interrogation regarding our own experiences of power and privilege. This goes beyond the usual self-reflection of the "reflective practitioner" (Schön, 1983) to a *critical* reflexivity (Beagan, 2015). Critical reflexivity, connected to critical theory, insists that self-reflection examines individual practices *in relation* to social structures and power relations. In critical theory, social structures and power relations are theorized not only as determining people's experiences and outcomes but also as continually recreated, undermined, or transformed through human actions and discourses. Mary Ellen Kondrat (1999) insists we all have "day to day involvement in the ongoing construction, maintenance or renewal of the structures of society" (p. 465). Thus, critical reflexivity asks us to examine how taken-for-granted everyday interactions, including with patients, maintain or transform social structures and power relations.

Critical Reflexivity and Cultural Humility

Critical reflexivity can be a path to identifying and deconstructing worldviews and practices that are systematically harmful to particular groups. It begins with questioning how one is implicated in structures of power (even as we may also experience oppression and disadvantage). Rather than stopping with reflection on personal feelings or biases, it interrogates "the *relationship* between seemingly unproblematic, everyday behavior and structured outcomes" (Kondrat, 1999, p. 468). Critical reflexivity understands the individual as always in relation to the social. Critically reflexive practitioners do not stop at asking how "cultural differences" may be affecting this patient/client. They may also ask how the person's experiences have been shaped by stigma, discrimination, and disadvantage. And they may also ask what part of the client/patient experiences may be a form of resistance to those forces. Nor does the critically reflexive practitioner stop at asking how *their own* cultural biases, values, and expectations affected the encounter. They may also question how their own privilege hindered them in seeing and hearing and how their client's privilege may have affected the therapist's ability to see/hear. They may also question how professional power and assumptions played out in the therapeutic encounter and even in the structuring of everyday clinical practices. But they will also ask whose sociocultural worldview is embedded in the core concepts and assumptions of their profession and their training (e.g., values of independence, development, individuation) (Furlong & Wight, 2011). Moreover, they will ask how their everyday interactions may have contributed to or undermined pre-existing social relations of power. Attending to the operation of privilege, and the relationship with disadvantage, is essential to critical reflexivity (Hollinsworth, 2013).

Where an emphasis on cultural difference highlights dissimilarities (usually positioning the Other as deviating from the unquestioned norm), critical reflexivity insists on critical relational analysis. It emphasizes not only understanding the ways client/patient lives may be shaped by racism, sexism, classism, ableism, heterosexism, colonialism, gender binarisms, and ethnocentrism but also how one's own life and practice are affected by those same forces, including sites of privilege. It asks us to examine not only where our privilege gets in the way of effective work but also how our privilege is maintained through the operation of the very disadvantages we seek to understand in therapeutic contexts. Some 25 years ago sociologist Sherry Gorelick (1991) wrote:

> Difference of condition does not mean absence of relationship. Black women's experiences are relevant not only to other Black women but to understanding the situation of white women, and indeed of Black and white men. It is only because Black women empty bedpans that white men can run hospitals. It is only because Native American

> women are poor that ruling class men and women are rich. It is only because Guatemalan peasant women are oppressed that North American businessmen have power. (pp. 472–473)

Critical reflexivity invites us to examine how these macro-level power relations are ever present in microlevel encounters. As Kondrat argues, "When reflective questions about bias and intolerance are confined to micro-examinations of personal understandings, affects and motivations" complex socially structured and structuring knowledges that shape the everyday go unexamined (Kondrat, 1999, p. 467). Critical reflexivity starts with the "assumption that no one and no institution escapes complicity in society and its structures" (1999, p. 468).

Knowledge and Assumptions in Cultural Humility and Critical Reflexivity

A final comment on the role of knowing in the approach to diversity that is being encouraged here. As critiques mount concerning the tendencies in cultural competence toward essentialism, culturalism, static notions of culture, and the potential for stereotyping, there is a growing counter-trend insisting on the need to treat every patient or client as an individual (Bassey & Melluish, 2013). It is obviously important to treat each person as an individual, as we can never know the ways in which another person's social and cultural identities affect their life. We always need to ask that person about their reality (Bassey & Melluish, 2013; Carpenter-Song et al., 2007; Owiti et al., 2014). There is a danger, though, of over-individualizing, reducing "diversity" to a kaleidoscope of individual differences that know no social structure or patterns (Baker & Beagan, 2014; Beagan, Fredericks, & Bryson, 2015; Beagan, Fredericks, & Goldberg, 2012; Beagan & Kumaş-Tan, 2009).

For example, in a critique of cultural competence and endorsement of cultural humility, Yeager and Bauer-Wu (2013) emphasize the potential to stereotype through the unquestioned application of cultural knowledge. In a chart contrasting cultural competence and cultural humility, they note that the view of culture shifts from a group attribute to uniquely individual, fluid, and changing (p. 252). Whereas the focus in cultural competence is on "Differences based on group identity and group boundaries," the focus in cultural humility is an "Individual focus of [sic] not only of the other but also of the self" (p. 252). This feeds into a desire in most health professions to see good patient-centered practice as sufficient to address the complexities of sociocultural diversity (Baker & Beagan, 2014; Beagan, Fredericks, & Bryson, 2015; Beagan, Fredericks, & Goldberg, 2012; Beagan & Kumaş-Tan, 2009; Harbin et al., 2012). This reflects a misunderstanding of the differences between stereotypes and generalizations.

Everyone is indeed an individual in relation to their culture, and their ethnicity always intersects in complex ways with race, class, ability, sexual and gender identity, age, citizenship status, religion, and other aspects of social location. But that does not mean there are not predictable social patterns that attach to social locations. While individual differences are valuable and prized, sociocultural differences are the stuff of hierarchy, of inequitable life chances, and of everyday experiences. As philosopher Donna Haraway has written, "Some differences are playful; some are poles of world historical systems of domination" (2004, p. 20). Distinguishing between these matters.

We are never just individuals; we are also always inherently social: "We are all (intentionally or unwittingly) vehicles for collective identities, carrying these identities into the arena of the health care system and playing out versions of larger political conflicts in the microcosm of the clinical encounter" (Kirmayer, 2013, p. 368). In social science, generalizations draw on the historical and current patterns in a given context; they draw on knowledge of the social world regarding patterned differences in the likelihood of securing the "good things in life," both material and nonmaterial. They recognize patterns in who has ready access to getting an education, getting a job, having a decent income, having a home, being viewed with respect, and being seen

as honest and trustworthy. Generalizations attend to existing social patterns and social realities and notice systematic tendencies. They acknowledge that, for example, racism shapes the lives of people in very different ways by race, that social class matters to everyday life, and that ableism affects the lives of people in patterned ways according to whether or not they are perceived to have impairments. While this form of generalized knowing may come from contact, including therapeutic encounters (Hook, 2014), it can also come from media; Wear et al. (2012) advocate for a particular kind of engaged reading that can both inform and help unearth complex emotions and knowledge.

Generalizations (knowledge about the "groupness" of individuals) sensitize us to ask good questions. They facilitate a stance of "informed not knowing" (Furlong & Wight, 2011, p. 39). With that knowledge of the general patterns discernible in the social world, we still always need to test the reality of those generalizations with each individual we encounter. As Hook et al. (2013) say, "Therapists should make hypotheses rather than jump to premature conclusions when working with clients from diverse backgrounds" (p. 354). If I assume all African-American individuals are religious, this is stereotyping. If I assume that most African-Americans have been harmed by racism, in differing ways, this may lead me to be sensitive to how racism may play out in my encounter with a patient. Even if this patient denies any experience of racism (perhaps inured through class or other privilege), assuming racism *may* be possible opens me to hearing its potential effects and watching for it in our encounter.

A common mantra in cultural competence literature is that skilled practitioners must avoid making assumptions. This intent is routinely expressed by health professionals (Baker & Beagan, 2014; Beagan & Kumaş-Tan, 2009). Yet it is not possible to make no assumptions; assumptions are central to the functioning of the social world. In Western contexts, we assume, for example, that strangers will treat us with a sort of removed politeness, rather than intense intimacy or overt hostility. We assume if we drive on the prescribed side of the road, so will others. Assumptions only become problematic when they are unquestioned and when they express the dominant, normative worldview without examination. In contrast, when we assume that our knowledge is limited, when we assume the person in front of us may well surprise us, and when we assume the person is not what they appear to be, we open up space for humble negotiation of differences.

Summary

Cultural humility and critical reflexivity are more likely to leave therapists feeling humble and uncertain than comfortable and confident; this is a good thing. Discomfort can be productive. Rather than having right answers – as measured in cultural competence – cultural humility and critical reflexivity emphasize asking good questions, questions sensitized through "informed not-knowing." In cultural humility, awareness and knowledge give way to critical analysis. Critical reflexivity insists that we reflect not only on the self and the Other but on the relations between those social locations and how we contribute to the social structuring of power through every day encounters.

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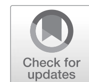

7 Psychological Reactions and Cultural Competence

Caroline Cummings and William O'Donohue

In the field of applied psychology, there have been a recent emphasis and even a requirement to employ what has become known as "culturally sensitive" or "culturally competent" practices in all professional services (e.g., Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016; Griner & Smith, 2006). This movement was built upon two different constructs that are central to these efforts, "cultural sensitivity" and "cultural competence." Cultural competence, although variously defined, has been characterized with a three-dimensional model (Chu, Leino, Pflum, & Sue, 2016), consisting of (1) a therapist's cultural awareness and beliefs; (2) knowledge of a client's cultural background, worldview, and therapy expectations; and (3) the development of cultural skills (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue, Zane, Nagayama Hall, & Berger, 2009). Cultural sensitivity, again diversely defined, has been characterized as the "awareness of how cultural variables may affect the treatment process" (Sperry, 2010, p. 316). A purported claim for the necessity of cultural sensitivity and cultural practice is that clients who experience culturally insensitive behavior report a variety of adverse psychological reactions (e.g., feelings of being insulted, disconnectedness, uncomfortableness, even trauma). These psychological reactions, in turn, are considered to either interfere with the professional services being delivered or result in needless and unwanted side effects (e.g., weak rapport or ability to relate/connect with the therapist; see Sue et al., 2009).

To address these potential concerns, the cultural competence movement has taken a number of steps in an attempt to prevent or remediate these potential problems, including mandating coursework in professional curricula, requiring test items for licensing in some states, and influencing the professional standards and ethical codes of various mental health organizations. It is interesting to note that some of these standards, but not all, also recognize negative psychological reactions may possibly be exhibited by minority clients, especially related to discussions of cultural differences. For example, the National Association of Social Workers' Standards and Indicators for Cultural Competence in Social Work Practice (2015) suggests that cultural competence entails the development of "skill and confidence to engage in and facilitate difficult conversations about cultural differences" (p. 49). The usage of the word "difficult" suggests that there is a reasonable likelihood that a client might feel some level of discomfort or some other negative psychological reaction, perhaps even with a culturally competent provider, as there may be no avoiding some level of "difficulty" in these complex conversations. While this standard appears

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to imply that the culturally competent provider should attempt to minimize the client's level of discomfort, this standard still appears to recognize the possible shortcomings of such efforts.

This chapter will examine some of the assumptions and assertions of the cultural competence movement in relation to clients' reported experience of negative psychological reactions and explain the problems with these, including the issues with reliability and validity of self-reports, lack of clarity of concepts related to key psychological reactions such as "uncomfortableness," lack of discernment between levels of adverse experiences/impairment, whether the effects of the listener are always relevant, utilization of cultural competence to combat egregious behaviors/values, pseudo−/problematic attempts at relating to culturally diverse clients, whether cultural competence results in positive psychological reactions, and the lack of empirical support for the causal pathways that are assumed.

Case Example #1

To illustrate what cultural competence experts would view as being culturally incompetent behaviors, let's consider a case example: Anderson, an African American male, arrives to therapy 15 min late. He states that he was late because he was being profiled by cops and was pulled over for speeding, though he was not going faster than the drivers around him. He spends 10 min of the therapy session stating that he was only pulled over because of his race and was unrightfully stopped. He continues, stating that African Americans are often mistreated by the police and it is hard being an African American with so many racists in the USA. Anderson's therapist, a white female, tells Anderson he should not assume it was because he was African American and that white people get mistreated by police officers too, so it is not a racial matter. Anderson becomes upset and states that his therapist does not understand him and should not compare the African American experience in the USA to that of whites. He leaves the session early and is visibly upset as he walks out yelling that he does not trust white therapists because they don't understand African Americans.

In this example, a cultural competence expert would likely view the therapist's actions as being culturally incompetent. It would be argued that a culturally competent therapist would have acknowledged the oppression and prejudice African Americans have historically experienced. The therapist would not have challenged the client's assertion that he was unrightfully pulled over or that African Americans get mistreated by police officers. It would be concluded that this therapist's behavior caused such understandable negative psychological reactions (i.e., upset, distrust, being misunderstood) in the client, which is inappropriate and avoidable on the part of the therapist. However, it could be that the therapist was trying to assess the client's core beliefs and help the client better understand whether him being pulled over was warranted or if his perceptions of being profiled were in fact true. Suppose the client is constantly in a state of anxiety and assuming he will be targeted by any white person he encounters, and this is a recurring theme in therapy. This cognitive schema could be exaggerated and not serving the client well. His exaggerated beliefs could be a target in therapy and reasonably rebutted by the therapist who perhaps comes from a rational emotive therapy orientation. However, such challenging of beliefs is prohibited in therapy by those in the cultural sensitivity movement when these beliefs are related to cultural factors, such as race. It is posited that by challenging the idea that minorities are oppressed in ways that they describe, a therapist will automatically cause a strong negative psychological reaction in the client and harm the therapeutic relationship. However, challenging inaccurate core beliefs is a common part of many forms of therapy, such as cognitive behavioral therapy, so should cultural competence standards forbid such practice?

It is important to note that there is no research that provides direct information about the kinds of psychological reactions, the frequency of these, how these may vary by minority status or other personal variables, or exactly what occasions minority clients might experience these reactions with behavioral health professionals

who are not "culturally competent." Further, there is no research to show the degree to which cultural competence training eliminates or reduces the likelihood or intensity of these adverse psychological reactions. The question also remains as to what does cultural sensitivity look like? At no point are professionals ever told what specific behaviors they need to exhibit to prevent these negative psychological reactions in their clients. Without this research to form a factual basis for these efforts, the cultural competence movement is built based on the various stereotypes of diverse groups and their reactions and assumes that, without such training (however unclearly defined, see Benuto, Casas, & O'Donohue, 2018), a professional will harm clients, particularly minority clients, either by not being as effective as possible or by unnecessarily causing negative psychological reactions in these clients. Also, interestingly, the culturally sensitive movement seems to be relatively sanguine about causing negative psychological reactions in majority clients or professionals, as there is very little effort in this movement related to avoiding similar adverse reactions when these individuals hear claims associated with the majority culture's alleged sexism, homophobia, racism, or other problematic behaviors (see O'Donohue, this volume). The question also remains as to when, if ever, the effects or psychological reactions on the listeners (i.e., client) are relevant in the clinical context. The next section will address this issue.

Are the Effects on Listeners Relevant?

Applied psychology is supposed to be a scientific discipline (McFall, 1991). Science evaluates propositions not by their effects on listeners but by other properties pertaining to the claim itself—is the claim falsifiable, is it clearly stated, has the claim been tested, what is the quality of these tests, what is the cumulative quality of the evidence in support of these, are there data that falsify the claim, and so on. Never are these propositions in a scientific worldview evaluated by the effect these have on the listener. To do so would be a radical shift from normal rational appraisal of claims. For example, whether the earth rotates around the sun (heliocentric view of the universe) or the sun rotates around the earth (geocentric) is evaluated by astronomic evidence—not whether it can make certain people feel less important.

As such, in a scientific orientation, the effect of a claim on the listener is neither a necessary or sufficient property of a problematic evaluation of an utterance. Saying someone is offended by x doesn't entail that the utterance is false, unwarranted, or otherwise problematic epistemically. Thus a listener's adverse psychological reaction is not sufficient, nor is it necessary property, that the claim is problematic. The statement "all humans are completely wonderful" may not offend anyone, and in fact it may make many feel good, but the claim is still false—thus offense or a positive reaction is not a necessary property of a problematic proposition.

As O'Donohue (this volume) pointed out, it may be the case that the sort of claims of most interest to the cultural competence movement are not empirical claims but ethical/normative ones. This is important to note because ethical/normative claims are evaluated differently than empirical claims. "It is your duty not to lie" is evaluated differently than "centipedes live an average of 2 years." The latter requires systematic empirical evaluations to evaluate its truth—the former does not. However, again, ethical claims are not evaluated by their effects on individuals. One may feel bad when one hears it is your duty not to lie, but if this is in fact a duty, these adverse psychological reactions are not evidence for the falseness of the duty.

Further, the major domain in which the effects on others are taken into consideration—and given the weight that cultural competence gives to it—is the domain of manners and etiquette. One often claims, for example, not saying "goodbye" upon leaving a social situation is problematic as it can make people feel bad. Not waiting until all are served before eating can make others at the table feel uncomfortable. Does cultural competence then become essentially a domain of professional manners? More evidence of this is also the claim that others will not only be offended by bad manners, but they will typically think ill of the "bad

mannered"—something that is also occurring in this domain. If one is culturally insensitive, one will "offend" others, and others usually will think of one as sexist, racist, homophobic, etc. However, this is not likely the case, though cultural competence implies this is so.

Cultural Competence to Combat Egregious Behaviors/Values

One way of justifying the goals of the cultural competence movement is by stating that it is intended to promote a professional environment that does not tolerate usage of racial epithets, stereotypes, hate speech, speech suggesting violence toward minority, actual discriminatory practices, and other egregious behaviors. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2002) states that:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. and accept differences between their own values and those of their clients. (p. 4)

However, there is a general consensus that this prejudicial behavior is wrong in any context, not just the professional setting. This is a moral duty of all individuals, including behavioral health professionals, and it is important to note that this is independent of whether the listener experiences a negative psychological reaction. Therefore, cultural competence standards are not necessarily needed to combat such egregious behaviors, as it is implied in all contexts that such behavior is not appropriate—there has been no research indicating a significant likelihood that an entering first-year student in a psychology doctoral program, let alone experienced therapists, would believe, for example, that using racial slurs in therapy is appropriate.

While blatant prejudices are clearly counterproductive to the therapeutic process, current cultural competence standards leave room to assert that other behaviors may cause a significant impact. For example, if a Mexican-American client is hesitant to continue with treatment because his/her culture does not support receiving mental health treatment, a clinician could try to educate the client about the positive outcomes of therapy and help the client make an informed decision. While this is intended to benefit/educate the client and to motivate them to engage in treatment to improve their life, it may be misconstrued as culturally insensitive to suggest a client disregard their cultural values. The client might feel invalidated or conflicted by the therapist's behavior or even that the therapist's behavior was culturally insensitive. The therapist could be accused of invalidating the client's values and culture when they are instead trying to provide an avenue of reducing distress in the client and assisting them with making the choice of whether it is beneficial to engage in therapy. This example also begs two questions: (1) who decides what is or is not a "cultural" variable or issue, and (2) even if this dispute of what constitutes as being a "culture," where is it validly argued that so-called "cultural" issues are sovereign? A gang member in therapy may claim that it is "cultural" to take revenge on another gang member by killing him. Should the therapist therefore accept this belief simply because it stems from a so-called cultural practice? Additionally, motivational interviewing, which is an empirically supported practice in behavioral health (Vader, Walters, Prabhu, Huock, & Field, 2010), is sometimes intended to make people uncomfortable or experience distress (cognitive dissonance) through having them recognize differences in their behavior and their goals (Miller, 2010). Doing so helps motivate clients to make changes in their behaviors, as a means to achieve their stated goals. However, by creating even a minimal level of distress or discomfort in the client, it also provides the opportunity for a client or another to claim that unwarranted culturally insensitive behavior occurred that created the negative psychological reaction.

Types of Negative Psychological Reactions

One commonly feared reaction to "culturally incompetent" practices is claims about the feeling of "uncomfortableness"—though it is unclear what exactly this encompasses. Utterances are of the ilk: "That made me feel uncomfortable." "I am not sure that I am completely comfortable with you saying that." Another commonly used term to explain one's negative psychological reaction although perhaps on the other end of the spectrum of seriousness is "trauma" or being traumatized. Again, statements could be along the lines of "When you did X, I felt traumatized"; or "Your failure to do Y made me feel traumatized"; or "When you mentioned Y, that was a trigger that caused me to reexperience my traumatization." This is somewhat related to the recent focus on "trigger warnings" as both prudent and necessary. According to the American Psychological Association (2008), trauma encompasses strong psychological sequelae (e.g., horror, terror, or helplessness) in a response to rape, natural disasters, or other catastrophic events that may cause injury or death in oneself or others. Other constructs used to label clients' negative psychological reactions include reported feelings of invalidation, dismissiveness, or being misunderstood. However, despite these potential negative psychological reactions, there are many issues with using these constructs as labels for such responses, primarily, that a negative psychological reaction, such as uncomfortableness or invalidation, is likely brief and far from being considered clinically significant.

First, there is a lack of operationalization of these adverse psychological reactions in the cultural sensitivity context, and, consequently, the terms can be commonly misused or used with significant variance. Relatedly of course these cannot be precisely measured as clarity in definition is a prerequisite for valid measurement. Is uncomfortableness a physiological response—or at least does this have a somatic component? Is it purely an emotional reaction? Is it unidimensional or multidimensional? Are there different kinds and levels of uncomfortableness? What magnitude of uncomfortableness is of concern—any? Can such uncomfortableness be multiply determined (e.g., caused by the therapist's comment but also caused by other factors such as the clients' own negative stereotypes about others)? Instead of parsing through these issues, cultural competence advocates instead use ill-defined labels such as "uncomfortable" to advance the position that a wrong was done and such ought to be prevented or perhaps the speaker ought to be punished.

Further, given that trauma encompasses intense psychological responses, such as horror, nightmares, and hypervigilance, even if the therapist said something related to culture that caused some sort of negative psychological reaction in the client, it seems unlikely a psychological reaction would reach the magnitude of being considered a traumatic event. To illustrate the difference in severity that would need to be demonstrated, we will refer to the canonical definition of reactions to trauma contained in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* diagnostic criteria for posttraumatic stress disorder (PTSD), which is defined as "the development of characteristic symptoms following exposure to one or more traumatic events" (American Psychiatric Association, 2013, p. 274), including:

A. Exposure to actual or threatened death, serious injury, or sexual violence directly experiencing the traumatic event(s), witnessing, in person, the event(s) as it occurred to others, learning that the traumatic event(s) occurred to a close family member or close friend, and/or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)
B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: (1) *recurrent, involuntary, and intrusive distressing memories* of the traumatic event(s); (2) *recurrent distressing dreams* in which the content and/or affect of the dream are related to the traumatic event(s); (3) dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the

traumatic event(s) were recurring; (4) *Intense or prolonged psychological distress* at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) and/or; (5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: (1) avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s) and/or; (2) avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: (1) inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs); (2) *Persistent and exaggerated negative beliefs or expectations* about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined"); (3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others; (4) *Persistent negative emotional state* (e.g., fear, horror, anger, guilt, or shame); (5) Markedly diminished interest or participation in significant activities; (6) Feelings of detachment or estrangement from others and/or; (7) *Persistent inability to experience positive emotions* (e.g., inability to experience happiness, satisfaction, or loving feelings).
E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: (1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects; (2) Reckless or self-destructive behavior; (3) Hypervigilance; (4) Exaggerated startle response; (5) Problems with concentration and/or; (6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. (American Psychiatric Association, 2013, pp. 271–274)

First, and most importantly, is that criterion A is simply not met by comments and behavior of therapists typically targeted in cultural sensitivity training; perhaps such behavior is insensitive or unfortunate, but it does not constitute a trauma. That is, culturally insensitive comments or behavior simply doesn't meet the definitional criteria of trauma. Next, given the strong wording of the diagnostic criteria (e.g., "persistent," "recurrent," "intense"), it is unlikely that one could validly claim culturally incompetent behavior solely caused the experience of diagnostically necessary negative psychological reactions (diagnostic criteria B–E), to the point of meeting all the diagnostic criteria of PTSD.

Acute stress disorder, which is a similar diagnosis to PTSD, is a psychological response to a traumatic event and lasts 3 days to 1 month (American Psychiatric Association, 2013). However, again, it encompasses the same strong, enduring psychological responses (e.g., persistent negative mood/lack of positive emotions, recurrent, distressing memories) and must cause significant impairment in functioning. These strong responses and impairment are not propor-

tioned to the nature of the cultural incompetent behavior; thus a report of being traumatized due to cultural incompetence is an improper use of this construct.

Also, when a client states that a comment or a behavior of a professional "triggered" them, what does actually this mean? Exactly what psychological reactions resulted, and how does one evaluate the causal claim implicit in this assertion—i.e., that it was solely the behavior that caused the reaction? For example, it is a tenet of rational emotive behavior therapy (REBT) and other evidence-based cognitive behavioral approaches that events do not trigger emotions by themselves but that beliefs always mediate between environmental events and psychological reactions (it is not S- → R but rather S = →B-- → R). In this cognitive behavioral therapy (CBT) model, what sort of beliefs and contributions of the client's psychological makeup or diatheses contributed to the alleged triggered reaction? Additionally, is the argument that a professional must comport oneself so that no level of uncomfortableness is ever evoked in any of their clients? Or is a certain level of discomfort acceptable—even around "cultural" issues?

With these allegations of experiencing adverse psychological reactions, it is also difficult to demonstrate causality, as there may be other variables contributing to the person's uncomfortableness or other negative psychological reactions. If someone with generalized anxiety disorder or social anxiety is in session, it is likely that their symptoms of anxiety (e.g., sweating, fear of saying something wrong) will be causing uncomfortableness, so the likelihood of a therapist saying something that makes the client feel uncomfortable is substantially increased. It could instead be that the person feels discomfort because of their disorder and not due to the alleged culturally insensitive behavior of the therapist. Additionally, if a client is having a substantially stressful day or in the middle of a crisis, it is difficult to distinguish between what is a result of the accumulation of stressors and what is a result of the clinician's actions. Also, suppose an African American therapist is working with a client who has biases against African Americans. It seems likely that the client would be seeking opportunities to see the therapist in a negative light (i.e., confirmation bias), when in actuality the client is being hypersensitive.

An additional problem with assuming causality is that, to our knowledge, there has been no research conducted that explicitly addresses the type and frequency of culturally "incompetent" behavior that produces negative psychological reactions, such as uncomfortableness or trauma in an individual. Does being told once that some of one's values are maladaptive cause the average minority member to feel uncomfortable? Do only egregious behaviors, such as hate speech or racial slurs, create negative psychological reactions? Or can more covert, latent forms (e.g., "benevolent racism") cause such distress? This also raises the question as to whether cultural competence is dependent upon the disorder the person has (see Frisby chapter in this volume on individual differences, this text). Would working with a client with a personality disorder cause different negative psychological reactions than a client with obsessive-compulsive disorder? Would people with these kinds of disorders have different (perhaps lower) thresholds? Given that individuals with personality disorders are more likely to make invalid or fabricated claims (see below), is it difficult to determine what kind of behavior a clinician could exhibit to avoid being deemed incompetent? Besides disorders, are there differences found between clients from different ethnicities or ages? There are too many unanswered questions and dimensions to understand or predict causality.

The Complexities of Self-Reports of Internal States

An internal state may also be called a private event. Skinner (1984) defined private events as those stimuli and events uniquely perceived by an individual, in that these can only originate and be experienced within one's own skin—no one beyond the individual can directly experience these private events, though the individual can attempt to describe or explain these to another.

When people report that culturally insensitive behavior makes them experience some sort of negative psychological reaction or internal state (e.g., angry, uncomfortable, anxious), there may be problems regarding the reliability and validity of their self-report since, by definition, these can only be directly experienced by the person reporting it. Therefore, one is unable to independently observe these events to determine whether those self-reports are in fact accurate and true.

There is some relevant research that illustrates these complexities. Between 9% and 18% of people are unable to "tact" or label the emotions they experience (Franz et al., 2008; Kokkonen et al., 2001; Parker, Taylor, & Bagby, 1989; Salminen, Saarijarvi, Aarela, Toikka, & Kauhanen, 1999). Alexithymia is defined as "individuals who presented to therapy with an inability to experience or at least describe emotions" (Darrow & Follette, 2014, p. 1) and commonly occurs when someone has a limited verbal repertoire, as a result of a history of a lack of shaping of behavior by their verbal community. Therefore, someone with alexithymia would have difficulty correctly labeling their emotions they are experiencing, which casts doubt on whether we can rely on all people's self-reports of their negative psychological reactions—even more if that emotion does not match their affect or behavior. Further, in social science research, there has been a problem with relying on self-reports, due to possible biases in responses, including acquiescence bias (tendency to agree with all questions, disregarding the content of the question), extreme response style (tendency to select responses on end points of a scale, e.g., strongly agree, 1 on a scale of 1–10), and social desirability bias, which are all posited to have a relation to the culture one belongs to (Johnson, Kulesa, Cho, & Shavitt, 2005).

Johnson and colleagues (2005) also found that individuals from cultures that emphasized masculinity and individualism had an inverse relationship with acquiescent response behavior. This raises an interesting conundrum: ought reports of adverse psychological reactions be seen as universal and a-cultural, or are these relative to culture themselves? Therefore, those from societies with low masculinity were more likely to agree with all questions even when they were in doubt about the answer. In the clinical setting, a person who responds acquiescently would endorse emotions and the severity of such emotions at higher rates than likely appropriate. For example, if a client with a minority background said they felt uncomfortable and the therapist asked them various examples of what "uncomfortableness" is sometimes described as (e.g., feeling distressed, sweating), the client would agree. Further, if they were asked if the level of impairment was severe, they could immediately respond yes without exploring the accuracy of whether they felt severely impaired or not. It is comparable to being pressured by peers, in that they are not making insightful decisions and rather agreeing with whomever they are interacting with. Somewhat similarly, someone who responds following a social desirability style would agree with what the listener says and make decisions independently of how they are feeling. Instead, they would adapt their responses to assimilate what they believe the other would want. Therefore, the accuracy of the self-report would be invalid, and the results would be entirely predicted by the question asked, instead of reflecting the actual psychological reaction of the client. Given that the cultural competence movement asserts that clients ought to feel even slightly uncomfortable or tense when discussing topics relevant to culture, it is possible that clients may inaccurately express/label these psychological reactions. Biases as such reflect the limitations in relying solely on one's personal account of their negative psychological reactions and, in this context, its relation to treatment and culturally competent practices.

As the cultural competency movement has expanded and more professionals are expected to implement practices to avoid being deemed "incompetent," there has consequently been an increase in a client's potential to either exaggerate or completely falsify claims of being distressed by a professionals' competency, perhaps even for the client's own gain. By making allegations of a professional's cultural incompetence or insensitivity, the accuser may be reinforced or benefitted (e.g., being granted

monetary damages, having their grade in class changed, seeking revenge for being rejected). Essentially, the movement has increased professionals' liability when it has not yet been demonstrated that (1) these behaviors make clients experience negative psychological reactions; (2) a professional should have known ahead of time that their behavior would have such an effect; (3) making a client experience negative emotions such as "uncomfortable" or "invalidated" reaches some threshold where it is actionable and; (4) instead it may entice clients, especially certain clients suffering from certain problems (see below), to make false claims for their own personal benefit.

For example, suppose a therapist refers to an African American client, as a "colored person," the client could (justifiably) become upset and report feeling distressed by being called a historically oppressive term (although the situation is a bit complex given the acceptance of the name of the NAACP). The therapist could then be sanctioned for culturally incompetent behavior that adversely affected the client's psychological well-being. In this case, while calling someone a "colored person" is not politically correct given the historical usage of the term, it is unlikely the client would be significantly harmed.

This issue is further exacerbated with providing services to individuals with personality disorders. There are various symptoms of personality disorders that would make the accuracy of such self-reports of negative psychological reactions questionable. For example, individuals with antisocial personality disorder repeatedly lie and/or con others for their own personal profit or pleasure (American Psychiatric Association, 2013). Additionally, individuals with histrionic personality disorder expect others to approach them with excessive admiration and feel entitled to be treated on how they expect (American Psychiatric Association, 2013). Therefore, individuals presenting with this disorder may feel displeased if a therapist does not treat them with the level of respect and kindness they desire and may exploit the therapist for their own gain. Therefore, individuals with either diagnosis could be more likely to make false allegations of negative psychological reactions experienced because of the nature of their personality disorder.

Additionally, various other personality disorders consist of emotional lability, which may increase the likelihood of a client reporting an experience of negative psychological reactions at some point in treatment. For example, individuals with borderline personality disorder demonstrate "affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)" and "inappropriate, intense anger or difficulty controlling anger" (American Psychiatric Association, 2013, p. 663). Individuals with histrionic personality disorder also demonstrate emotional lability and show "self-dramatization, theatricality, and exaggerated expression of emotion" (American Psychological Association, 2013, p. 667). Individuals with either disorders experience negative emotions at higher rates than the general population; thus if they experience anger, discomfort, or some other negative emotions in therapy, it is likely not solely caused by the therapist but instead the nature of how the disorder manifests.

Lastly, paranoid and avoidant personality disorders include symptoms of feeling persecuted without sufficient evidence (American Psychiatric Association, 2013) and feelings of being criticized during social interactions (American Psychiatric Association, 2013); thus the highly sensitive manifestation of such paranoia (i.e., lower standard required to cause negative psychological reactions) may contribute to inaccurate or unwarranted allegations of incompetence. It is for these reasons that clients with borderline personality disorder, narcissistic personality disorder, and other personality disorders file higher rates of malpractice lawsuits because these populations are more likely to find faults in their therapists—either because of their own beliefs of persecution or victimization by all or because of their generally poor interpersonal skills (Hoffman & Steiner-Grossman, 2012). Despite these potential obstacles one may face while providing services for an individual with a personality disorder or overly sen-

sitive individuals, this fear should not guide professional practice, nor do they warrant developing additional professional standards and required trainings.

In cases as such, where it has to be determined whether a therapist demonstrated culturally competent practices or not, the client's accuracy and truthfulness about their report of adverse psychological reactions are a key factor. The only sources of information within these disputes are often the client's own reports of their negative psychological reactions and perception of the events versus the clinician's observations/inferences of the client and the events. This reliance on self-report of clients is problematic, as there is no current formal assessment of negative psychological reactions that is free of possible biases (e.g., social desirability, halo effect; Mazaheri, 2014). Some individuals may either intentionally falsify these claims or possibly even believe the therapist is cultural incompetent, when this may not always be the case. Given the various factors to consider, the validity and reliability of the causal effect assumed to exist between culturally incompetent practices and negative psychological reactions remain unknown.

Another issue that needs to be explored is whether allegations of cultural incompetence may cause reciprocal negative psychological reactions for the accused behavioral health professional. For example, if clinician is African American and is treating a LGBTQ client who says "You made me feel uncomfortable. All of you blacks are homophobic," such an accusation may cause a negative psychological reaction in the clinician. What if this therapist is a practicing Catholic and, after much deliberation, views that the Church's teachings are that homosexual behavior is sinful? Is this homophobic and does the clinician deserve this label? What if the clinician respected the views of others and did nothing to force his or her views on the client? The negative psychological reaction of the clinician is usually completely disregarded in these analyses, and instead the clinician is expected to ignore any negative comments about cultural insensitivity aimed at them, even if these might be prejudicial in nature. Cultural competence training usually does not address this potential prejudice exhibited by the client.

This problem is also found when the clinician and client are affiliated with the same cultural groups. For example, if an African American client becomes upset with their African American therapist and states that the therapist is "not black enough" and "does not understand the struggle of being black" because they are now in upper-middle-class socioeconomic strata, this may cause an even larger reciprocal negative psychological reaction in the therapist. However, scenarios as such are overlooked in current cultural competence trainings, and there is a sort of an inherent invalidation of a therapist's psychological reactions (with the exception of psychodynamic therapies, where transference and countertransference are acknowledged and tackled). Therefore, if cultural competence training is deemed to be necessary, there needs to be an aspect that acknowledges that reciprocal negative psychological reactions may occur within the therapeutic setting.

This sort of asymmetry is also found when a majority culture clinician is working with a minority culture client (or vice versa). Only the negative psychological reactions of the minority culture member are considered of concern—not that of the majority culture member. It is even more problematic when the clinician and client are from separate minority groups. Race and sexual orientation are typically prioritized over other minority groups (e.g., based on religion, physical disability). Therefore, we would also see an asymmetry in the consideration of negative psychological reactions racial or sexual minorities experience, in comparison to that of religious minorities, for example.

Level of Impairment

In assessing the negative psychological reactions that are presumed to be caused by culturally incompetent clinicians, an important step to consider is whether these psychological reactions are causing any actual impairment and, if so, how and to what extent. Similar to diagnosing mental

disorders, it might be suggested that there are three different levels of impairment. To distinguish between the three, it is important to consider the frequency and duration of the psychological reactions or symptoms, as with the diagnosis of psychological disorders (see American Psychiatric Association, 2013 for further detail about differentiation between levels of impairment).

First, there are acceptable levels of adverse psychological reactions such as stress, distress, disappointment, and interpersonal strife that occur in day-to-day life and the normal interactions with others, all of which in the usual case do not cause any sort of abnormal amount of impairment. For example, a teen may become nervous when a clinician asks them about their romantic relationships. While the teen may feel awkward or nervous for the moment, these negative psychological reactions disappear when the discussion moves onto a different topic or the teen habituates to the discussion of romantic relationships. Another example would be the improper usage of pronouns to address an individual. Since the expansion of possible gender pronouns an individual may identify with, a therapist may incorrectly address an individual as "she" when the individual prefers being referred to as "they." In the context of race, an example would be improperly addressing someone as Mexican when they instead identify as El Salvadorian. While all of these examples may cause minor discomfort within an individual who is improperly addressed, it does not reach the magnitude assumed to be caused by culturally incompetent behaviors, and these are very easily addressed by having the client educate the therapist of what they identify as—no formal training is necessary. This sort of behavior is not warranted to be considered culturally incompetent, but very rarely is this level of impairment considered.

Next, there is subclinical impairment of functioning. In this level, some impairment in functioning is present but not sufficient to be considered a disorder or "clinically significant." In this sense, the source of stress or some other negative stimuli causes some negative effect on one's life, but these negative effects are not present in many contexts of the person's life (e.g., at home but not at work or school), do not last long, generally are of lower magnitude, or do not occur often. Benevolent sexism, defined as patronizing a woman in a way that appears to be flattering but simultaneously promotes male dominance (Becker & Wright, 2011), would likely fall under this category. For example, if during an assessment a female client states that she works at a law firm and the clinician states "oh secretaries are an important part of any organization," this would be a form of benevolent sexism because the clinician assumes that the client's profession is a secretary because she is a woman. This, along with microaggressions (i.e., subtle racial slights or insults; Torres, Driscoll, & Burrow, 2010), may make the client feel offended and become momentarily upset. They may hold onto that anger for longer than the session (maybe even for a day or two); however, it is unlikely that they would be able to identify any sort of significant impairment in their functioning at home, school, or work life. This would generally be considered subclinical because, while they exhibit some symptoms and negative psychological reactions, the client's life is not being significantly impacted to the point that intensive intervention is required to improve. The negative psychological reactions will likely remit on their own without individual therapy—the same principle of the mind being able to naturally recover, void of intervention, applies as it does in other psychological symptoms (e.g., PTSD, social anxiety; Kolassa et al., 2010; Vriends, Bolt, & Kuns, 2014).

Lastly, there may be significant impairment of functioning that is considered in the disordered or clinical range. This would be when the "disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013, p. 21). In this regard, the negative psychological reactions would be longer-lasting, be apparent in various contexts, and occur more often than not. Given the extent of impairment, treatment would be necessary to extinguish such symptoms. More blatant forms of prejudice (e.g., hate speech, racial slurs) may cause impairment to this extent,

especially if the therapist is constantly bullying the individual. However, more acute and minor forms likely would not reach this level, and it seems unlikely that a client would continue attending treatment if the behavior was so overt and hurtful. In addition, it seems unlikely that such a person (one who bullies individuals and uses hate speech in therapy) would be able to graduate from a program and gain a license, as there are no known cases of this. The cultural sensitivity movement can't be validly predicated on the assertion (or strawman fallacy) that this type of behavior frequently occurs and needs to be remediated.

Despite these distinctions between levels of impairment, when one makes a claim about a professional exhibiting culturally incompetent practices, it is generally assumed that the negative psychological reactions are significantly impairing them and thus deserve the attention that these generally receive. However, that may not necessarily be the case—it is almost unlikely it could. This is an important distinction to make. Is it justifiable to have a professional be reprimanded for breaching the ethical standard of being culturally competent when the client has a brief moment of "uncomfortableness" within the session? Given that there are often standard topics that come up during treatment, especially during assessment, which commonly make people feel uncomfortable yet are not reported, why are only topics related to culture considered inappropriate and capable of significantly impairing an individual? Are such feelings idiosyncratic—some individuals react strongly to x (e.g., "being called a girl"), while others not at all. How is a therapist to predict this? Is very bland behavior always recommended?

Pseudo/Problematic Attempts at Relating to Culturally Diverse Clients

From the cultural competency perspective, when a clinician attempts to relate to diverse clients by perpetuating stereotypes of the client's culture, the client may experience negative psychological reactions. This is purported to occur when a therapist treats a client as a token of the cultural group they belong to, instead of as the individual that they are. Could this in fact cause negative psychological reactions in the client similar to overt prejudices? For example, if a therapist says "I like burritos" to a Hispanic American or "Barrack Obama was my favorite president" to an African American, does this have the ability to engender feelings of "uncomfortableness" or "trauma" or "being triggered" in the client? Exhibiting these behaviors may reinforce one's distrust or disdain for majority culture, but it is unlikely the reactions could result in psychological reactions or disorders or any sort of significant distress. Further, is this truly considered culturally incompetent behavior? Nowhere in current professional standards are these attempts directly prohibited, and this may be beneficial to building rapport with an individual. With child clients, professionals try to not sound like an authoritative figure and instead try to seem "cool" and relatable, so why is it any different to make such attempts with clients belonging to other forms of culture, such as ethnicity or religion? Further, are children or individuals with low cognitive ability likely to understand and be aware of when they should be offended or uncomfortable?

In addition, there has been little concern to identify or address possible negative effects induced by cultural competence training itself. Does such training itself produce adverse psychological reactions? Does it rely on stereotypes such as Hispanic males are macho that can produce adverse psychological reactions? Does it avoid critical problems such as prejudice and oppression and instead deal with proxy and more minor issues which can produce negative psychological reactions? Does it produce psychological reactions in certain groups like Catholics, Jews, and Muslims because of their religious beliefs? Does it create a sense of fundamental incompetence in dealing with the vast arrays of minority groups and their intersectionality? Does it produce a false sense of competence

that will inevitably lead to future adverse psychological reactions because it fails to do what it attempts to do—produce cultural competent behavior?

Cultural Competence and Positive Psychological Reactions

Given the promised benefits of the cultural competence movement, it is important to assess whether cultural competence results in positive psychological reactions. To our knowledge, no data exists that directly addresses the relationship between positive psychological reactions and cultural competence. Instead, research focuses on patient satisfaction and/or patient adherence to health care/treatment (e.g., Beach et al., 2005; Way, Stone, Schwager, Wagoner, & Bassman, 2002). While the data demonstrates overall moderate effect sizes, it does not provide any insight into the psychological reactions of the patients, and there may be confounding variables (e.g., less life stressors, recent job promotion, good rapport building). Therefore, the reported satisfaction does not necessarily mean the patients have positive psychological reactions solely as a result of culturally competent practices.

Additionally, it is unclear what dosage of culturally competent practices is necessary to yield positive psychological reactions, as well as what demographic variables serve as predictors—do culturally competent practices yield positive psychological reactions for Jewish individuals? Physically disabled individuals? Does it differ depending on how many distinct minority cultures one belongs to? It seems unlikely one would be able to parse through these various steps to decide upon how to be culturally competent enough to only create positive reactions, which could explain the lack of research directly addressing this. It is also possible that attempting to only cause positive reactions in a client could detract from the therapeutic process, as a clinician would be hypersensitive, out of fear of making a client uncomfortable, triggered, or traumatized.

Conclusions

The cultural competence movement has aimed at improving treatment for diverse individuals by equipping professionals with more culturally sensitive/appropriate tools to reduce commonly reported negative psychological reactions in clients. However, despite these attempts, there are various limitations that need to be acknowledged. The commonly reported negative psychological reactions are not well-defined, the primary data used in these allegations are self-reports which may be biased and invalid, the level of impairment often is not assessed, and there are no empirical data to support whether these culturally competent trainings even reduce negative psychological reactions or rule out iatrogenic effects. In addition, it is not clear that the psychological reactions of a person are even relevant in evaluating a claim in a scientific epistemology.

Further, can cultural competence even ensure this happens? It is unlikely one could be trained in how to be competent at working with all diverse individuals, as there are many subgroups of cultures (e.g., upper class vs. lower class, urban vs. rural, Mexican-American vs Cuban-American). Cultural identity is too complex and heterogeneous (Leung & Cohen, 2011). Psychological reactions vary between individuals from the same culture, and even popular opinions of cultural groups regularly fluctuate (e.g., during a time of political turmoil, individuals affected may be more sensitive). There is also no research that demonstrates what specific things related to culture will upset individuals or make an individual experience positive emotions. These shortcomings make cultural competence training unimportant, as it does not capture the perspectives of diverse individuals as well as it claims to.

Despite that these questions and limitations remain unresolved, a plethora of organizations continue to adapt their ethical standards and principles to include cultural competence considerations (e.g., the American Psychological Association, National Association of Social Workers). They continue to state all the detrimental effects that may result from culturally incompetent behavior, and while there may be some

level of discomfort or anger within a session, it does not warrant such a comprehensive, new approach toward treatment. Thus far, instead of serving as a scientific or "best practices" movement, it has instead become a sociopolitical advocacy movement.

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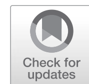

8 Problems in Professional and Ethical Standards and Guidelines Regarding Culturally Competent Practice with Racial, Ethnic, Linguistic, and Culturally Diverse Groups

Caroline Cummings and William O'Donohue

Historically, disadvantaged racial and ethnic groups (Institute of Medicine, 2002) and sexual minorities (Avery, Hellman, & Sudderth, 2001) have been problematically served by mental health interventions. This problem is even more complex because an additional aspect is that there are often more barriers for members of minority groups for accessing behavioral health services (Benuto & O'Donohue, 2016). To adapt mental health services to better serve individuals from minority groups, there has been a movement to incorporate cultural considerations into professional guidelines and ethical standards in a variety of disciplines within the fields of behavioral health (e.g., Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016; Griner & Smith, 2006). This effort often is encoded in a variety of documents that can range from suggestions or requirements for professionals to complete continuing education credits, to self-evaluation on various constructs related to cultural competency, to requiring or suggesting increased (or some) contact with (some) minority members—all presumptively, in order to be eventually result in some professional to be considered "competent" in providing mental health services tor some proper or improper subset of minority culture individuals.

These suggested processes to attain increased cultural competency, and some description of what this competency might consist of/look like is embodied in a variety of documents including guidelines, ethical codes, and other professional standards. However, despite these efforts over a number of years, the wide variety of standards and guidelines developed related to these activities are, interestingly, themselves diverse. These often have different foci, make different assertions, vary on what is required or suggested, and even vary both on what constitutes a minority group, as well as on how obligatory such culture competence is.

These documents can be evaluated on a number of dimensions: these are human products and as such can have both strengths but also limitations and flaws. These evaluative dimensions can include unclear function and scope, conflict with other important values (e.g., sensitivity to certain sexual minority vs. sensitivity to religious freedom or even common religious orientations often found in certain minority groups that view homosexual behavior as morally proscribed and sinful), a lack of empirical evidence related to the extent to which these documents actually have any effect in producing desired competence

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outcomes, inconsistent restrictions on professionals to judge and thus target potentially maladaptive behaviors and values in minority cultures, a problematic assumption of homogeneity within each minority culture, and the assumption that an understanding of universal values such as a prohibition against prejudice and discrimination will not suffice to improve these services. This chapter will examine each of these issues with respect to some of the major documents in the behavioral health field, provide specific examples of how these problems exist within current documents and standards, as well as provide suggestions for future development of more sound standards.

This sort of analysis has been conducted on individual documents. For example, O'Donohue (2015) examined the current version of the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2010; Ethical Code) and found that this document places ethical obligations upon psychologists based on another's, "age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status." However, over a dozen problems with the ethical prescriptions in this document were identified including:

1. Problems in its clarity.
2. Its failure to describe the oppression, prejudice, and privilege, making these kinds of categories less important but perhaps also less distinctive.
3. Its failure to include some important dimensions related to prejudice that also identifies vulnerable minority groups, such as mental health status.
4. It is inconsistent, as it involves apparent internal contradictions.
5. Its reliance on scientific and professional epistemologies may render it internally inconsistent as this reliance ignores critiques of these epistemologies as being culturally biased.
6. It is impossible for psychologists to actually adhere to it.
7. It surprisingly picks out "autonomous decision-making" as a key property but ignores other important properties associated with prejudice and oppression.
8. It uses an inappropriate standard of "established knowledge."
9. It relies on an inadequate and impoverished understanding of the reputed empirical regularities regarding these dimensions.
10. Its reliance on "professional knowledge" adds vagueness.
11. It may blame the victim.
12. It is unclear on how a psychologist can validly engage in self-assessment regarding his or her own biases and prejudices.
13. It may entail privacy violations in order to adhere to it.
14. It ignores important questions regarding the moral status of these differences among groups.
15. It ignores other rivals and plausible construals of solutions for these problems.

This sort of analysis raises serious questions about the quality and actual function of these documents related to cultural competence. Steele (2009) has raised the specter that some apparent ameliorative efforts regarding problems relating to prejudice, oppression, and discrimination may have more do to with making some people (ironically often those in the majority culture) "feel good" about themselves (specifically to combat what he calls "white guilt") because of these sorts of minimalistic efforts that usually also results in problematic complacency. Duckworth (this volume) has also written on the importance of authenticity in addressing these important social problems. The following analyses of these documents are done with this sort of intent: Are these of the highest quality?; Can these be improved?; and Do these documents have the unintentional effect of creating a complacency that substantive steps have been made when actually this is not the case?

In addition, to illustrate some of these complex issues we've identified within the standards, we will first present two recent lawsuits in Missouri involving the social work department and counseling departments at Missouri State University. The January 24, 2017 edition of the Missouri Family Policy Council

included the following story, titled "Christian Student Wins Settlement from Mo. State University" stated:

> Missouri State University has agreed to pay $25,000 to a former student who was dismissed from the University's counseling program because of his Christian beliefs. MSU is making the payment to Andrew Cash in return for his dismissal of a lawsuit he filed against the university.
>
> Cash was pursuing a Master's Degree in Counseling from Missouri State after enrolling in the program in 2007. He was booted from the program in 2014 when he stated he would be unable to affirm a homosexual relationship in a counseling session because of his religious beliefs. Cash said he would refer such clients to another counselor.
>
> Cash had served his internship for his Master's degree at the Springfield Marriage and Family Institute, a Christian counseling center. When Missouri State officials learned that the Institute adhered to Biblical standards regarding homosexuality, they expunged 51 hours of his internship counseling from his academic record. Cash was then instructed to undergo 10 hours of "remediation" training because he had not repudiated his Christian convictions about the subject.
>
> Cash's faculty advisor, Dr. Kristi Perryman, scolded him, saying that his behavior was "discriminatory toward gay persons." She said that his Christian values on marriage and human sexuality were "unethical," and in conflict with the Code of Ethics of the American Counseling Association. When Cash appealed the removal of his internship credits, he was then dismissed from the counseling program altogether despite the fact that he had a 3.81 grade point average and was nearing the completion of his Master's degree.
>
> Andrew Cash filed his civil rights lawsuit last summer in U.S. District Court in Western Missouri. He alleged that the University's actions were a violation of his First Amendment rights to freedom of religion and freedom of speech.
>
> In his complaint, Cash asserted that three counseling department faculty members and the University's Board of Directors had "denigrated his personal and professional abilities" because of his religious convictions. Cash claimed that University officials had caused him "devastating emotional distress and financial hardship" by ruining his opportunities for a career in counseling.
>
> Cash was represented in his lawsuit by Thomas Olp, an attorney with the Thomas More Society. Olp says that no Christian student should be subjected to academic bigotry because of their deeply held religious beliefs. "Andrew Cash's religious convictions are protected by the U.S. Constitution and should have been respected in an academic environment."
>
> "We were honored to have represented Andrew in his quest to serve others with professional counseling, while maintaining his religious beliefs. The good news now is that Andrew Cash will be able to move on with his life to finalize a degree at a university that respects his rights of conscience," Old added.
>
> Missouri State University says the $25,000 settlement will be paid from the college's legal defense fund. The amount is the estimated cost for Cash to obtain a master's degree at another higher education institution.
>
> Andrew Cash isn't the first student to confront harsh anti-Christian hostility in the counseling and social work departments at Missouri State University. Twelve years ago a student named Emily Brooker faced the same anti-Christian bigotry from bullies on the University's faculty.
>
> Brooker was a student in MSU's Social Work program in the fall of 2005. She was enrolled at the time in a class called "Social Welfare Policy." As part of the class, a representative from PROMO, the state's leading homosexual rights group, was invited to speak to the social work students.
>
> Following the presentation, each member of the class was instructed to write a letter to state legislators advocating for the right of homosexuals to adopt children. Brooker declined, saying it conflicted with her personal standards and religious beliefs. Her professor then filed a grievance against her.
>
> Brooker then was brought before an inquisition of faculty members who aggressively interrogated her about her religious values. She was then ordered to write a paper demonstrating that she had "lessened the gap" between her personal beliefs and the "professional obligations" of the social work "ethics code." Brooker was threatened with removal from the program and loss of her diploma if she did not comply.
>
> Emily Brooker then sued Missouri State University with the help of local Springfield attorney Dee Wampler. The University reached an out-of-court settlement in which they agreed to pay Brooker $27,000 to cover her tuition and living expenses for two years of graduate school. The grievance was removed from Brooker's academic record, and the professor was placed on academic leave.
>
> The University commissioned an independent study of the College's Social Work Department in the wake of the controversy. The study results revealed what the reviewers described as a "toxic environment." The study concluded that faculty members "browbeat" students "with possible bias against students who are faith-based." The report further stated: "Neither of the reviewers have ever witnessed such a negative, hostile, and mean work environment."
>
> The final report from the independent study stated that the School of Social Work was such an

> exceedingly hostile learning environment that the University should either close the Department, or disband the faculty and restart the Department with a fresh staff. Then-University President Michael Nietzel said the report was "as negative a review of an academic program I have ever seen."

The two cases provide some preliminary evidence of some of these problems within the cultural competence standards for mental health professionals. First, both the Code of Ethics of the American Counseling Association (case #1) and the Social Work Ethics Code (case #2) were used by some in the profession to judge and punish certain values of others trying to enter the profession. In both cases, the ethical codes were used as a basis to critique the students' religious beliefs and punish the students to the point where their education and reputation were seriously compromised. In the counseling case, the student agreed to refer the client whose values conflicted with his own, yet this was deemed insufficient, and the student was expelled from the program. This is ironic considering standards typically suggest individuals to self-monitor implicit biases and refer to others when they are aware they cannot provide culturally competent services, yet this specific professional was persecuted for doing exactly this.

These cases also provide evidence that the standards often clash with other rights of the professionals. In these two cases, the professionals were not permitted to exercise their right to free speech and the freedom of religious practice. Professionals are not informed of this waiver of human rights at any point in the standards; it is instead latently embedded within these by the interpretation of some. Within these standards of culture competence, religion is often (but interestingly not always) considered a dimension that professionals are to be "sensitive" towards. However, sensitivity toward sexual orientation minorities seems to be so prioritized in both cases that it overrides this dimension. In addition, no further analysis was given to the protected class status of the students—one is apparently a female. The cases are prime examples of how there are apparently preferred cultural groups that are often prioritized over other minority groups (e.g., ethnic minorities, sexual orientation minorities). However, nowhere in the ethics code are these latent preferences explicitly stated or guidelines given how conflicts ought to be resolved. It would seem to be an improvement if these documents would attempt to do the hard intellectual work of attempting to provide good ways to resolve value conflicts within the values of various minorities cultures which also identify with the majority culture in some ways (e.g., White female, heterosexual Hispanic).

The two cases are examples of how a well-intended but poorly constructed set of ideas, such as those contained within the cultural competence movement, may have adverse effects on some individuals. In both cases, this lack of clarity resulted in serious consequences for the students, including flunking courses, redoing academic work expulsion, possible denigrating entries on academic records, and, even when successfully resolved, personal pain and inconvenience as they had to enroll in new academic programs. The overarching problem is that this advocacy for a reasonable tolerance of diverse viewpoints is equivocal; thus, it is difficult for professionals to translate this into practice. Or there is even a more serious interpretation: these documents can be used for the illiberal person of punishing and excommunicating individuals who do not agree with the rather narrow, non-diverse values that are implicit in these documents. These documents define the dogma of the profession.

Unclear Function of These Standards and Guidelines

Within the extant standards, there are issues regarding the function and purpose of these guidelines. What exactly are the problems these documents are intended to help ameliorate? What exactly are the ends that these documents seek to achieve? What exactly are the processes that will produce these objectives?

First, it seems that many of the standards are intended to improve behavioral health professionals' abilities to interact competently (often

poorly specified) with members of certain minority cultures. However, these documents often fail to explicitly state how this outcome is defined or even how it can be validly discerned. Does one need to assess a particular individual's current status on this—if so what exactly are the dimensions to be measured? (What are the dimensions of cultural competency?) And how does one validly measure these? Is self-evaluation sufficient? Is there some generic set of cultural competencies relevant to all minority groups (such as "open mindedness") or some such construct but then perhaps an added set of particularities for each individual minority group—or is competency in interacting with each minority group *sui generis*? (And of course what constitutes an individual minority group—like GLBTQ—one minority group or several?) What is the threshold (cut score) to be considered competent versus incompetent? Does this vary across minority groups or tasks (e.g., teaching at the undergraduate level might require a lower threshold of competency than psychotherapy)? How is and what is increasingly called "intersectionality" to be handled—when a person is a member of two or more minority groups? Is this another somewhat separate competency to be achieved? How many individual competencies then are there? How are cultural conflicts between minority cultures be handled (e.g., an African-American Baptist who views homosexual behavior as a sin)? What range of professional activities does this apply to—teaching, research, assessment, prevention, treatment, consultation, and personal behavior—and, again, does the content of cultural competency varies across these domains? What exact knowledge is required to know how to work with culture x versus culture y? What is the evidence that makes such information "knowledge," e.g., well-designed scientific research that has been replicated—or because a member of a minority group—deemed because of their status as an expert says so? How does one "certify" or in some sense accredit—some achievement of competence (and to what extent is this durable across time)? How valid is a person's claims of their own cultural competency, and what does this claim even look like (e.g., "I am competent to treat any minority member" vs. "I am competent to treat African-Americans)." Further, "I am competent to treat heterosexual African-Americans" (perhaps due to some lack of training in GLBT cultural issues) vs. "I am competent to treat African-Americans for problems in PTSD" and so on).

This lack of specification and operationalization of these key issues handicaps professionals' abilities to properly and thoroughly understand these documents and make reasonable assessments of this competency or competencies, let alone achieve this competency (or competencies), as it is unclear what the specifics of this end state are and what the process of achieving it consists of.

For example, the Association of Applied Sports Psychologists (AASP) Ethical Principles and Standards (2011) states that "members recognize that differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status can significantly affect their work. AASP members working with specific populations have the responsibility to develop the necessary skills to be competent with these populations, or they make appropriate referrals." This specific standard, along with standards of various other organizations, often are both vague and minimalistic. "Recognizing" is a very low bar. One can recognize that tobacco smoking is bad for one's health, but that means very little about subsequent behavior. Further, the standard states that professionals have a "responsibility" to be competent but does not specify either what this means exactly or how one could discern this responsibility has actually been met. There is no suggested process or specified measurable outcomes, thus crippling the ability of the standards to be a clear, realistic, and substantive standard of competence.

Further, there is another set of interesting variance regarding these documents: some standards mandate these competencies (still usually vaguely defined) be met, while others simply suggest professionals "aim" to meet these. For example, the National Association of School Psychologists Principles for Professional Ethics (2010) suggests that "practitioners are obligated

to pursue knowledge and understanding of the diverse cultural, linguistic, and experiential backgrounds of students, families, and other clients. When knowledge and understanding of diversity characteristics are essential to ensure competent assessment, intervention, or consultation, school psychologists have or obtain the training or supervision necessary to provide effective services, or they make appropriate referrals" (pg. 6). This standard states that psychologists are "obligated" to seek knowledge about diverse backgrounds when such knowledge is "essential"—although importantly the document recognizes that this obligation is not universal as apparently and also claims that such knowledge is not always "essential." A question becomes what research or evidence exists that shows this knowledge related to culture is essential for treating any DSM-5 diagnosis. What research or other evidence demonstrates that this knowledge related to culture is essential for teaching or consultation?

Further, the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2010) states that "psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices" (pg. 4). These standards state that professionals should only attempt to restrict their biases from entering into their practice, but language such as "trying" allows room for them to argue that any "culturally insensitive" behavior they may exhibit is "unintentional." Moreover, how does one actually discern if some psychologist is meeting the respective standard? Is being critical of some difference sufficient to show that "disrespect" has occurred? Or does this only rule out certain egregious behavior such as the use of epithets? This all contributed to the considerably unclear interpretation of these documents.

Furthermore, the standards that explicitly mandate these competencies be met fail to state what the repercussions are for not achieving such competencies. How many cases are there of any individual behavioral healthcare practitioner being charged and adjudicated, let alone experience any repercussions for failure to meet these mandatory standards related to culture competency? The second author once wrote the APA Ethics committee (two times actually) asking for this information, and both times the request was ignored. Is there an embarrassing lack of substantive identification, adjudication, and enforcement of these standards relating to culture competency? Should we thus assume that nearly all professionals have such competencies or judiciously avoid any professional situation that they do not have the skills for? This is related to serious questions about what sort of trainings or other interventions have been shown to produce these competencies (see Benuto & O'Donohue, 2016). If, as a field, we have no empirically validated training programs that can reliably produce these competencies—how can we then assume that nearly all professionals have attained these competencies?

Moreover, the lack of consequences may result in a lack of motivation for professionals to actually take these mandates seriously and to actually engage in any corrective processes. These guidelines may produce a "feel good" do-nothingism as professionals may feel a false sense of satisfaction that something is being done about a vital issue—or that all is well—simply because these documents exist. Increased clarity within these documents regarding their function is warranted, in order to yield more competent services being provided.

Of course this leads to another fundamental question: how much do these documents really intend to change the status quo? There seems to be a paradox here. These documents seem not to have the function of challenging the status quo. Professionals read these and seem to think all is fairly fine or that just minor personal adjustments need to be made. Or perhaps instantiate the problematic view that "I am fine but this problem only applies to others." However, if there is a significant amount of ignorance, prejudice, discrim-

ination, misallocation of healthcare resources, and microaggressions, then it seems fair to say that these documents are failing, as there is little evidence to support the notion that these have functioned to promote significant changes related to these issues.

Unclear Scope

Beyond the lack of clarity regarding the function of these documents, there are also problems embedded within the scope of these standards and guidelines. Some of this problem may be understandable as it could be the case that these documents have legitimate differences in their scope—e.g., some only apply to the behavior of sports psychologists, while others apply to the behavior of all psychologists. Typically, the documents often provide categories of cultures to be that fall under their purview (e.g., groupings related to ethnicity, sexual orientation, religion). However, these often fail to further explain why these groups (and why not others) fall until the scope of the document. For example, religious categories are less often mentioned in these documents, which is somewhat unusual given anti-Semitism and the persecution of the Jews in the twentieth century. Does any minority group fall into the purview—Catholics, Mormons, Polish-Americans, the obese (which is problematic since everyone is really a member of multiple minority groups); any disadvantaged minority group (disadvantaged in what way or to what extent?); and any minority group the professional deals with or is likely to deal with—i.e., can a professional argue that, given the particular details of my practice and general time constraints, it is unlikely that I will have professional contact with an Aleutian islander and thus I will not devote time to developing competency regarding this group? Thus, in attempting to understand these documents, the reader is left with the question as to which minority groups (as well as their intersectionality) do professionals need to be culturally competent?

For example, the Association for Multicultural Counseling and Development's Multicultural and Social Justice Counseling Competencies (2015) only uses the terms "marginalized" vs. "privileged" to describe the groups of individuals one needs to be knowledgeable about. But this leaves the extension of these terms unclear. Are Roman Catholics marginalized? Mormons? Vietnam war veterans? Conversely, Association of Applied Sports Psychologists (AASP) Ethical Principles and Standards (2011) asserts that professionals need to be aware of differences between members from different age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status. This might be too inclusive—as, again, this might cover everyone in some capacity. Everyone has a socioeconomic status. Does one need to have a certain income or educational level to have this apply? The American Counseling Association's Code of Ethics (2014) even further expands upon the groups to be considered, including "age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law" (pg. 9). No other standards found consider marital/partner status as a factor that needs to be considered. Is this a problem for these other documents—or even an "insensitivity"? This begs the question as to what data demonstrates mental health treatment disparities among single, married, divorced, or widowed individuals, in that interventions need to be adapted to each group. This lack of consistency across documents all dealing with the much the same general construct—cultural competency—is problematic, and a consensus on what constitutes a relevant "minority" group or group that is "disadvantaged" or what groups one needs to be knowledgeable about is warranted, as it is currently unclear how to reconcile either the vagueness or inconsistency among these standards.

Another issue within the scope is the lack of clarity about how stable, if at all, these competencies are. How often, if ever, do professionals need to update their knowledge of different cultures and skills, or is it assumed that cultural issues are rather stagnant (are cultures dynamic?)? Further, can someone from a minority culture use their personal experiences to contribute toward their competency level with regard to some other

minorities, or do they require the same formal training as a person from the majority culture? This lack of clarity regarding the scope of these guidelines leads to a possible issue of liability and puts professionals at risk for malpractice or charges of violating a standard.

Lack of Empirical and Scientific Support

As with other sciences, in the field of psychology, there is an emphasis on the need to provide evidence-based services. However, these ethical and professional standards about providing culturally competent services are not based on science. Specifically, the standards suggest that taking (often unspecified or vaguely defined) steps, such as completing continuing education credits (which begs the question of the efficacy of this content or the skill at which it is taught or the "dose" necessary), leads to individuals being competent (with unknown cutoffs, with unknown measurements, with unknown scope, with unknown duration) in providing culturally diverse services (of unknown scope and duration).

For example, the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2010) vaguely states that "psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (pg. 5) but do not state what kind of training or how much experience is required to be considered culturally competent. This vague language of needing to obtain training, but lack of specification of what this training would consist of or where to find it, is also found within the National Association of School Psychologists Principles for Professional Ethics (2010), which states that "when knowledge and understanding of diversity characteristics are essential to ensure competent assessment, intervention, or consultation, school psychologists have or obtain the training or supervision necessary to provide effective services, or they make appropriate referrals" (pg. 6). This issue further extends to the Association for Multicultural Counseling and Development's Multicultural and Social Justice Counseling Competency (2015) document, which states that multicultural and social justice competent counselors "assist privileged and marginalized clients in unlearning their privilege and oppression" (pg. 11). Can privilege or oppression be unlearned? Are there any successful appropriately controlled trials of this published in peer reviewed journals? What would this even look like? Does teaching a professional to unlearn these help improve treatment or other professional outcomes?

Additionally, the National Association of Social Workers' Standards and Indicators for Cultural Competence in Social Work Practice (2015) states that culturally competent organizations include "cultural competence as a requirement for job performance, by including it in job descriptions, performance evaluations, promotions, and training" (pg. 41). Thus, it is assumed that including cultural competence as a measure of job performance will entice more social workers to engage in culturally competent practices. An example of culturally competent behavior suggested by the standards is to "develop the skill and confidence to engage in and facilitate difficult conversations about cultural differences" (pg. 49). However, this is not measurable, as there is no scale to measure such skill or confidence. Further, the assumption that engaging in such behavior will in turn result in improved treatment outcomes has not yet been demonstrated in the literature. This assumption of causality is problematic and results in providers being deemed by some process as culturally competent, though they may not be actually improving in their approach toward serving minority culture members. The title of being culturally competent is being prioritized over ensuring that all steps in the process of becoming competent with these populations are being properly completed. One reason this causality has not yet been demonstrated is due to the lack of measuring operations to assure the attainment of cultural competence (Benuto & O'Donohue, 2016). In the standards, there are no well-defined outcomes for professionals to demonstrate they

have achieved the competency; thus, no study has a basis for determining causal processes for this outcome. In all likelihood this causality would be probabilistic—just like therapy outcome research, not everyone would show improvements, and some would show more improvement than others. However, again—there is no evidence-based cultural competency training.

Further, Weinrach and Thomas (2002) have argued that there is a lack of psychometric information within the development of the standards, including a lack of inter-rater reliability of assessments of cultural competency. For example, it is unclear whether different raters would agree on the level of mastery that professionals have, following these competency trainings. Weinrach and Thomas (2002) also have argued that it is unclear whether the level of mastery after a cultural competency training will generalize over time. A prospective longitudinal study design would help clarify whether this competency is stable and provide further insight into how often organizations should require trainings. Lastly, these authors have argued that the trainings are not necessarily generalizable to real-life situations. The standards again assume that completing a training will equip mental health professionals with how to treat members of various cultures, yet there is no scientific basis behind these assumptions. Further insight into how applicable the scenarios in these trainings are to various clinical settings is imperative to determine their efficacy. These assumptions of evidence-based underpinnings and causality are problematic and result in providers being deemed culturally competent though they are not improving in their approach toward serving diverse populations.

Restricts Ability to Criticize Maladaptive Behavior and Values

Beyond not being based upon empirical evidence and having an unclear scope, the standards also provide restrictions on a professional's ability to serve individuals. Specifically, criticism of diverse cultural values is either directly or latently disapproved within all cultural competence standards. For example, the National Association of Social Workers' Standards and Indicators for Cultural Competence in Social Work Practice (2015) asserts that "social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures" (pg. 14). This specific competency standard suggests providers familiarize themselves with strengths of minority cultures but does not suggest they be aware of possible weaknesses or shortcomings of minority cultures. The American Counseling Association's Code of Ethics (2014) states that "counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (pg. 5). This again restricts counselors from critiquing any values that are incompatible with their own. Just because a minority group holds some value doesn't mean that the value is correct.

This lack of room for providers to criticize some aspect of a minority culture follows the notion that mental health professionals have to accept "diverse" values or they are immediately considered "culturally insensitive." However, this ought not to be the case. This cultural sensitivity movement is usually based on manifold and rather strong critiques of a culture—the majority culture. Masculine culture is criticized as it promotes patriarchy—males are also criticized as they promote a "rape culture." White culture is criticized as it has created institutions such as the justice system that privileges them; certain expressions used by majority cultural members are criticized as either outright racist or as microaggressions; certain mainstream religions are criticized as homophobic.

However, this sort of permissibility of criticism seems to come to a sudden stop when a minority culture is being examined. Instead of criticizing the patriarchy possibly contained in Hispanic culture, or the homophobia possibly contained in African-American culture, or the misogyny embedded in rap music—this sort of

criticism is either nonexistent or muted. This asymmetry of such cultural evaluation is problematic but seems to be problematically a key part of the construct of cultural competency in these documents. If a cultural weakness is found (e.g., the number of children born out of wedlock among African-Americans), this must be quickly explained as part of the legacy of slavery and discrimination even when historical facts do not seem to support this. Sowell (1975), for example, has shown that this out-of-wedlock birth was actually the same as or lower than whites until the 1960s—a fact that does not allow such glib explanations.

Given that various evidence-based treatments, such as cognitive-behavior therapy, incorporate the identification of irrational ideas and then utilize cognitive restructuring, it seems problematic to not allow the restructuring of maladaptive thoughts, values, and schemas (Bryant et al., 2008). At some point professionals should be permitted to state that a value of a minority group member is inappropriate because it contributes to their problematic functioning or to problems in their health status and therefore needs to be adapted to assimilate majority culture values. For example, if a client reports being abusive toward their partner and justifies it as their culture valuing the partner being submissive, should providers only be able to "respect" this cultural difference or be able to restructure this type of problematic value system? If they do the latter, will they be at risk of being sued for being "culturally insensitive" toward these cultural values?

This situation becomes even more problematic when these maladaptive behaviors and values are contributing to the individual's distress. In this instance, adapting these values and behaviors to be more reflective of popular culture seems to be most beneficial for the client. If some minority subculture values smoking or their cultural preferences in diet result in diabetes or obesity—are these above critique? However, it appears that these guidelines would make practitioners hesitant to do so, as the standards do not currently permit it and thus practitioners are not acting in their client's best interest. The National Association of Social Workers' Standards and Indicators for Cultural Competence in Social Work Practice (2015) assert that a culturally competent social worker should "demonstrate intentional effort to ensure that they do not impose their own personal values in practice" (pg. 37). The problem arises when a professional has a client whose values are maladaptive. For example, is it unethical to argue against the views of a "skinhead" based on one's "personal values" and to ensure steps that they cannot put their views into action? The standards would argue that it is unethical to do so because the professional is inflicting "their values" onto the client. This standard assumes a problematic ethical relativism, in which values are seen to belong to people and are right because people hold these, as opposed to an ethical absolutism that indicates that there are rational standards upon which values can be appraised. Note that it would seem more intellectually consistent for cultural sensitivity training to hold to an ethical objectivism and absolutism as the values against prejudice, for justice, and for equity—fundamental values upon which this movement is based—are not seen as just personal preferences but rather absolute, objective values.

It is also interesting to note that these restrictions also infringe upon professionals' right to freedom of speech. A professional's private behavior can also come under scrutiny, even if they follow cultural competence guidelines within the therapy setting. One possible solution is for standards to include an advisory that conveying disapproval of a client's values may complicate the client-professional relationship while still providing the professional the opportunity to exercise their constitutional right to do so.

Assumption of Intra-culture Homogeneity

A common issue within the cultural competency movement is the assumption of a fair amount of homogeneity within cultural groups—i.e., that it makes sense to talk about the Hispanic community or Asian-Americans. However, this is patently false and, even, ironically insensitive

itself and insulting. Obviously these groups have very large numbers of individuals associated with them. Moreover, as others have pointed out, these groupings used in the cultural sensitivity movement are artificial—the use of the term Hispanic-American encompasses such diverse cultures as Mexican-Americans and Chilean-Americans—and even paradoxically Brazilian-Americans who are not even Spanish speaking.

Cultural sensitivity assumes interventions have to be tailored, based upon specific cultural considerations, as cultural groups have differing values and beliefs (Kumpfer, Alvarado, Smith, & Bellamy, 2002). However, these standards generally fail to allow individuals within a specific culture to differ as well—which is problematic in its own right but especially problematic when one considers assimilation and acculturation. For example, the Association for Multicultural Counseling and Development's Multicultural and Social Justice Counseling Competencies (2015) encourages counselors to "develop knowledge of historical events and current issues that shape the worldview, cultural background, values, beliefs, biases, and experiences of privileged and marginalized clients" (pg. 5; it is important to note the American Counseling Association endorses this document). This assumes that all clients within privileged and marginalized cultures have the same view on all things, the same beliefs, and the same experiences, such as in regard to how historical events and current issues influence both groups. This is also rather stunning as the historical, sociological, anthropological, and economic analysis of any particular culture would require years of careful study—all with the opportunity cost of not using this time and energy to gain more knowledge in, say, assessment and treatment of behavior health problems. This is problematic as there may be many subgroups or differing views within cultures (within a culture there are differing socioeconomic strata, different religions, differing cohort experiences, and so on). For example, there is a common misperception that Mexican-Americans and Puerto Rican-Americans are homogenous as they are both "Hispanic," when there are indeed differing values between the two. Relative to mental health treatment, Mexicans are more likely than Puerto Ricans to utilize psychotherapy, and Puerto Ricans are more likely to utilize psychopharmacology (Gonzalez, Tarraf, Whitfield, & Vega, 2010). Assuming homogeneity of values and beliefs within the Latino-American culture, as these documents seem to do, or any large encompassing cultural grouping is therefore problematic.

Moreover, within the LGBTQ community, there are also differing values (e.g., whether HIV-positive status is mandatory to be considered properly a gay male; Dean, 2009). Therefore, it is important to understand that humans are heterogeneous and one cannot assume that there is a prescriptive value set belonging to every individual from a single culture. However, it is also either pragmatically very difficult or even unmanageable to identify all the subcultures groupings within a single culture (let alone intersectionality). Therefore, it is unlikely a mental health professional can become competent in treating every possible type of individual that he or she may encounter.

Moreover, these standards do not require further inquiry into whether the client actually holds their culture's values to be true. Thus, assimilation and cultural dissent are other critical variables but ones that are often ignored in these documents. For example, a client could physically appear to be Asian-American but identify with European-American values. This leads to the issue of whether assessing the level of acculturation a minority culture member has experienced is warranted. Acculturation refers to the "phenomena which results when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Redfield, Linton, & Herskovits, 1936, pg. 149). Researchers propose four different dimensions of acculturation: assimilation, separation, integration, and marginalization (Berry, 1997). Depending on the dimension of acculturation that an individual falls into, their values may differ from the majority culture. There are again important questions regarding whether the degree to which acculturation can be

validly measured (especially again as acculturation may need to be measured differently across cultures: the items for measuring a Mexican-American's assimilation may be different than measuring the way a GLBTQ individual assimilates to a majority heterosexual culture). Therefore, the assumption of homogeneity within cultures contained in these documents is problematic (Berry, 1997). However, the standards do not currently require professionals to conduct such an analysis, which investigates either acculturation or individual heterogeneity, likely because it is time-consuming and complicating. However, it is problematic to skip this step if the standards are intending to thoroughly equip mental health providers with the necessary techniques to actually understand the diversity found in individuals.

One standard attempts to address this issue and help the professional develop a broader view of cultures, outside of an academic context. The Association for Multicultural Counseling and Development's Multicultural and Social Justice Counseling Competencies (2015) states that professionals should "take action by immersing oneself in the communities in which privileged and marginalized clients reside to work through the discomfort that comes with learning about privileged and marginalized clients" (pg. 8). Additionally, professionals are expected to "work in communities to better understand the attitudes, beliefs, prejudices, and biases held by privileged and marginalized clients" (pg. 11). While on the face of it, this seems to be a reasonable way of expanding professionals' knowledge of the individual cultures outside the context of the counseling setting, which may also decrease the assumption of homogeneity within a culture; is it reasonable to require professionals to do so? If so how much time and what exact experience produces the kinds of desirable outcomes? Interestingly is this standard inadvertently placing minority members in a position to be used by majority culture professionals for their own purposes—like exhibits in a field trip to the museum? How many times a month and for how long are they required to do these activities?

Assumption of Interculture Heterogeneity

As previously stated, there is a problem with assuming homogeneity within a single culture, but, conversely, there is also a problem with assuming heterogeneity across cultures (Frisby, 2013). The National Association of Social Workers' Standards and Indicators for Cultural Competence in Social Work Practice (2015) states that "what is assessed as behaviorally appropriate in one culture may be assessed as problematic in another. Accepted practice in one culture may be prohibited in another. To fully understand and appreciate these differences, social workers must be familiar with varying cultural traditions and norms." This need to assume heterogeneity across cultures provides the opportunity for professionals to develop stereotypes about various cultures, which is ironically counterintuitive to the end goal of cultural sensitivity. Additionally, some standards suggest addressing intercultural differences between the counselor and client, possibly during the rapport building process. The Association for Multicultural Counseling and Development's Multicultural and Social Justice Counseling Competencies (2015) document states that competent counselors "take action by inviting conversations about how culture, stereotypes, prejudice, discrimination, power, privilege, and oppression influence the counseling relationship with privileged and marginalized clients" (pg. 11). However, is this necessary? Do such conversations always produce desirable outcomes? Could doing so be counterintuitive and make the client think the counselor is focusing too much on race and too little on their presenting concerns? How would one even utilize such knowledge to adapt treatment?

Instead of participating in such processes, it is important to consider whether we should even require a completely new schema to understand each culture. These standards currently ignore universal values across cultures and instead assumes each culture is independent and completely distinct from one another. For example, it is sometimes stated that "Hispanics value family"—but what culture doesn't? Is there any

sound scientific evidence that Hispanics actually value family more than the majority culture does? Isn't it the case that all cultures value family—that this value is a human universal. It can be argued that there is no need to explore specific cultures and that simply better understanding humans as a whole would suffice (see Frisby, this volume). For example, in a meta-analysis of 12 different values inventories, a total of 48 value concepts were identified, with 16 being listed in at least five of the inventories (Cheng & Fleischmann, 2010). The 16 commonly identified values included freedom, helpfulness, accomplishment, honesty, self-respect, intelligence, broad-mindedness, creativity, equality, responsibility, social order, wealth, competence, justice, security, and spirituality. These values appear to be universal and may serve as a basis of understanding individuals, regardless of their culture.

Failure to Directly Target Prejudice, Oppression, and Discrimination

These documents also generally fail to directly target what seem to be the more important and more central problems involved in these matters: prejudice, discrimination, and oppression. It can be argued that dealing with individuals in a way that is not racist is more fundamental and thus more important than being culturally competent with regard to that individual. Prejudice can seem to be pernicious rather than a lack of cultural incompetence. The civil rights movement was not a movement related to cultural competence but was a movement attempting to combat discriminatory voting practices and employment and housing practices. Most would agree that this work has not been completed. The question becomes: should a movement to understand and combat prejudice in mental health professionals, in clients, and in institutions be more fundamental and important than a cultural competency movement? Tellingly, there is little direct mention of problems of prejudice, injustice, discrimination, and oppression in these documents.

This also raises the important question of "reverse prejudice"—prejudice against the majority culture. When a radical feminist such as Catherine MacKinnon (1987) states that "all men are rapists," is this seen as a reasonable radical feminist viewpoint or a prejudicial statement similar to the view that "all African-American men are rapists"?

While some standards apparently attempt to address prejudice, oppression, and discrimination, they fail to effectively do so—though it is more progressive than those who fail to even attempt to address these concepts. For example, the American Counseling Association's Code of Ethics (2014) states that promoting social justice, which is defined as "the promotion of equity for all people and groups for the purpose of ending oppression and injustice affecting clients, students, counselors, families, communities, schools, workplaces, governments, and other social and institutional systems" (pg. 21), is one of the core professional values. However, at no point in the standards are the means of promoting social justice addressed. How does one promote equity? Further, the standards assert that "counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and strive to become aware of and address such biases in themselves or others (pg. 11)." While this does require professionals to be aware of prejudices, such as the high rate of schizophrenia diagnoses in African-Americans, it does not help professionals parse through the decision-making process of whether or not to diagnose an individual with a commonly misdiagnosed disorder. Is it better to lean toward not diagnosing, in order to combat prejudices? How does one know if they are being biased or if the person really does have x diagnosis? Additionally, the National Association of Social Workers Code of Ethics (2008) states that "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity" (pg. 3). Besides becoming knowledgeable

about oppression and discrimination of certain groups, the standard does not explain what specific behaviors social workers can engage in to promote social justice. How can a social worker end social injustice? Are any feasible actions within the scope of their practice? Or is this completed outside of the 400-h week? This lack of clarity undermines the efficacy of such a standard. Though these attempts are better than those standards that fail to address these problems beyond stating not to discriminate and deny services to minority clients or deny jobs to minority applicants (e.g., American Psychological Association), there is still much work to be done.

Conclusions

Given the issues that have identified within the standards and guidelines associated with cultural competency, there is a need to revisit and revise these documents to eliminate these problems, so professionals can better serve individuals who need behavioral health services. Moreover, the organizations that produce these documents should be held accountable. Organizations should be asked to produce evidence related to the quality and function of these documents. They should also be able to provide evidence that the standards are correcting the problems that they are developed to address. The extent to which these standards help produce culturally competent professionals should also be explored. Lastly, they should put forth a considerable amount of intellectual work toward clarifying the critical constructs, such as culture, cultural groupings, cultural competence, and acculturation.

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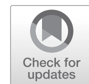

9 Viewpoint Bias and Cultural Competency Advocacy Within Applied Psychology

Craig L. Frisby

The study of "bias" has a long and distinguished history among researchers in various branches of psychology and touches upon a wide variety of areas. These include, but certainly are not limited to, attribution bias (Gawronski, 2004; Mezulis, Abramson, Hyde, & Hankin, 2004); self-perception bias (Pronin, Gilovich, & Ross, 2004; Pronin, Lin, & Ross, 2002); biases related to perceptions of in-groups versus out-groups (Brewer, 2007; Robbins & Krueger, 2005); test bias (Reynolds & Carson, 2005; Warne, Yoon, & Price, 2014); bias in various aspects of thinking, judgment, and memory (Joorman, 2008; Pohl, 2004); biases associated with political ideologies (Hibbing, Smith, & Alford, 2014; Young, Ratner, & Fazio, 2014); and attitudinal biases against racial and/or ethnic groups (Lev-Ari & Keysar, 2010; Rubin, Paolini, & Crisp, 2010) – to name a few.

The purpose of this chapter is to discuss *viewpoint bias* as this concept applies to cultural competence advocacy in applied psychology. This application of bias does not have the advantage of being supported by a large body of prior research. Therefore, the meaning of bias – as discussed within this narrow context – must first be clearly defined. Viewpoint bias, as applied to cultural competence advocacy in applied psychology, is based on four assumptions:

1. There is an objective *truth* that psychological researchers must aspire to discover or at least to approximate more closely. It is certainly well beyond the scope of this chapter to explore the philosophical literature on the nature of truth (as one among many areas studied by epistemologists; Audi, 2011). For the purposes of this chapter, truth is colloquially understood as "the way things really are," as opposed to "the way we'd like things to be" or "the way things should be."
2. The accurate characterization of this objective truth is suppressed or *distorted* to a significant degree (see Jussim, Crawford, Anglin, & Stevens, 2015). Distortions occur for any number of reasons, which include – but certainly are not limited to – sustained exposure to inaccurate information; the lack of exposure to accurate information; the influences of subjective prejudices; errors in thinking, reasoning, and/or perceptions; or the influence of strong emotions and subjective attitudes.
3. This distortion is *systematic*, meaning that it does not originate from random or chance factors and that predictable regularities and/or patterns can be observed in distortions. This suggests that distortions are organized and shaped by a coherent sociopolitical worldview, philosophy, or ideology.

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4. This systematic distortion leads to *undesirable consequences* for students, professors, scholarship, training programs, and professional organizations.

Starting from these assumptions, therefore, viewpoint bias can be defined as the systematic ignoring, suppression, and/or distortion of research and writing that challenges fundamental tenets of cultural competence advocacy, the effect of which ultimately undermines effective training of applied psychologists to serve racially and ethnically diverse populations.

Getting at the Root: Unconstrained Verses Constrained Visions

In psychology, factor analysis has been defined as a data analytic method, typically aided by a computer, for reducing a large set of variables to a smaller number of unobserved (latent) sources of variance in data that are called factors (Mulaik, 2009). As one among many examples, hierarchical factor analytic results from the assessment of child and youth behavior ratings often reveal two broad underlying sources of variance in problem behaviors that are called "internalizing" versus "externalizing" factors (e.g., Achenbach, 2009; Reynolds & Kamphaus, 2015). These concepts are used, in turn, as a concise yet robust way to understand the broad dimensions of child and adolescent psychopathology (Evensen, Lyngstad, Melkevik, & Mykletun, 2016; Mrug & Windle, 2010; Zhang & Markon, 2014).

In the same way, the eminent economist and social philosopher Thomas Sowell (2002) has devoted a lifetime of thinking and writing on historical, philosophical, political, economic, and social issues to conduct a "conceptual factor analysis" of ideological and political struggles throughout recorded history. His work has resulted in the identification of a *consistent pattern* which explains the nature of political and ideological conflicts that have endured for generations up until present times. Sowell writes:

> One of the curious things about political opinions in how often the same people line up on opposite sides of different issues. The issues themselves may have no intrinsic connection with each other . . . Yet the same familiar faces can be found glaring at each other from opposite sides of the political fence, again and again. It happens too often to be coincidence and it is too uncontrolled to be a plot. A closer look at the arguments on both sides often shows that they are reasoning from fundamentally different premises . . . They have different visions of how the world works. (p. 13)

According to Sowell, these two competing visions disagree on the nature of man, the nature of knowledge, and the nature of social processes. He defines a "vision" as:

> Visions are like maps that guide us through a tangle of bewildering complexities. Like maps, visions have to leave out many concrete features in order to enable us to focus on a few key paths to our goals . . . [Visions are] what we sense or feel *before* we have constructed any systematic reasoning that could be called a theory, much less deduced any specific consequences as hypotheses to be tested against evidence. A vision is our sense of how the world works. (pp. 13–4)

Sowell has named these two visions the *unconstrained vision* and the *constrained vision* – which have subsequently been integrated into psychological research and theory on the nature of moral judgments (e.g., see Graham, Haidt, & Nosek, 2009). Key features of these competing visions, with a specific application to cultural competence advocacy, are briefly described next.

How Competing Visions View the Nature of Man

The unconstrained vision (UV) is rooted in optimism for the unlimited possibilities of human potential that can be put to use for the ultimate perfectibility of human society. In this vision, man is capable of empathizing with the needs and pain of other human beings, considering these to be more important than his/her own. According to the UV, man possesses the intellectual and moral capabilities to develop *virtuous intentions* – which in and of themselves are sufficient for creating social programs for mankind that will ultimately result in human happiness.

Mankind is bound by a higher sense of social duty to do the right thing because of an inherent capacity to understand that it is simply "the right thing to do" (Sowell, 1987).

In contrast, the constrained vision (CV) views man as having consistent moral limitations that are "basic facts of human existence" which have not, will not, and cannot be changed. Therefore, the fundamental moral and social challenge is for mankind to make the best of life within these moral constraints, as opposed to wasting time and effort in futile attempts to change basic human nature. In essence, efforts to improve society must do so only within the context of the natural constraints and limitations of human nature. This is done most effectively by studying how man is motivated by *incentives*, rather than by what is perceived to be futile attempts to change man's inherent dispositions (Sowell, 1987).

Application to Cultural Competency (CC) Training The entire justification for CC training is built on an implicit vision of human nature.

The Unconstrained Vision (UV) Although CC training does not often begin with an explicit theory of human nature, it becomes readily apparent that the potential for "goodness" and "badness" is not evenly distributed among persons as a function of their racial, ethnic, language, or sexual orientation group membership. Here, certain classes of human beings – because of their inherent privilege, power, or sense of "supremacy" – are thought to possess a greater record of wrongdoing toward out-groups or at least have a greater propensity for the future oppression of persons from other groups that are unlike them. CC training encourages members of "oppressor" groups to view the problems of "oppressed" groups as being a function (whether directly or indirectly) of their history of mistreatment and victimization in society (D'Andrea & Daniels, 1999, 2001; Helms, 1992; Jun, 2010; Sue & Sue, 2016). Roy (2007) coined the term "radical psychiatry theory" to describe how these assumptions of human nature are integrated into mental health therapy. His remarks most clearly illustrate the fundamental premises of the unconstrained vision (UV) of human nature:

> Radical Psychiatry theory begins with the simplest of premises: people are good. We do the best we can under the conditions we are given. Those conditions are social in nature, and because they are severely stressed for most of us, they stress and distort human experience. The first step, therefore, is to name the material conditions in which emotional and interpersonal life is lived . . . We resist explanatory notions of pathology, of addictive or self-destructive behavior, or of biochemical flaws, believing that, in their cultural and professional popularity, they overshadow a view from a more political and material angle . . . . . Instead, such behaviors, and the feelings that intertwine them, are products of oppression and its internalization. (p. 67)

The Constrained Vision (CV) In the constrained vision of human nature, human limitations and weaknesses – and the inter- and intrapersonal problems and vices associated with such – are a given. Arguably the most direct and explicit view of the limitation of human nature comes from Judeo-Christian theology as recorded in the Bible (Grudem, 2000). Here, humankind is depicted as born sinful and utterly incapable of perfecting human nature or creating a society free of human conflict, war, suffering, and lawbreaking. Although models of Christian psychology and counseling are based on a wide variety of different viewpoints as to how biblical scripture and secular psychology should be integrated (Greggo & Sisemore, 2012; Johnson, 2010), clients who willingly submit to counseling based upon these principles must face squarely their own personal limitations.

The CV of human nature is not limited to religious principles but is also acknowledged by secular sources. For example, most researchers agree that cultural variation within and across groups can shape biological, psychological, and developmental definitions of normality versus pathology (Canino & Alegría, 2008; Lewis-Fernández & Aggarwal, 2013). However, all human groups experience – to greater or lesser degrees – difficulties in living that are a function of physical/medical/mental problems, work/school problems, family/marriage problems, as

well as various problems that are a direct or indirect outgrowth of greed, money mismanagement, sexual lusts, jealously, anxiety, broken relationships, substance abuse issues, anger, selfishness, laziness, and assorted other manifestations of the imperfect human condition. Hence, greater or lesser frequencies of human vices and virtues are not viewed as correlated with gender, skin color, language, or sexual orientation subgroups but instead are viewed as being universal among persons living in all human societies (Antweiler, 2016; Brown, 1991, 2000; Geher, 2014; Norenzayan & Heine, 2005). In addition, the CV acknowledges that human subgroups (however defined) differ, on average, in their histories, interests, abilities, talents, cultural habits, personality traits, and achievements (Gottfredson, 2005, 2006; Rushton & Jensen, 2005; Sowell, 1981, 1994, 1996, 1998a). Therefore, to expect perfect statistical and representational equality in all societal outcomes is seen by many writers as having no basis in reality (Gottfredson, 1994; Lynn & Vanhanen, 2006, 2012; Sowell, 1998b, 2012a). If power or socioeconomic imbalances between groups are observed at any given point of time within a given society, plenty of evidence shows how all groups are fully susceptible to mistreating other groups when social conditions change (Flaherty, 2013; Goad, 2015; Mercer, 2012; Rubenstein, 2016; World Net Daily, 2017a, 2017b).

How Competing Visions View the Nature of Knowledge

In the unconstrained vision (UV), superior human knowledge and reason – possessed by a few on whom is conferred the status of being "top experts" in a particular narrow specialty – are sufficient for guiding the broader society toward improvement and enlightenment. Under the constrained vision (CV), in contrast, valuable knowledge is gained by the collective experiences of many people (most of whom are not experts in a narrow area of specialty) over time. These collective experiences manifest themselves in behaviors, sentiments, and habits – the accumulation of which, over time, reflects the *collective wisdom* of the many – rather than specialized knowledge of the few.

Application to Cultural Competence Training

The nature of knowledge, wisdom, and expertise in cultural competence is understood differently by the two visions.

The Unconstrained Vision (UV) According to the UV, it is the singular task of a select group of "special people" to train others to solve society's problems. Some believe that racial/ethnic group membership alone confers a special expertise in this regard. According to Hale-Benson (1986), for example, it is the singular task of the "black community" of psychological scholars to pool their scholarly talents so that black children can succeed educationally (p. 4). Similarly, Swisher (1998) argues that only Native American educators can significantly improve education for Native American children.

At other times, a high profile status, earned positions, and bestowed awards confer special expertise and influence to which audiences should defer. Select individuals who have achieved scholarly prominence in applied psychology are given high profile platforms from which to promote cultural competence ideology to national audiences. Some garner a greater degree of attention to their views due to their achievements as high elected officials of large organizations representing psychologists. Others' opinions are given an increased measure of respect due to honors and awards received. For example, the American Psychological Association confers annual awards to select members for Distinguished Contributions to "Professional Practice," "'Independent Practice," "Psychology in the Public Interest," and "Career Contributions to Education and Training in Psychology," to name a few. Award recipients are invited to give speeches at annual conventions, in addition to having their speeches published in the APA's flagship journal, *The American Psychologist*. According to the UV, for example, it is the singular task of a select group of distinguished multicultural experts to establish the research, training, and practice agenda of

professional psychology (e.g., see Helms, 2015; Sue, 2005; Vasquez, 2012).

The Constrained Vision (CV) Under the CV, in contrast, caregivers do not need to be experts in cultural competence (or even have a university degree in psychology) to internalize and apply useful principles for effectively serving racially, ethnically, or culturally different clients. This is because sustained experience with serving culturally different populations is sufficient for persons to induce principles needed to effectively understand specific client groups in specific contexts.

To illustrate this difference between the UV and CV as pertaining to the nature of knowledge, consider a young woman in a dimly lighted parking garage late at night. After getting into her car, she instinctively locks her car doors from the inside after seeing a group of young men loitering in the garage just a few feet from her car. This behavior represents "common sense," or the product of an *accumulated wisdom* that transcends all cultures living in urban, industrialized nations (the constrained vision). In contrast, compare this behavior with the musings of a nationally renowned professor of "critical race theory" or "social justice education." If the woman in the scenario is white and the group of young men are nonwhite, the professor argues that this behavior is indicative of "negative racial stereotyping," "unconscious racism," or "white privilege." According to the counsel of such experts, if the woman is to be psychologically freed from these evils, she should unlearn these behaviors in her path to racial enlightenment (the unconstrained vision; see also Helms, 1992; Ridley, 2005; Sue, 2003).

The constrained vision also acknowledges that even the most well-meaning efforts to improve society are fraught with unanticipated negative consequences, the appreciation of which severely limits what can reasonably be accomplished. As an example, consider the convoluted reasoning identified in one psychologist's efforts to encourage psychology to embrace social justice initiatives (Vasquez, 2012):

> The meaning of justice, in its broadest sense, is 'fairness'; it implies behaving toward others in an impartial manner, with the goal of treating others equally. Sometimes treating others fairly means treating them differently, however; that is, justice may involve treating equals equally and unequals unequally but in proportion to their relevant differences . . . such as is true in the application of affirmative action practices. (p. 338)

Yet later in the same article, the author admits that not even psychologists within the American Psychological Association (APA) agree on which social justice positions should be endorsed by APA – or whether social justice should be a priority at all. At various spots, she writes:

> [T]here have been and continue to be differences among individuals and groups in prioritizing the application of social justice, both in society as well as in our association. (p. 339)

> While some members believe that APA advocates too much for social justice and social issues, others do not think that APA does enough. There will probably always be some degree of tension between those perspectives. The tension is particularly generated around specific issues about which members disagree. (p. 342)

> Many psychologists interested in social justice get involved and stay involved in order to have an avenue through which to affect change. On the other hand, those who do not value these activities may leave the association or may work within it to restrict those activities. (p. 342)

How Competing Visions View the Nature of Social Processes

The UV is not burdened by the assumption that man's deliberate reason is much too limited to devise workable schemes for social planning (Sowell, 1987). The UV sees no difficulty with changing centuries of the evolved collective wisdom of society if it clashes with social science theories or social justice crusades. One consequence of this thinking is that desired results (usually defined as the equality of outcomes between subgroups) is a worthy goal to be pursued directly. If grand visions for social reform do not work (e.g., failure to achieve equality of results), it is

not because of a fundamental misdiagnosis of the complexity of the situation to be changed. Rather, the UV assumes that failure is due to the deliberate obstruction from forces that lack the "correct" social vision or from the fact that those with the "correct" social vision just did not try hard enough (Fein, 2001).

In contrast, the relationship between social processes and societal outcomes under the CV is succinctly summarized by Hollis (2017), who writes:

> History shows with painful clarity that whenever human beings get too much power, that power ends up corrupting the very values that prompted people to seek it in the first place. Why? Because human beings are flawed, self-interested, imperfect creatures. No one has complete understanding or unimpeded wisdom, and the failure (or refusal) to recognize one's limitations leads to oppressive consequences . . . Those who start by believing that they deserve power because they are right, eventually come to believe that because they *have* power, they *must* be right. Anyone who disagrees becomes the enemy, and enemies must be eliminated.

The CV puts little to no faith that a small group of decision-makers can grasp the enormous complexities of the real world in order to design blueprints for running economic, legal, or political systems. Instead, the CV:

> . . . relies . . . on historically evolved social processes and evaluates them in terms of their systemic characteristics – their incentives and modes of interaction – rather than their goals or intentions. (Sowell, 1987, p. 68)

In the CV, the concept of "justice" is descriptive of processes, rather than serve as an indicator of results. To illustrate:

> If a footrace is conducted under fair conditions, then the result is just, whether that result is the same person winning again and again or a different winner each time. Results do not define justice in the constrained vision. (Sowell, 1987, p. 89)

Application to Cultural Competence Training

The contemporary manifestation of different visions of social processes can be clearly seen in the different reactions of each vision to current interest in "social justice advocacy" as the ideological foundation for cultural competency (CC) training.

The Unconstrained Vision (UV) CC training rests on the assumption that preservice and in-service clinicians can call upon a reservoir of social justice "goodness" (which resides "in here") to fix the social injustice "badness" (which resides "out there"). Social injustice "badness" is operationalized as various "isms" that oppress people (e.g., racism, heterosexism, male sexism, ageism, ableism, etc.), social inequities, prejudice, and discrimination. The role of the applied psychologist in CC advocacy is to matriculate through a training program that has taught students to first recognize these problems within themselves, avoid behaviors that would manifest these ills within the therapeutic relationship, engage in activities that would assist vulnerable clients to either cope with or overcome the effects of these ills, and explicitly advocate for them outside of the therapeutic relationship (Choudhuri, Santiago-Rivera, & Garrett, 2012; Chung & Bernak, 2012; Ridley, 2005).

Social Justice and Counseling Psychology Numerous writers have made the claim that social justice advocacy represents the "fifth force" of counseling psychology (Chung & Bemak, 2011; Crethar, Lewis, Toporek, & Hutchins, 2013; Ratts, 2009). Fouad, Gerstein, and Toporek (2006) define social justice within the context of counseling psychology as "helping to ensure that opportunities and resources are distributed fairly and helping to ensure equity when resources are distributed unfairly or unequally" (p. 1). They define the appropriate activities for counseling psychologists who adhere to social justice in their work as involving:

> . . . working to promote therapists' multicultural competence; working to combat racism, sexism, homophobia, and ageism; increasing access to educational and occupational opportunities; understanding and ameliorating career barriers for women; reaching out to work with homeless individuals; resolving ethnopolitical conflicts; nation building; empowering individuals, families,

> groups, organizations, and institutions outside of the United States; attempting to resolve border disputes between nations; advocating for the release of political prisoners; developing and implementing strategies to eliminate human rights abuses; striving to protect the environment; and influencing the legislative process. (pp. 1–2)

According to Arrendondo and Perez (2003), "social justice has always been the core of the multicultural competency movement" (p. 282). According to Ratts and Pedersen (2014):

> If counselors lack multicultural competence, they will be ineffective social change agents . . . The need to acknowledge and combine multiculturalism with social justice cannot be overstated. (p. ix)

The Multicultural Counseling Competencies Revision Committee of the American Counseling Association revised the *Multicultural Counseling Competencies* developed by Sue, Arredondo, and Davis (1992; operationalized by Arredondo et al., 1996). These guidelines (Ratts, Singh, Nassar-McMillan, ButMeeting the psychoeducationaller, & McCullough, 2016) were subsequently endorsed by the Association for Multicultural Counseling and Development (AMCD) on June 29, 2015. The revised guidelines include a new conceptual scheme that subdivides the counseling dyad into "privileged" versus "marginalized" categories. Privileged group members are defined as "those who hold power and privilege in society" (p. 36), while marginalized group members are defined as "those who are oppressed in society and lack the systemic advantages bestowed on privileged groups" (p. 36). Thus, four counseling dyads are now possible: (1) a privileged counselor working with a privileged client, (2) a privileged counselor working with an oppressed client, (3) an oppressed counselor working with a privileged client, and (4) an oppressed counselor working with an oppressed client. Whites, males, the able-bodied, and heterosexuals are depicted as belonging to the privileged categories, while nonwhites, gays, the transgendered, the disabled, and women are depicted as belonging to the oppressed categories (Ratts et al., 2016).

Social Justice and School Psychology Shriberg, Song, Miranda, and Radliff (2013) summarize developments in school psychology that, in their view, encourages school psychologists to become more involved in social justice initiatives within the field. These include the publication of the American Psychological Association's (APA) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, in which Principle 5 states "Psychologists are uniquely able to promote racial equity and social justice" (American Psychological Association, 2003, p. 382). They also mention the formation in 2007 of the "Social Justice Interest Group" within the National Association of School Psychologists (NASP), the formation in 2010 of "Social Justice and Child Rights Working Group" by Division 16 (School Psychology) of APA, and citations to social justice on multiple occasions as an aspiration in four NASP *Standards* documents (p. 3). In addition, a special theme issue of *School Psychology Review, Issue 37, No.4* (the flagship journal of the National Association of School Psychologists) was published on the topic of social justice.

Shriberg et al. (2011) surveyed 1000 randomly selected members of NASP and obtained a sample of 214 respondents who rated the phrases "ensuring the protection of educational rights and opportunities" and "promoting nondiscriminatory practice" as significantly more critical to the definition of social justice compared to other items.

Social Justice and Clinical Psychology Aldarondo (2007) traces the intersection of social justice and mental health to the early work of feminist therapists and community psychologists, about which he opines:

> [T]hese groups have persistently reminded us of the need to understand people's lives within the social contexts in which they develop, highlighted the political nature of mental health problems, and advocated an activist stance for human services providers and scholars. (p. 6)

In a frequently cited article published in the *American Psychologist*, Albee (1986) urged

psychologists to appreciate the link between symptoms of mental health, psychological distress, and unjust structural social conditions. Citing the influence of the eminent psychologist Kenneth Clark, he writes:

> Clark asked psychologists to do research on the effects of human institutions and social arrangements and to study issues of status and hierarchical distinctions as these relate to injustice and cruelty. Psychologists should listen. Psychologists must join with persons who reject racism, sexism, colonialism, and exploitation and must find ways to redistribute social power and to increase social justice. (p. 897)

The contemporary social justice movement gives voice to these concerns, and as a result, social justice training is beginning to forge an explicit presence in clinical psychology training. One published example of social justice training in clinical psychology, specifically oriented for APA Division 49 (Society of Group Psychology and Group Psychotherapy) members, describes such work as follows (Chen, 2012):

> A systems perspective is useful in exploring the various ways in which we as group psychologists within an organizational system may serve as advocates for individuals or marginalized groups in our society . . . Central to this systems perspective are questions such as: How do we shape the organization's culture (e.g., attitudes, beliefs, and behaviors)? How do we create favorable conditions (e.g., structures, dynamics, decision-making, distribution of power) and remove problematic ones within organizational culture in order for the organization to be more receptive to social justice and empowerment activities? How do we give voice to those voiceless members within the organization? . . . One component of [an exemplary program's] scientist-practitioner-advocate training model involves doctoral students developing awareness about social justice in group work as well as learning how to co-facilitate intergroup dialogues around racial and cultural issues. It is evident that the time has come for our professional roles as group psychologists and trainees to help our clients find their own voice and advocate for them beyond the therapy hour.

At the time of this writing, one website for a PsyD training program in clinical psychology advertises the curriculum content for its "social justice track" (Alliant International University, 2017) as follows:

> A goal of the Social Justice Track is to prepare the next generation of leaders within the profession of clinical psychology. These leaders will understand systems of oppression and how those systems impede healthy development and quality of life for marginalized groups. Through special courses, field placements, and dissertation work, students. .. will develop the skills and knowledge to intervene in ways that emphasize change and advocacy at a systemic level and that emphasize consciousness-raising and help clients and communities understand the extent that their difficulties are rooted in larger historical, social and political contexts.

The social justice perspective gives rise to new branches of applied practice specifically designed for "people of color." As one example, Comas-Diaz (2007) coined the term "ethnopolitical psychology" as an approach that:

> [A]cknowledges ethnic, racial, gender, social, and political realities as they converge with socioeconomic, historical, psychological, and environmental factors. It examines oppression, colonization, and cultural imperialism, paying special attention to the effects of racism, racial terrorism, sexism, and political repression on individuals, groups, and society . . It aspires to social justice, racial equity, and solidarity as psychosocial outcomes. (p. 93)

The Constrained Vision (CV) The concept of "social justice" rings hollow to the CV. As an example, Goldberg (2013) traces the term "social justice" to the writings of Catholic theologian Luigi Taparelli d'Azeglio in an 1840 treatise on natural law (Behr, 2003). This theologian conceived of "social justice" essentially as a vehicle for communicating that important sources of spiritual and moral authority (namely, families, churches, and communities) lie outside of the nation-state. With the passage of time, however, the term as morphed into a vague and ill-defined notion of "do-goodery" that distinguishes the UV from the CV. Goldberg writes:

> A cry for social justice is usually little more than an assertion 'for goodness' . . . Social justice simply *is* goodness, and if you can't see that . . . you're either unintentionally 'part of the problem', or . . . you're for 'badness.' . . . Social justice is one of those phrases that no mission statement – at least

> no mission statement of a certain type – can do without. One simply cannot be in the do-goodery business without making reference to the fact that you're fighting for social justice . . . All these organizations . . . claim that social justice sits at the center of their mission, and yet rarely does any organization go on to explain what they mean by it, other than connoting some sort of implied goodness . . . The social justice syllogism goes something like this: 1) We are liberals. 2) Liberals believe it is imperative that social justice be advanced wherever we fine it. 3) Therefore, whatever we believe to be imperative *is* social justice . . . If you oppose liberals in advancing what they want, you are against not just liberals but social justice itself . . . This is the beauty of the phrase social justice. It means everything to those who care about it and it means nothing to those whose eyes glaze over when they hear what they think is mere boilerplate. (pp. 132, 133, 135, 137)

Sowell (2012b) criticizes the perceived lack of social justice as an explanation for group differences, and writes:

> Surely most of us are repelled by the thought that some people are born into dire poverty, while others are born into extravagant luxury – each through no fault or virtue of his own. If this is an injustice, does that make it social? . . . Whose fault is this disparity or injustice? Is there some specific society that caused this? Or is it just one of those things in the world that we wish was very different? . . . Anyone who studies geography in any depth can see that different peoples and nations never had the same exposure to the progress of the rest of the human race. People living in isolated mountain valleys have for centuries lagged behind the progress of people living in busy ports, where both new products and new ideas constantly arrive from around the world . . . there was never any real chance for all peoples to have the same achievements – even if they were all born with the same potential and even if there were no injustices . . . Every group trails the long shadow of its cultural heritage – and no politician or society can change the past. But they can stop leading people into the blind alley of resentments of other people.

Summary

All of these observations lead back to a central problem, which is the *fundamental incompatibility* between two competing visions that underlie disagreements over cultural competency issues in applied psychology: the unconstrained versus constrained visions (Sowell, 1987). In the unconstrained vision, societal flaws have allowed racial and ethnic injustices to fester – which in turn create disparities in various aspects of schooling, health, mental health, and psychological status and/or treatment outcomes (Krieger, 2014; Roberts, 2012; Tucker et al., 2007; Williams & Mohammed, 2009). Under the guidance and scholarship of recognized experts, professional organizations can develop guidelines for the field and marshal their resources to train psychologists with race/ethnicity-specific dispositions, knowledge, and skills that have the potential to reverse these disparity trends (Barrera, Castro, Strycker, & Toobert, 2013; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014) – which ultimately fulfills the goals of social justice (Goodman, Liang, & Helms, 2004; Speight & Vera, 2009; Suyemoto & Toporek, 2014; Tucker et al., 2007). This view is aggressively promulgated in textbooks, journals, and guild newsletters, which are readily available to pre- and in-service psychologists and counselors within the context of their training (see History and Development of Cultural Comptence Advocacy chapter, this text)).

In the constrained vision, racial/ethnic disparities in schooling, health, and mental health outcomes have roots in complex factors, which may or may not be directly related to race or ethnicity (Frisby, 2013; Klick & Satel, 2006). Said differently, outcomes may indeed vary by race or ethnicity, but not necessarily *because* of it. Because factors in real life are simultaneously nuanced, multidimensional, and complex, viewpoints influenced by the constrained vision are more willing to entertain the possibility that race/ethnicity may not be the most important variable (and in some cases may not be a significant variable at all) for influencing educational, health, mental health, and/or psychological status or intervention outcomes (Frisby, 2013; Sanghavi, 2009; Whitman, 2008).

In the constrained vision, cultural competency consists of flawed professional guild committees constructing flawed multicultural guidelines to be followed by flawed university trainers, who in turn use flawed teaching methods to train flawed

students, who will graduate from flawed training programs and eventually serve flawed clients in flawed settings. Under these assumptions, therefore, there is no reason to expect "perfect mental health outcomes" to consistently result from cultural competency advocacy/training, no matter how well intentioned. In fact, the constrained vision openly acknowledges a variety of negative outcomes that may result from even the most well-intentioned "culturally sensitive" interventions (e.g., see Dalrymple, 2003; Hayek, 1978; Olasky, 1992; Satel, 2000; Satel & Forster, 1999; Wolters, 1992, 2008).

It is generally considered beyond debate that most American universities and colleges are overwhelmingly liberal in their ideological outlook, political viewpoints, and general approach to their disciplines (Gross, 2013; Langbert, Quain, & Klein, 2016; Pew Research Center, 2016; Maranto, Redding, & Hess, 2009; Yancey, 2017) – although there is robust debate as to reasons for this imbalance (e.g., see Gross, 2013). Nevertheless, different branches of applied psychology, and different subspecializations within each branch, vary widely with respect to their openness for entertaining differing viewpoints, particularly those originating from the constrained vision.

A leading psychology journal has recently published a series of articles on the problem of viewpoint hegemony in social/personality psychology (see *Perspectives on Psychological Science*, Vol. 7, No. 5). Counseling psychology is generally considered to lean "left/progressive" in its sociopolitical orientation, although it has entertained published debates holding divergent views on cultural competency guidelines in the field (see *Journal of Mental Health Counseling*, Vol. 26, No. 1). Frisby (2013) has opined that if multicultural school psychology could be likened to a political system, it would be characterized as a "one-party system" (p. 511), in the sense that opinions on multicultural issues almost always reflect the unconstrained vision. Unlike social and counseling psychology, no school psychology journals have published formal debates on sociopolitical influences affecting the field. The closest that school psychology has come to giving a hearing to the constrained vision (as applied to multicultural issues) is to periodically publish articles from individual scholars who take positions on specific issues that, at the time of their writing, deviate from the unconstrained vision (e.g., see Braden & Shah, 2005; Frisby, 1993a, 1993b, 2005; School Psychology Review, Vol. 24, No. 1).

> Although this chapter frames the issue of viewpoint diversity as reflecting tensions between the "unconstrained" versus "constrained" visions, most writers on the subject of bias will frame the issue as a conflict between "liberal" versus "conservative" sociopolitical worldviews. Thus, some writers may equate the unconstrained vision with the assumptions that underlie modern liberalism and equate the constrained vision with assumptions that underlie modern conservatism (e.g., see Graham, Haidt, & Nosek, 2009). Although this writer has no objections to this melding of conceptual schemes, readers are encouraged to keep in mind that important subcategories exist within broad political labels (e.g., economic conservatism, social conservatism, foreign policy conservatism) and that individuals may integrate worldviews that borrow freely across political boundaries (i.e., a person can be socially liberal but fiscally conservative). Nevertheless, the general message in the following material is that viewpoint bias – however it manifests itself – is detrimental to applied psychology on many levels. The consequences of this bias, with a particular emphasis on its application to cultural competence advocacy, are discussed next.

Negative Consequences of Viewpoint Bias in Cultural Competence Advocacy

Many authors have written scholarly pieces or have made professional presentations on the general problem of viewpoint bias in academic and applied psychology (e.g., Duarte et al., 2015; Inbar & Lammers, 2012; Jussim et al., 2015; Konnikiva,

2014; Redding, 2001). Raising awareness of how viewpoint bias operates in cultural competency advocacy requires an investigation behind carefully crafted images promulgated within formal academia. These insights and observations can only be obtained by affording scholars (who think deeply about these issues) an opportunity to be interviewed on the condition of anonymity.

Anonymous Interviewees

Seven academics agreed to be interviewed for this chapter on the condition of anonymity. Six of the seven were interviewed by phone, and one submitted written responses to interview questions. Phone interviews were carried out during the Spring and Summer of 2017 by this author. All phone interviews were transcribed in writing by this author as they occurred and after completion.

Six interviewees are male, one is female, and all are Caucasian. Each interviewee can be described as serving at the pinnacle of their respective professions at the time of this writing. Two interviewees are high level college administrators (with academic backgrounds in applied psychology), three interviewees are full professors, one interviewee is a fellow at a Washington DC think tank, and one interviewee was a retired full professor at the time of the interviews. Each of the interviewees represents diverse specialty areas related to academic and applied psychology, which includes clinical psychology, counseling psychology, school psychology, psychiatry, social psychology, forensic psychology, and law. Over the course of their combined academic careers up to the time of this writing, the interviewees have published over 1000 journal articles, book chapters, and books in their respective areas of expertise.

Each interviewee was initially selected by this author on the strength of their reputation as being a critic of "viewpoint bias" as this relates to academic and applied psychology in academia. Each interviewee was sent a brief description of the chapter objectives and was invited to share their thoughts on their experiences as graduate students, university scholars or administrators, and as members of professional guilds/organizations. Each interviewee was assured that their identities would be blinded in any published material based on their interview responses. All interviewees were sent a prepublication draft of this chapter and were invited to provide constructive feedback, as well as to edit any material that did not accurately reflect their comments.

Interviewees' self-described political orientations were also quite diverse. Two interviewees identified themselves as political conservatives, and two interviewees never stated their political orientations. One interviewee explicitly stated that he/she "does not consider myself to be a conservative. I never voted, and I never was a member of a political party." One interviewee stated "I am not conservative or libertarian. I used to be on the left, but now I am a political centrist." One interviewee stated that he/she considers him/herself to be a political moderate and is not a "classical liberal" on all issues. This interviewee went on to state: "I get a lot of surprised looks from colleagues when I say that I could potentially vote Republican. I don't consider myself a Republican, but I am more like a squishy Joe Lieberman Democrat."

Interview topics were subdivided into eight areas: (1) graduate student experiences, (2) experiences in scholarly publishing, (3) professional work climate, (4) university teaching experiences, (5) experiences in tenure/promotion decisions, (6) experiences in grant activities, (7) experiences in the context of guild/professional organization membership, and (8) experiences in university administration. All interviewee responses were dictated and transcribed to be as accurate as possible yet are paraphrased when needed for clarity. Brackets [ ] are inserted in various spots, as necessary for filling in clarifying information not included verbatim in interview responses.

Consequences of Viewpoint Bias for Students

Prentice (2012) cites data from large surveys showing that students who self-identify as liberal significantly outnumber students who self-identify as conservative – both within and across a variety of academic disciplines. Between

April 17 and 23, 2017, for example, McLaughlin and Associates (McLaughlin & Schmidt, 2017) conducted a secure online survey of 872 undergraduates attending Yale University. The political party identification of those taking the survey was 14% Republican, 44% Democrat, 27% Unaffiliated, and 8% Not Registered. Ideological leanings were self-reported as 52% Liberal, 21% Moderate, and 24% Conservative. Among numerous findings, the results from the survey found that, overall, six in ten students (57%) reported feeling comfortable voicing their opinions in the classroom and on campus on issues related to politics, race, religion, and gender – while four in ten students (42%) do not. A breakdown by political party affiliation revealed stark subgroup differences in these figures. While 70% of Democrats reported feeling comfortable, 75% of Republicans and 53% of Independents felt uncomfortable. While a majority of students overall reported feeling intimidated to share their views when it comes to a divergence of opinion with their classmates and peers (55%), 80% of Republicans reported often feeling intimidated, while 65% of Independents and 41% of Democrats reported often feeling intimidated. While eight in ten (78%) students overall felt that they have *not* often been treated unfairly on campus by either fellow students or professors as a result of their political opinions or beliefs, 47% of Republicans, 39% of conservatives, 7% of Democrats, and 8% of liberals report that they often feel intimidated. The interpretation of these findings, though informative, is to be viewed with caution – since the differences between those who completed surveys vs. those who did not complete surveys have not been empirically investigated.

Many students enter applied psychology training programs to explicitly advance liberal/progressive political values (e.g., see Part II chapters in Casas, Suzuki, Alexander, & Jackson, 2017; Chung & Bernak, 2012; Toporek et al., 2006; Unger, 2011). In contrast, Redding (2012) cited large-scale survey research which found that conservative students who enter academia lack academic role models, have fewer opportunities to do research, and have more distant relationships with their professors (pp. 512–13).

The unconstrained vision sees racism as a societal sickness to be cured or at least as a menace to be isolated and quarantined from decent society so that racial/ethnic minorities can achieve social, economic, and political equity. The cultural competence movement, taking its cue from the unconstrained vision, therefore views white racism as a problem that must be explicitly recognized, discussed, and subsequently banished from the attitudes and thinking of whites seeking to become applied psychologists – much like an exorcist must banish a demon from a possessed individual (Constantine & Sue, 2006; Ridley, 2005; Sue, 2003, 2004, 2005). The ideological disagreement with the unconstrained vision by those operating from the constrained vision is not over the existence of racism within the human heart or society, but rather rests in a fundamental disagreement over the importance of racism as a sufficient explanation for minority problems in society (D'Sousa, 1995; Roth, 1994; Steele, 2007; Taylor, 2004; Williams, 2011).

Students whose thinking on racial issues aligns with the constrained vision quickly learn to "keep their heads down" and "go along to get along" in training programs dominated by liberal/progressive ideology. According to Redding (2012), "[d]iscrimination begins in college or graduate school and continues throughout the. .. [contrarian] academic's career" (p. 512). Interviewees were asked what kinds of past experiences they recalled when they were graduate students, and their reflections reflect a painful awareness of viewpoint bias:

> *(Interviewee #5) I remember experiencing a "strong ethos" of liberal politics in my undergraduate and graduate education. Professors would often made denigrating comments about conservatives and/or Republicans. The conservative point of view was never given in assigned readings. This bias also existed in most of [my fellow] students' views as well. As a person who held more conservative views, I always felt quite uncomfortable, and felt under constant pressure to "self-censor" myself – remembering that it was a very bad feeling to fear that what you might say could be taken negatively. I never raised my hand in class to offer an alternative viewpoint.*

> (*Interviewee #1*) *I was fortunate. I was never actively dissuaded from pursuing an idea by any faculty member. In fact, our program director appreciated it when I critiqued her longitudinal study on ADHD children. Some faculty for whom I had much respect were concerned that I would publish something that would haunt me later in my career. There was strong encouragement to temper what I might say or how I might say it. In those days, Prof. Arthur Jensen was on the faculty of the educational psychology department. There were a few of my fellow grad students who warned me not to work with him, as that would be the "kiss of death for your career". Art Jensen was never a person that told me what to write or what I should find. He always encouraged me to make a strong argument for whatever I wrote. Jensen was my worst critic, but probably my best teacher.*
>
> (*Interviewee #4*) *I started my undergraduate schooling as a liberal. When Reagan was elected, I thought the world was going to end. However, I started reading George Will, Milton Friedman, Thomas Sowell and Karl Popper, and then I became conservative. I liked the fact that these writers did not only have assertions, but their writing was backed by arguments and analyses. And I slowly began to see that these arguments and analyses made people uncomfortable. People would say to me "I cannot attack your argument . . . but I know its wrong!" They would see me as "well you are good at arguing, but you are just perverting 'the truth'." People started to react to me as "you are a bad person in some ways". "You used to be good, because you had these (liberal) values, but now you are odd and somewhat of a problem". I worked closely with a professor whose son was a conservative political scientist, so as a result of that I experienced no problems in graduate school.*

When students are exposed to a wide range of views on controversial topics, each view must present its best data, evidence, and arguments in order to persuade audiences. When the objectives of a training program revolve around the advancement of "social justice," then classroom pedagogy shifts from a reliance on scholarly persuasion to an enforced *conformity of thought*. Although cultural competence training materials may pay lip service to the need for respecting students' different points of view on controversial issues involving race and ethnicity, bruised feelings among students are difficult to avoid.

White Students and CC Advocacy Many white students are staunch supporters of CC advocacy and its supporting assumptions. The concerns of white students who publically object to perceived indoctrination in cultural competence training are acknowledged as genuine but are often dismissed as little more than symptoms of "denial," "white blindness," or "white privilege" that need to be eradicated if one is to be a culturally competent psychologist (Constantine & Sue, 2006; Sue, Rivera, Capodilupo, Lin, & Torino, 2010; Sue & Sue, 2016).

Cultural competence advocates see their mission as confrontational in nature, with whites needing to "wake up" from their lack of engagement on racial issues (see D'Andrea & Daniels, 2001 as reported in Ponterotto & Austin, 2005, pp. 20–21). In the following quotes, variations of the term "forced" have been italicized by this author to highlight this mind-set in cultural competence advocacy. As examples, Ponterotto and Austin (2005) state:

> The Multicultural Counseling Lab course can prove to be an extremely challenging experience, as students are *forced* to confront difficult issues in regard to their worldview, such as their own entrenched stereotypes, prejudices, privileges, and internalized racism . . . Immersion in a new cultural milieu *forces* trainees to examine their own cultural socialization as they experience firsthand variant and possibly conflicting worldviews. (pp. 25–26)

Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) state:

> The creation of [cultural competence measures] was important because it allowed the operationalization of the competency areas in training and *forced* counselors to demonstrate observably their multicultural competency. (p. 124)

According to Sue et al. (2008), when whites feel anger, defensiveness, or guilt in response to being confronted with topics related to racism, their emotions are interpreted as reflecting "guilt about their privileged status" or a threat to their self-image as "fair, moral, and decent human beings" (p. 277). According to Sue et al. (2008), whites are motivated to deny "racial realities" of people of color, because the conscious acceptance of these realities forces one to "[confront] one's own unintentional complicity in the per-

petuation of racism" (p. 277). According to these authors, criticisms of microaggression theory and advocacy illustrates the "invisible nature of aversive racism" (p. 277). Thus, when three authors published short pieces in *The American Psychologist* that criticized the concept of microaggressions, Sue opined that "their letters indicate how strongly they are working to impose their racial realities on [people of color]" (p. 277). In other words, criticisms of microaggression theory have no inherent scientific merit, but instead reflect little more than white blindness to the pain and suffering of racial minorities. At one point, Sue et al. (2008) write:

> As a privileged White male, [critic's name] failed to understand how European Americans have historically had the power to impose their own reality and define the reality of those with lesser power . . . it seems truly arrogant for any White person to define and impose their racial reality on marginalized groups. (pp. 277, 279)

White students enrolled in cultural competence training classes sometimes express frustration and defensiveness from the perception of being attacked because of their race. One white student reacted as follows to being required to read one of Dr. Sue's textbooks:

> I didn't get very far with my highlighting and notetaking before I started to react to Sue's book with great anger and disgust . . . It seemed that Sue didn't have a single good thing to say about White America . . . I resented that I had to read his book . . . I felt that Sue had an axe to grind with White America . . . [and] that his accusations were grossly exaggerated and, at least to some extent, unfair. And I felt defensive because I am White and my ancestors had not perpetrated any of the offenses against ethnic minorities that Sue had charged. I looked forward to the day when I would be relieved of him and his writings. (Sue & Sue, 2016, pp. 11–2)

When white students change from a stance of skepticism to finally acknowledging that they are indeed conscious or unconscious racists, this is viewed in a self-congratulatory fashion as evidence of the healing power of cultural competence training (see Sue & Sue, 2016, p. 13). The following excerpt from a student who finished a course – in which Dr. Sue's textbook was used – typifies this process:

> I now realized Sue was right! The system had been destructive toward people of color, and although my ancestors and I had not directly been a part of that oppressive system, I had unknowingly contributed to it. I began to think about how I had viewed people of color throughout my life, and I had to admit to myself that I had unconsciously bought into the racist stereotypes about African Americans and Latinos . . . Sue's book forced me to remove my blinders. He helped me to see that I was both a product and an architect of a racist culture . . . It was as though I was in a deep sleep and someone had dumped a bucket of ice- cold water onto me, shocking me into a state of sudden wakefulness: The sleep was the denial of my racism; the water was Sue's provocative words; and the wakefulness was the painful recognition that I was a racist. (Sue & Sue, 2016; pp. 12–3)

Not only must whites see themselves as conscious or unconscious racists, but they must actively champion anti-racism and "white privilege" consciousness-raising among their fellow whites in order to demonstrate the sincerity of their commitment to social justice (e.g., see Irving, 2014; Trepagnier, 2010; Wise, 2011).

The Underdevelopment of Critical Thinking Skills Only students who are committed to considering a wide range of viewpoints are most harmed by viewpoint bias, in that they receive no exposure to scholarly research and writing that would support the constrained vision (e.g., that psychology is limited in solving deep problems of the human condition, that racial/ethnic stereotypes are sometimes accurate, that what is often labeled as "racism" reflects normal cognitive processes in all humans, or that racism and discrimination do not always provide sufficient explanations for racial/ethnic minority problems).

In these narrow intellectual environments dominated by the unconstrained vision, certain corrosive thinking patterns flourish and are often actively nurtured within students. Students latch on to popular slogans (e.g., "privilege," "social justice," "othering," "microaggressions," "marginalized," etc.) and slavishly use these terms without explicating any logical connection of these terms to the subject under consideration. Words and ideas are used, not as a means for evaluating the logical merits of arguments but as a means for manipulating emotions. Magical

thinking is accepted without being challenged (e.g., "white racism permeates all aspects of society"; Flisiuk, 2016; Ponterotto, Utsey, & Pedersen, 2006). There is an inability to reason closely through cause-and-effect relationships (e.g., "microaggressions cause group disparities in outcomes"; Sue & Sue, 2016). Students do not learn how to carefully weigh opposing ideas, nor do they experience insights that come from changing their minds on an issue when confronted with evidence that suggests that they may be wrong or mistaken (see Frisby, 2013, chapter 10). The constant emphasis in cultural competence classes is for students to *focus inward*. That is, students are encouraged to view the world through the personal and subjective prism of their own racial, ethnic, language, and sexual orientation group membership (e.g., see Part II of Casas et al., 2017), as opposed to learning to view and appreciate the world through objectively determined criteria (i.e., that there are truths that exist beyond one's immediate feelings, personal experiences, or tribal loyalties).

Some students automatically become fearful of ideas from the constrained vision, as the unconstrained vision has been effective in convincing them that not only are contrarian ideas simply wrong, but that they are patently dangerous and *evil* (e.g., see Gottfredson, 2007; Jensen, 1981). Thus, for many students taking cultural competency classes, students will avoid any public endorsement of any aspect of the constrained vision (as this applies to matters of race, ethnicity, sexual orientation, etc.) because of an unspoken *fear of being misunderstood or exposed as a "bad person*."

Justifications for cultural competence advocacy, whether they be empirically or philosophically based, incorporate frequent references to "virtue words" such as "justice," "equity," "sensitivity," and "nonbiased" (e.g., see Dean-Coffey, Casey, & Caldwell, 2014; Hernandez & Kose, 2012; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009; Skiba, Knesting, & Bush, 2002). Thus, students who publically endorse the aims and goals of cultural competence advocacy are seen as "good and virtuous people."

The use of "virtue words" (sometimes called the "glittering generality" technique in textbooks on fallacious reasoning; Shabo, 2008) involves the use of vague, ill-defined, but emotionally appealing words that lead students to approve or accept a conclusion without closely examining relevant reasons, evidence, or specific advantages or disadvantages of an argument or proposal being made. Liberal use of virtue words serves to distract audiences from a close examination of specific implications or consequences of accepting an argument or adopting a policy or proposal, which can more easily trigger disagreement (Browne & Keeley, 2004). Thus, to publically take issue with, level a disagreement toward, or raise an objection to any or all aspects of cultural competence advocacy makes one vulnerable to charges that she/he is *against* justice (and "for" injustice), *against* sensitivity (and "for" insensitivity), *against* equity (and "for" inequity), and *against* nonbiased practices (and "for" biased practices). As reported in Weinrach and Thomas (2004), for example, scholars who publically disagree with any aspect of cultural competence theory and/or advocacy become targets for being labeled as "racist," "ethnocentric," and "Eurocentric" or slurred as being influenced by "white privilege" or "white supremacy" by their professional peers (see also Helms, 1989).

Politically correct thinking on CC issues creates problems for students who cannot be easily categorized into mutually exclusive "victim vs. oppressor" subgroups. One interviewee commented on this problem in his/her department:

> *(Interviewee #4) We had a Hispanic student here who took the cultural diversity classes. He was a practicing Catholic that had some concerns about homosexuality because of his faith, and the leaders turned on him. He went from "you are one of the victims that we want to value" to "you are homophobic and horrible". Multiculturalism was OK as long as he was viewed as just another brown person, but as soon as he disagreed with the program's views on homosexuality, he was viewed as "part of the problem". It is a sociological fact that a strong component to some people of color's cultures are traditional religious views about homosexuality – but the advocates do not want to be sensitive to this. Leftists do not want to see Christianity in any way as being a positive influ-*

ence on popular culture. The bottom line is that they are really not interested in cultural sensitivity, but are more interested in a political ideology. Minorities are used as pawns for a political agenda, but they really have no interest in the specific aspects of minority group culture that they do not like.

Students can allow their fear of appearing "insensitive" damage their budding research careers. Some years ago two talented graduate students conducted the necessary research to assist this author to write a book chapter on a specific topic related to race, culture, and contemporary schooling. The chapter summarized research and writing that challenged popular explanations for the causes of disproportionate minority group failure in schools. The students put in a lot of work on the chapter, and they deserved to be appropriately rewarded with their names listed as secondary authors. As the chapter neared publication, however, the graduate students respectfully requested that their names be removed from the publication – out of fear that the chapter's criticisms of conventional thinking (no matter how mild) would offend minority groups and damage their reputations in the broader scholarly community.

Consequences of Viewpoint Bias for Professors

According to Jussim (2012), liberal viewpoint dominance in the academy allows liberal professors to enjoy certain privileges that are not afforded to conservative professors – which are more or less salient in certain disciplines compared to others. As examples, liberal professors do not have to spend time surrounded by colleagues who mistrust them due to their politics. If they apply for a job, they do not have to worry that their political views will put them at a disadvantage for being selected. They do not have to worry that their research results or opinions on policy issues will be mocked or insulted by colleagues at conferences or rejected by editorial boards because of political considerations. They do not have to alter, water down, or camouflage research findings due to fear of offending the political sensibilities of reviewers and editorial boards. They do not have to worry that reviewers and editors will require higher standards to publish or fund their research due to political considerations. Liberal professors can mock, misrepresent, misinterpret, caricature, and ignore the views of conservative colleagues without facing any significant penalties from colleagues or editorial boards. They can freely criticize colleagues' research without fear of being accused of being a racist, sexist, homophobe, religious zealot, "sellout," or a bigot (adapted from Jussim, 2012, p. 504).

Inbar and Lammers (2012) found that the more liberal that a professor reported to be, the more they reported being willing to discriminate against a conservative colleague in reviewing a grant application, reviewing an academic paper, or in making hiring decisions (for criticisms of Inbar and Lammers' survey methodology, see Prentice, 2012; Skitka, 2012). Rothman and Lichter (2009) found that conservative academics needed to publish more to get the same jobs compared to their liberal peers. Conservatives are more likely to view their work environment as hostile, while the hostility seems invisible to those who are not conservative (Inbar & Lammers, 2012). As a result, very few professors are willing to openly identify as conservative (although this may not be the case if individuals are permitted to express their views privately and/or anonymously; Haidt, 2011). This comes as little surprise, since academics depend on the opinions of their colleagues for grant funding, publication acceptance, and tenure/promotion decisions.

Interviewees were asked about colleagues' reactions to publications whose results may have run counter to the unconstrained vision. Interestingly, there comments reflected very diverse experiences (i.e., negative, mixed, and positive):

(Interviewee #4) I have received some positive feedback from my [homophobia critique article] thanking me for looking at the measurement aspects of this construct critically. If I only did this kind of research, my [liberal] colleagues would see me as a problem – but since I do research in other

areas that they agree with, I am not viewed so much as a problem.

(*Interviewee #3) I recently wrote an article that is critical of [a popular concept in cultural competency theory]. I suspect that when this article gets published, I anticipate receiving hate mail.*

(*Interviewee #6*) *The reactions to [one of my publications] was mixed. Some were snarky, but others were positive. I am certain that being a part of [the think tank in which I work] has gotten me disinvited from a number of panels . . . But I notice that the practice of accusing doctors of racism has stopped. I'd like to think that it was at least partly because of my work, but I cannot be sure.*

(*Interviewee #4) I volunteered to teach the cultural competence course, but I have always received strange looks and "no's". They feel that as someone more conservative, that what I would bring to the course would be a problem.*

(Interviewee #5) I have had nothing but positive experiences from my articles published in Directions in Psychological Science and American Psychologist. I have been invited to talk at various colleges/universities on the topics that I write about. I was actually quite surprised at the positive reactions I got. People who are positive will write me letters of support. I have only heard "rumblings" secondhand from persons who had negative reactions. Even though my article was critical of contemporary psychology, the reason for the positive reaction to my article was that I presented it on "psychology's terms" – as beneficial to psychology with respect to its own values (rather than attacking psychology from outside the discipline). I received 300 letters of support from persons who would share stories about their negative experiences [about having conservative leanings within professional psychology]. I have never had a negative experience from any of my articles being rejected – on the contrary, I am sought out for my diverse opinions. I felt that the review process [for my writings] was very fair. Although psychology has been slow to come around to adopting the recommendations made in my articles, a growing movement has begun in the science and profession towards greater sociopolitical diversity in research, training, and professional practice.

An interesting observation from one interviewee involved conversations she/he had with faculty members about viewpoint bias in expectations for budding minority scholars:

(*Interviewee #1) [There is] a concern that many minority scholars, early in their career, get co-opted into a groupthink. For minority scholars, if you "join the party", the party can be pretty good to you. I have seen some of the African-American scholars go that route. It is a road that is already paved for you. I don't know how many workshops that I have been to where, when I see a person of color as a speaker, they will cite the predictable sources.*

One interviewee testified as to the power of good scholarship for sowing seeds of doubt among those who are initially inclined to accept uncritically the assumptions of cultural competence advocacy:

(*Interviewee #4) I have colleagues that will say to me that they have thought along those lines [critical of excesses in the CC movement] but never thought anyone else had these same ideas, so they never vocalized what they were thinking. They would say to me: 'Now that you wrote what you wrote, I feel more empowered to speak up about my reservations'. The [cultural competence] movement is led by a very active minority of fairly leftist professors. Then there is this middle ground of slightly center-left people that do not hold these views, and it is a fairly big percentage, but when they hear other people voicing these concerns, it causes them to slow down a bit and not readily go along with the activists.*

One interviewee reported experiencing significant problems in promotion and tenure, perceived to be due to viewpoint bias:

(*Interviewee #1*) *When I went up for tenure and promotion at my university, I thought it would be a "slam dunk". I had good teaching ratings, I had more publications than most all of the other faculty in my department combined, and was running a graduate program – yet the vote at the department level was only narrowly in favor of my getting a promotion. However, I got pushback from a small minority of persons who said I was a racist because I collaborated with Arthur Jensen and that my writings on deafness called into question the standard assumptions about language deprivation and IQ. At the policy level, they denied me tenure but gave me a promotion to the rank of Associate Professor. [After I moved to another university] I waited until I got tenure before I felt comfortable enough to publish research about group differences in IQ because quite frankly I was scared.*

Classroom, Department, College, and Campus Climate Race, religion, and sexual orientation, among countless other topics, are minefields that could result in dire consequences should professors transgress formal or informal free speech codes

(Volokh, 2016). One of the most volatile of these minefields involves classroom teaching – specifically the relationship between what professors are permitted to say in their classrooms and how this is received by students. Again, interviewee comments on this topic were diverse:

> *(Interviewee #1) I do think we provide in imbalanced presentation of some issues today to graduate students. Most of the graduate students that I taught do not understand that the black/white achievement and cognitive ability gap has not changed since the 60s on many of these measures. Most grad students are surprised when I tell them to research the difference, because they kind of think "that was then but this is now". The differences are there, but no one makes graduate students grapple with that issue. We just all prefer "not to stir that pot". We just all don't want to talk about this anymore. That is still very much alive and well for graduate students. I like to use non-confrontational analogies that do not provoke much emotion. Females are generally different when it comes to muscle mass. No one completely believes that if the NBA doesn't have 50 percent of their rosters be women, that they are biased. Most do not argue that muscle mass, speed, and power are disproportionately found mostly among males. However, I have actually had some women challenge me on that! To talk about gender differences now is actually more controversial than when I was in grad school.*
> *(Interviewee #2) I had to go through due process at my school where I was brought before the equal opportunity commission. The process itself is the punishment, as it ends up being quite arduous, particularly if students launch a social media campaign against you – terrible things are written about you. I now find that – "I have to teach to the most sensitive student in the class" – which means that I cannot be as provocative as I used to be. I used to use the Socratic method in leading students' reasoning to uncomfortable places – I don't do that anymore.*
> *(Interviewee #1) I did have a few issues around teaching with individual students. There were some students that really wanted me to be politically correct. When I wouldn't do that, I actually didn't suffer as much as others had. I did find that I had to censor myself. I never had a situation where a student complained about me to a higher authority that I thought was mishandled.*
> *(Interviewee #4) I have not reformed my classroom behavior [to be overly cautious about saying potentially controversial things] because this is my area of scholarly interest. But I do feel that now I have to teach 'defensively' against potential claims that "I will be offended". Now I have to think (before I say something) "how would I defend myself if I say X, Y, or Z in the offhand chance that a group of students might complain?"*
> *(Interviewee #5) I do engage in some self-censorship in public policy issues. I teach a forensic psychology course. On the topic of racial bias in the criminal justice system, I find that I present only "politically acceptable" viewpoints. I do not present research that finds "no bias" in racial sentencing, for fear of being accused of being racist.*
> *(Interviewee #2) Once or twice, I have experienced significant problems from videos that I have shown including having charges brought against me as a result of a student that was offended. While I would not say that students are generally close minded, I would say that there is a very vocal group of social justice advocates on the left that have ideas about classrooms that were unthinkable 10 or 20 years ago – which is "I have a right not to be offended" – if you discuss a theory that they find objectionable, you are guilty of marginalizing a group and therefore that is grounds for bringing charges against you. I have had to delete certain videos and topics from my lectures because it is simply not worth the time that it takes to defend yourself. Most of the controversies revolve around African Americans, women, and LGBT groups. When talking about anything that could possibly offend any one of those groups, then I have to walk on eggshells.*
> *(Interviewee #3) Some people are using one of my articles in their syllabi, which is one of the biggest compliments you can get. It means that there is a possibility that you can influence some students. I like it when a student comes up to you to say that their thinking has changed (or at least that they are thinking about some things differently) from reading one of my articles.*

Two interviewees give examples of wrong-headed university policies that resulted from left/progressive thinking:

> *(Interviewee #7) As far as the administrators and my colleagues at [my university], I have no complaints regarding their protection of my right to free speech. In fact, the Faculty Senate, with my minor advocacy, eliminated the faculty speech code while I was still a faculty member. Plus, I was a member of an active ad hoc committee, sponsored in part by the Bradley Foundation, whose purpose was to protect the free speech of faculty and other faculty rights. Both conservatives and liberals were members of this committee. There were, however, incidents where students inhibited free speech. The most notorious of these was a speech opposing special preference admissions attempted by Ward Connerly. Connerly was shouted down by a large and organized group of Black students to such an extent that he eventually*

walked off the stage stating that [my university] was the worst place he had ever been invited to speak. Regrettably, one of the individuals involved in, or at least complying with, the demonstration was reputedly someone from the student affairs' section of the University. The Faculty Senate's reaction to this incident was initially one of mild outrage, but after a month or so the fault seemed to be placed less on the demonstrators and more on the individuals who had invited Connerly to campus without proper vetting and formal authorization. Another interesting incident involving the administrative aspect of the University concerned with student affairs was the distribution of a brochure that had been doctored to include a Black student in a photograph of students attending an athletic event. The student bravely pointed out that he had not attended the event, and the brochure was changed when the situation was reported in the press.

(Interviewee #4) This whole idea that "I feel uncomfortable" has gotten way out of hand. "Feeling uncomfortable" in my father's generation meant that you had to go to war, and if you went overseas you were sometimes exposed to killing, or attempts to kill you, or malaria, and a number of other hardships. There is no balancing afforded to academic freedom or free speech. The message for administrators is to "cave", "cave", "cave" and you will not lose your job. When Trump was elected, our college president wrote an open letter to students assuring them that minorities will be "safe". However, when Yiannopoulos was prevented from speaking on campuses, the college president didn't write a letter to assure the protection of free speech. Shelby Steele is right when he says that people of majority demographics posture/present themselves in a way that is very shrewd and says "I am a good person", "I am one of the good ones", "I am not a racist". "I won't disagree with anything you say" " I won't hold you to any rational standards" "I will agree with your demands, as I do not want to be seen as a racist". Notions of rationality, evidence, and reasoning simply go out the door with all of this.

One interviewee commented on his/her degree of confidence in administrators to support professors in free speech conflicts:

(*Interviewee #4*) *I am still going to adhere to the values of intellectual courage and intellectual virtue, but I don't have confidence that university administrators (or Title IX administrators) would adjudicate complaints in a fair or rational manner – and that is what is worrisome. A twenty-something student has a lot to learn, but a 55–60 year old college administrator should know better. I have no confidence that values like academic freedom and due process or rationality would be upheld. As a white heterosexual male who was raised Christian, I would be considered guilty until proven innocent.*

On the positive side, however, one interviewee (formerly a professor but now an administrator) had this to say:

(*Interviewee #1*) *Now that I am on the other side, I tend to support my faculty when they do not tow the party line with an over-sensitive student. I will not make it a problem for them.*

Consequences of Viewpoint Bias for Scholarship

How do scholars evaluate the soundness of the science that supports popular topics in their fields? How do emerging scholars determine what research is worthy to pursue? How do granting agencies determine what research to fund or not fund? How do training programs determine what books or journal articles to which students in training programs will be exposed? How do professional conference organizers decide what research to feature? How do journal editorial boards determine what to publish? All of these questions relate to the broad topic of scholarship within an academic discipline. Viewpoint bias touches upon many aspects of the scholarship process that surround the cultural competence concept and related areas.

Perceptions of Bias in Academic Fields Sociopolitical views influence scholars' choice of research topics and the perspective that they bring to such research (Gross & Simmons, 2014). Since science ideally involves a self-correction process, homogeneous sociopolitical beliefs that become embedded in one or more fields of research have the unfortunate effect of influencing how research questions are framed and how hypotheses are tested (Redding, 2015). Some of the interviewees commented on the sociopolitical bias that characterized their field's approach to certain topics:

(Interviewee #2) In psychology, the portrayal of the psychology of the left and right is very unbalanced. Do I feel that the research literature misleads audiences? I say YES on many matters concerning race and gender. Sensitivities are so strong, that only a subset of hypotheses can be considered and only certain findings can be published. This is clearest in the areas of stereotypes and prejudice which is clearly one of the largest areas of research in social psychology. It substantially downplays or ignores findings on stereotype accuracy and this continues decade after decade in teaching that stereotypes are false or are exaggerations. The literature generally does not acknowledge that stereotypes are often accurate. This causes a trainwreck in social sciences' efforts to deal with issues of inequality. There is some truth to the notion of an authoritarian personality, but most conservatives don't have it. Much of the research on political personalities is good, but it is just not balanced. It is like doing research with a pervasive breeze blowing to the left, so everything ends up going to the left.

(Interviewee #6) Every topic that I have written about since 1990 fits the category of bias in science. The first time I encountered bias was in my study of post traumatic stress disorder (PTSD). In my opinion, PTSD is a highly politicized diagnosis. It was instigated in large part by psychiatrists who were against the Vietnam war. An element of their passion to enter PTSD into the formal lexicon was to codify that "war is bad." And by inflating the numbers who are psychologically "crippled," which some researchers and clinicians routinely do, they try to drive home the urgency of their political agenda. To be clear, the politics of these psychiatrists aside, PTSD – defined as a fear reaction that persists after stressors are removed – is a very real clinical phenomenon. It can be devastating; though usually it is treatable to various degrees. It became clear to me and some of my colleagues that we were doing veterans no favor by regarding them as victims. The disability system, though well-meaning, locks too many veterans into a life of invalidism. They are not faking symptoms but they have much greater rehabilitation potential than is generally acknowledged.

This interviewee goes on to opine that sociopolitical bias can come from all sides of the political spectrum:

(*Interviewee #6*) *The extent to which there is bias from a political perspective depends on the area. There are some areas in which the politicized agenda comes from the left (e.g., global warming), but other areas in which the politicized agenda comes from the right (e.g., effects of abortion on women's mental health). There is a strain of public health practitioners who think that bigger government can solve most problems and they dominate the field. When it comes to infrastructure, they have a point. But when it comes to other issues, I thought they deployed public health as a smokescreen for social change. For example, they claimed that doctors were racist and that this was the major cause of 'Health disparities'. Health disparities is a phrase that should simply refer to differences in healthcare and health status but instead has come to mean evidence of malign bias. While it is true that minorities as a group, have poorer health status and may have less access to certain procedures, there is no evidence that this is due to "racism" practiced by doctors. This is not to say that an individual doctor might not have his own prejudice but efforts to prove this were weak. Studies confirmed differences in health status but they tended to melt away when socioeconomic factors were taken into account.*

Premature Acceptance of Unsubstantiated Claims The unconstrained vision leads to emotional enthusiasm for ideas that have not withstood empirical scrutiny but instead are oversold to audiences in order to fit popular narratives. When research is dominated by one sociopolitical viewpoint, particularly when such research deals with politically charged areas, it runs the risk of failing to converge upon the truth (Redding, 2015). Two interviewees opine how this applies to the cultural competence movement:

(*Interviewee #3*) *There is not a well developed body of knowledge that we can point to that indicates what we need to do to develop cultural competence.*

(*Interviewee #4*) *There is no evidence that you can train someone to be culturally competent. There is no behavioral evidence. They do experiential workshops where these ideas are only vaguely defined, but they have no evidence based protocols. Then they do self ratings (for example, "do you feel more culturally competent") where if they gain a point or two from pre to posttest they pat themselves on the back for teaching cultural competence. So advocacy for cultural competence is based on a small handful of bad studies that do not generalize to groups outside of the narrow range of groups studied in the research. The shocking thing is that no-one is willing to say that "the emperor has no clothes". If cultural competence advocates can show that cultural competence actually helps people have access to healthcare and makes them*

feel better, I would certainly join them. But they cannot. It is a faith-based movement. It is a secular religion.

On an unnumbered page following the preface of a major text on multicultural counseling competencies, the text authors' qualifications are summarized. On this page, the following is written on microaggression research:

> . . . recent research on racial, gender, and sexual orientation microaggressions has provided a major breakthrough in understanding how everyday slights, insults, and invalidations toward marginalized groups create psychological harm to their mental and physical health and create disparities for them in education, employment, and health care. (Sue & Sue, 2016)

One interviewee discusses how his/her decision to study the concept of "microaggressions" originated from popular campus trends that eventually could not be ignored:

> *(Interviewee #3) I heard the term 'microaggressions' floating around campus. Students were talking about it, and there were a lot of demands from African American organizations. Students wanted the administration to do something about them and went so far as to insist that two items [dealing with microaggressions] be added to student course evaluations [asking whether or not the instructor had engaged in microaggressions]. Then a dean came into one of our faculty meetings to say that one of his initiatives was to train faculty in how to identify microaggressions. The more I read about this, the more I began to see that its claims were running way ahead of the data. As I read more, I became quite concerned about the poor quality of that literature.*

This interviewee goes on to decry how the microaggression concept has been inappropriately promoted far ahead of the data which supports it:

> *(Interviewee #3) [on the topic of microaggressions] I will admit that with society changing very quickly, some people are often insensitive and callous in their comments to one another. There are real racial slights that may be unintentional. But referring to them as aggressive in nature, there is not a shred of evidence that supports this. Many scholars are running around making these claims when there is no evidence for them at all. Yes, people do make racist comments, but let's make the effort to parse these things and not lump them all into one big category. If we constantly tell people that you need to be hurt by this or that statement, then they will eventually feel hurt by them – even if previously they were not hurt by these statements. As psychologists, we can agree that we want to do good by training people on microaggressions, but we don't think about the unintended consequences of what we are doing (i.e., making students more hypersensitive).*

Perceptions of Bias in Grant Application Approval Certain kinds of research can be conducted only if sufficiently funded. Researchers write grant applications in hopes that review panels of granting agencies/bodies approve funding for the proposed project. Two interviewees commented on the viewpoint bias they experienced during this process. Both interviewees commented on the fear, reluctance, unwillingness, or an inability to consider "taboo" hypotheses (see also Inbar & Lammers, 2012):

> *(Interviewee #1) I can give you a very specific example of a grant opportunity that was thwarted, which involved The National Institute of Deafness and Child Disorders. A researcher called me who read my book and said "do you want to find out if kids who are genetically deaf have a higher IQ"? By this time, the technology for finding this out was well developed. I called the granting agency and said that I can get hundreds of subjects for a study of the genetic links to deafness. He told me not to waste my time sending in an application, because the research sounded too much like "eugenics". In essence, they said : We are not going to fund anything that suggests a link between genetics and intelligence. I don't think I was denied the opportunity to compete for other kinds of grants (consultation, restructuring of schools, etc.).*
> (*Interviewee #4*) *I applied for an internal grant but it was not approved by the [campus Institutional Review Board] because I wanted only to study males. At another time, I applied for a rape prevention grant that had females identify high-risk situations and the grant reviews were very, very negative, saying that I was blaming women for their own rape. They said that working with females to reduce their own risk of rape was sexist. I feel that you can work with males also, but this was not our research question – as our question was what can women do in social situations to reduce the chance of rape. I felt that the grant was rejected on purely political grounds. We eventually had to pursue this without grant funding "on the cheap". In my opinion, if we had wrote the grant to be consistent with a leftist ideological position*

(e.g., how females avoid rape in a patriarchal culture, for example) the outcome would have been different.

Viewpoint Bias in Journal Editorial Board Reviews The term *publication bias* is the formal term given to the process where the outcome of an experiment or research study influences the decision (either pro or con) to either publish or distribute research findings (e.g., see Kicinski, Springate, & Kontopantelis, 2015; Peplow, 2014; Rothstein, Sutton, & Borenstein, 2005). Viewpoint bias is exacerbated, in part, by the intentional or unintentional suppression of alternative viewpoints that is instrumentally accomplished through bias in the process of determining which articles will be published or not published in scholarly journals.

Double Standards In many studies of publication bias, the criterion for deciding whether or not to publish a study centers on whether or not a study demonstrates statistical significance. At other times, publication bias occurs due to the pressure to suppress viewpoints perceived as a threat to a professional organization (e.g., see Lilienfeld, 2002). Unfortunately, many scholars document the existence of blatant double standards, rooted in ideological biases, that sometimes influence publication decisions. Double standards, as this concept is applied to the publishing of controversial material in the social sciences, can be defined as the erection of harsh, unreasonable, and sometimes unattainable standards as a condition for the publication of unpopular, unexpected, or divergent viewpoints (i.e., viewpoints that threaten the "status quo") – while at the same time holding considerably more lax publication standards for viewpoints that harmonize with politically fashionable, socially popular, or "politically correct" positions (Deahl, 2017; Gottfredson, 2007; Jensen, 1981).

Certain professional opinions, policy viewpoints, empirical conclusions, and areas of scientific inquiry are politically unwelcome in academic contexts that are committed to promoting comforting narratives to which audiences must conform and accept. Gottfredson (2007) argues that scholars who study controversial topics or hold contrarian opinions than the current zeitgeist are held to blatant double standards from journal editors than would be the case if their research conformed to accepted academic narratives. In her view, journal editors have been surreptitiously applying double standards "for decades" in their decisions to accept or reject manuscripts for nonscientific reasons (p. 217; see also comments from Jensen, 1981, p. 490). One interviewee's comments are particularly illustrative of this observation:

> (*Interviewee #7*) *The articles written with my co-authors were published eventually in reputable journals but were often subjected to what could reasonably be described as very biased and ridiculously negative reviews. In fact, one of my co-authors, shortly before his premature death, was planning a journal article based upon the numerous rejection notices we had received and the content of the reviewers' comments. Although I do not remember specifically many of the reviewers' negative comments, there were frequent implications that we were racists for even questioning the sacredness of the multicultural movement and the validity of the multicultural counseling competencies as well as rather snide remarks regarding our writing skills and general professional competence. I recall that one reviewer recommended that we work with a more experienced author to mentor us through the publication process – despite that fact that, by that time, we had collectively published more than 200 refereed articles and book chapters. My co-author frequently sent manuscripts to individuals who were regarded as leaders in the field of counseling for their input prior to submitting the manuscripts for publication. At an American Counseling Association (ACA) national conference prior to the time our first multicultural article was published, one of these reviewers approached [my co-author] and urged him not to publish the manuscript because of the damage it would do to the multicultural movement. In addition, the American Counseling Association (ACA) published an extensive letter from a prominent multicultural leader in its newsletter that was highly critical of our article and of us for publishing the article. Fortunately, some readers of the newsletter commented on how they considered it rather unorthodox for a professional association to publish a non- refereed comment in its newsletter on an article published in its flagship journal rather than in the journal itself.*

This viewpoint suppression was perceived to occur even after the offending articles were published:

> (*Interviewee #7*) *Another observation is that our articles, despite their importance in presenting an alternative point of view, were rarely cited in the multicultural counseling literature. My co-author and I used to joke about how effective, but unprofessional, this strategy was in stifling alternative viewpoints. It was almost as though multiculturalism had been deemed beyond reproach and that any criticism of the philosophy underlying it or the techniques used to implement it were heretical. Thus, such views should not even be mentioned as they might pollute the minds of fledgling and experienced scholars and practitioners.*

Overall, however, this interviewee reported no significant negative consequences that occurred from his/her reputation as a "contrarian":

> *(Interviewee #7) In addition to articles on multiculturalism, I authored or coauthored a few articles and two chapters with a conservative political emphasis. Although none of these manuscripts, as I recall, was rejected or critiqued based upon its political emphasis . . . Although all of these articles were very controversial, I doubt that my career was damaged in any significant way for writing them. In fact, I was affectionately given the nickname "Dr. Controversy" by one of our former students, and these articles were frequently cited.*

Gottfredson (2007) gives an example of how research discussing non-environmental causes of racial differences in cognitive abilities was rejected outright by journal editors with the rationale that such research must be "absolutely impeccable" in order to be published. Perhaps the most well-known case of viewpoint bias that employed lax publication standards involved the utterly fabricated and nonsensical paper *Transgressing the Boundaries: Toward a Transformative Hermeneutics of Quantum Gravity* submitted by physics professor Alan Sokal to the journal *Social Text*. *Social Text* advertises itself as "a daring and controversial leader in the field of cultural studies . . . [focusing] attention on questions of gender, sexuality, race and the environment, publishing key works by the most influential social and cultural theorists" (see https://www.dukeupress.edu/social-text/?viewby=journal). After the article was accepted for publication, Sokal publically admitted to the hoax, arguing that the incident proved the deterioration of academic standards by left-leaning journals (Editors of Lingua Franca, 2000; see also Enloe, 2017). In a similar observation regarding a fabricated conference presentation supporting multiculturalism, one interviewee recalls:

> (*Interviewee #7*) *During the time period when my co-author and I were writing articles critiquing aspects of the multicultural counseling movement, the leadership of the American Counseling Association was convinced that it would be appropriate if every program or paper session presented at the national conference should include a multicultural component. About the same time, my co-author attended a national ACA conference and left dismayed that such a superficial topic as using flower arranging as a therapeutic technique was on the program. He decided as a spoof to apply for a session at the next national conference that involved using the celebration of Purim, a minor Jewish holiday, as a therapeutic technique. Every part of his proposal was completely made up and patently ridiculous. His purpose was to cover all the bases satirically (i.e., a potentially multicultural topic with a totally ridiculous theme). To his surprise, the program proposal was approved and to his credit he was able to pull the session off with a spirited discussion of the push by some in the Association at the time to promote what was a very controversial, and possibly anti-Semitic, advocacy of the Palestinian position in the Israeli conflict. Although the session was a success, my point here is to illustrate how far the Association, by accepting my co-author's proposal, would go to accommodate its politically correct objectives, even if it meant undermining its intellectual and professional standards.*

Being Offended Becomes a Substitute for Thinking Certain viewpoints exclusively dominate select fields of study because of the conviction that certain groups perceived to be most vulnerable (or those who style themselves as their spokespersons) would be deeply offended should contrarian views be allowed to enter the marketplace of ideas (Gottfredson, 2007).

Several years earlier, this author guest edited a journal miniseries on the topic of "Straight Talk About Cognitive Assessment and Diversity" (see

School Psychology Quarterly, Vol. 14, No. 3). The general "takeaway" from the miniseries was that standardized cognitive tests do not show evidence of statistical bias when used with American-born, English-speaking groups. The natural implication was that test bias is not a defensible explanation for mean differences in IQ scores across American racial/ethnic groups. Shortly after the series was published, the journal editor received an irate phone call from a minority psychologist who occupied a high level position in an APA subdivision. The critic stated how "deeply offensive" the miniseries was and berated the editor for publishing it (T. Gutkin, personal communication, 1999). The editor expressed regret for the offense taken, but extended the offer for the critic to write a response that the editor would be happy to consider for publication - provided that the article passed the normal standards of peer review. Approximately 18 years have passed since this incident, and no article from the critic has been submitted for publication.

When a person claims to be offended by a scholarly position with which a critic disagrees, four objectives are accomplished:

1. The person who has been offended directly is viewed with sympathy as a "victim," which accrues a certain degree of sociopolitical power (see Steele, 2007). Similarly, the person who takes offense on behalf of a group different from his/her own is seen as possessing a deep reservoir of care, compassion, and sensitivity that is so highly developed that it marks them as an exceptionally good, noble, and moral person.
2. It puts the offending party on the defensive and increases pressure on them to recant their views, modify or "soften" their position, or apologize to the offender.
3. It is an intellectually lazy but effective debate tactic that encourages audiences to overlook the fact that the offended party has no confidence in his/her ability to marshal facts and/or evidence to defend an argument, or simply has not grappled with the substantive ideas or facts underlying an argument.
4. It seeks to convince audiences that the offending party's ideas are wrong, dangerous, stupid, or immoral.

All human beings are susceptible to being offended by anything. A quote, attributed to the late conservative William F. Buckley, concisely characterizes this problem: "Liberals claim to want to give a hearing to other views, but then are shocked and offended to discover that there are other views" (Goldberg, 2016). In all fairness, this quote applies to human beings on any side of a controversial issue who allows themselves to be influenced by pervasive groupthink (e.g., see Esser, 1998; McCauley, 1998; Paulus, 1998).

Confronting "Sacred Cows" Prentice (2012) argues that the lack of viewpoint diversity results in an ideological narrowness, where the overwhelming concern in the field centers on "how to measure what everyone knows to be true" (p. 517). This also involves the erection of rigid barriers around favored "sacred cows" (e.g., see Tierney, 2016), the challenging of which must be encouraged in order to advance principled science (Frisby, 2013, Table 10.3, p. 519).

Redding (2012) opines that failure to incorporate diverse perspectives inevitably leads to research that is "faddish" and will ultimately fail to stand the test of time. As one example, school psychology was enamored in the 1980s–1990s with "alternative assessments" to standardized IQ testing. The alternative assessment narrative portrayed IQ (intelligence) tests for English-speaking racial/ethnic minority children as being seriously "biased," with alternative testing being touted as the "wave of the future" that would inaugurate a new era of nondiscrimination and fairness to racial/ethnic minorities in a culturally diverse society (e.g., see Feuerstein, Rand, & Hoffman, 1979; Haywood & Switzky, 1986; Jones, 1988; Samuda, 1975; *School Psychology Review*, Vol. 6, Issue 3; Vol. 8, Issue 1). This thinking ultimately resulted in the statewide ban of IQ testing in special education decision-making for African-American students in the state of California in the mid-1980s (which has continued to this day) for the purpose of reducing disproportionalities (see Frisby & Henry, 2016). In the enthusiasm that accompanied these efforts to bring social justice to testing, contrarian voices that urged caution, restraint, and a more sober evaluation of the

psychometric literature went largely unheeded (e.g., see Frisby & Braden, 1992; Gordon & Rudert, 1979; Jensen, 1980).

Assessment methods such as the *System of Multicultural Pluralistic Assessment* (SOMPA) and the *Learning Potential Assessment Device (LPAD)*, at one time touted as the "solution" to test bias in the school psychology literature, have all but disappeared from the scene. At the time of this writing, there has been no credible evidence that has demonstrated statistical or cultural bias in frequently used IQ tests for American-born, English-speaking persons (Gottfredson, 2005; Jensen, 1980; Reynolds & Lowe, 2009), and black students continue to be overrepresented in proportion to their numbers in classes for intellectual disabilities in California despite not taking IQ tests for close to three decades (Frisby & Henry, 2016). Yet this has resulted in no appreciable self-examination among IQ test critics, who continue the tests-are-biased-against-minority-children narrative (Motulsky, Gere, Saleem, & Trantham, 2014; Reese, 2013; Young, 2013) or continue to portray the issue of racial/ethnic test bias as an "open, unsettled controversy" (Ford, 2008; Valencia & Suzuki, 2001).

Popular concepts such as "stereotype threat" (Steele & Aronson, 1995) and "racial microaggressions" burst on the psychology scene with much fanfare as "hot topics," only to see this enthusiasm become more muted as patient, painstaking research uncovered serious conceptual and empirical flaws (Ganley et al., 2013; Jensen, 1998; Lilienfeld, 2017; Sackett, Hardison, & Cullen, 2004; Wei, 2009).

Tetlock and Mitchell (2009) argue for scholars to adopt the principle of *adversarial collaboration*, where researchers conduct multimethod research with other scholars who hold differing ideologies in the spirit of "ensuring unbiased policy-relevant research" (Redding, 2012, p. 514). This can be accomplished by researchers taking the time to understand the worldviews of those holding opposing viewpoints (e.g., see Haidt, 2012). One interviewee's statement concisely summarizes the attitude of all of the anonymous interviewees on the topic of publishing contrarian viewpoints in the face of hostile opposition:

> (*Interviewee #5*) *We need to say what needs to be said although no one is listening.*

Consequences of Viewpoint Bias for Professional Organizations

Redding (2001) has argued that the lack of viewpoint diversity in organizations such as the American Psychological Association damages the credibility of psychology in the eyes of the broader public as an intellectually honest science. When members of professional organizations become aware of viewpoint bias within its ranks, the natural first response is to attempt to form subgroups within the organization consisting of members that share similar viewpoints. This is not always successful, however. When ideological schisms are so sharp, contentious, and fundamental, members break away and form new organizations. This occurred with the formation of the Association for Psychological Science (APS) as a breakaway group from the American Psychological Association in 1988 (Cautin, 2009a, 2009b).

In a similar fashion, many of the interviewees expressed dissatisfaction with the professional organizations in which they formerly held memberships. This eventually led them to terminate their memberships as a consequence of a deep discomfort with what they perceived as excesses of the unconstrained vision within the organization:

> *(Interviewee #4) I got an offer to be in the International Academy of Sex Researchers because by that time I had a certain amount of publications. I quickly noticed that this academy followed an implicit agenda to "make everything normal" – this was in the late 1980s and early 1990s when gay and transgender issues were coming to the forefront in academia. I felt like a stranger in a strange land when I would go to these meetings. They would often be inappropriate. There was one prominent gay male researcher that talked openly about "liking the taste of sperm in his mouth" – and everyone was supposed to laugh and be*

accepting of this. If a heterosexual had talked the same way openly about these sorts of things, it would definitely be regarded as inappropriate. So I was in this organization for a few years and there was this guy that ran a pedophilia journal out of the Netherlands which he said was devoted to overcoming the last bias in society, which is "intergenerational sex". He is openly gay and is for adult male/young boy sexual interactions. His point was that previous research conflated boys who were raped by older men with boys who had consensual relationships, and that when you disentangle this data, you will find that the boys who had consensual relationships had positive experiences with older men. He ran for president of the organization, and I voted against him – but he was elected anyway. I resigned, and wrote a letter detailing the reasons why, and I was shocked that an organization would elect a person who advocated pedophilia as legitimate. I think I was the only person who resigned from this organization out of 150 members or so.

(Interviewee #1) The two examples I have about bias in professional organizations don't look particularly good for the National Association of School Psychologists (NASP). Shortly after the Bell Curve was published, I went to the president of NASP (an African American woman) with a proposal to do a symposium on the Bell Curve. Although the proposal had been turned down by the program committee, to her credit she approved it. They scheduled us for the last day of the convention in a hard to find small room. There were so many attendees, that they spilled out into the hallway. The other example that leaves the most bitter taste in my mouth was about three years ago when I was asked to serve on a task force on disproportionate representation on school discipline. There was a contingent of west coast persons who were "true believers" in Positive Behavior Support that were going to argue that any racial differences were evidence of discrimination. I told them that I am only going to participate in this task force if we put on the table that group differences in and of themselves is not prima facie evidence of bias. I am not saying that there ISN'T bias in school systems, but only saying that we must hold open the possibility that, as scientists, groups may differ. We have to be agnostic to the idea that some groups may have higher rates of misbehavior that runs afoul of school discipline. I made this argument early, and often, and after about a year I was told that I was no longer on the committee. I have very mixed feelings about NASP. I am consistently disappointed with how reluctant we are as a professional organization to bring in the science. I think NASP is more of a guild than it is a scientific organization. They are not a source of knowledge or new ideas, but are a source for controlling the means of production. [They believe that] If we convince all of the programs to use our standards in order to be accredited, then we gain control over entry into the profession. NASP does not draw on science to inform public debate to advance understanding.

(*Interviewee #3*) *I think the American Psychological Association (APA) has dug its own grave a bit by taking political stances on controversial issues. They have gotten a bad rap on Capitol Hill because they take liberal positions on policy issues and a lot of conservatives trash APA by saying "there APA goes again". I would argue the same thing about gay marriage. While I am personally for gay marriage, I think APA should stay out of taking a position on it. I believe that the job of APA is to get out the best data. One of the reasons I left APA for APS (Association for Psychological Science) is because I did not feel that APA was committed to science.*

(*Interviewee #4*) *I resigned from APA a long time ago. I have said in my writings that APA takes political positions on topics in which they have no expertise. And their political positions are all forged from a leftist ideology. They would argue that abortion has no negative effect on women, and I would argue that this was not true. Second, APA never deals with the fundamental argument that abortion is the killing of a baby. They want to present it as a settled scientific matter, which is misleading to the general public – so I resigned from the APA.*

Consequences of Viewpoint Bias for Training Programs

Ponterotto and Austin (2005) opine that the critical importance of training psychologists and mental health professionals for work in an increasingly multicultural society – at least at the time of their writing – "is now unquestioned" (p. 19). They further state that "continuing demographic transitions and evolving mandates of professional accrediting bodies *demand* (emphasis mine) that all mental health training programs address multicultural issues" (p. 19).

Fair enough. However, this statement must be properly understood and evaluated in light of certain bedrock principles. Namely, the ultimate purpose of a training program in applied psychology is to take advantage of the best scholarship in order to accurately understand reality, and then to prepare preservice practitioners for that reality after they graduate (Frisby, 2013).

Within academia, advocacy for particular viewpoints and training methods is acceptable, provided that it is based on a solid and reliable body of findings that have been empirically validated (Zane, Bernal, & Leong, 2016). In short, sick human beings *want* physician training programs to advocate for treatments that have shown to be effective in ameliorating certain kinds of diseases. When advocacy movements are not based on a consistent, reliable, and/or widely validated pattern of converging conclusions from rigorous empirical investigations – or when the conclusions from an established stream of reliable research *contradicts* an advocacy movement – then advocacy movements are little more than vehicles for propaganda. Cultural competence "training" becomes sociopolitical "indoctrination." Ultimately, propaganda has no relationship to solving actual problems or meeting human needs in the real world.

Cultural competence advocacy in applied psychology is rooted in implicit narratives that are rarely, if ever, explicitly challenged (Redding, 2012):

> The first assumption is that people's physical traits and cultural background are central to their personal identity, influencing their view of themselves, their world, and their interpersonal relationships. The second assumption is that people frequently suffer discrimination due to such characteristics. The third assumption is that with demographic diversity comes a diversity of life experiences, values, and ideas, which produces benefits for learning and scholarship. (p. 513)

One interviewee offers a devastating indictment of the "skin-color-equals-identity" mind-set that dominates many institutions of higher learning:

> (*Interviewee #4) In my professional life, I have had more minority students work with me and be happy about it than any other faculty member – and I attribute this to my conservative political views – because I don't view these individuals as racial "tokens", but view them as individuals and treat them as I would treat anybody else. I graduated the only African- American student from our clinical program, and I have the only African-American student in our clinical program lab. I have a lot of Hispanic students that work with me. I have a lot of gay friends. My students will often say to me "I like the way you treat me as a person, rather than as a Latina first and a person second". I think people see and appreciate honesty in who I am. That is, they hear my point of view, and they don't suspect that I have another agenda. My minority students will often say to me, "I find my liberal professors prejudiced, because they expect me to conform to a stereotype. They expect me to do ethnic research because I am an ethnic minority." In contrast, I ask all my students "What do you want to do research on?" These liberal professors seem to think that demographics is the only part of students, or at least a big part. I know one [liberal professor] who would view her minority students as if they were "badges of accomplishments" for her. They act as if to say "I am a good person, I can teach about cultural competence because I have four Latinas in my lab and we do Hispanic research". Students think "Am I here because of merit, or am I here because I am some sort of affirmative action token". I think this issue is huge psychologically. I think the cultural competence movement is contrary to Martin Luther King's "content of your character".*

One can add to Redding's (2012) three assumptions two additional implicit assumptions, which are (4) demographic diversity is directly linked to differences in how individuals experience and cope with health, mental health, and psychological problems, as well as differences in the interventions needed to address such problems; and (5) there is a body of well-developed and empirically validated skills, techniques, and interventions – specific to race or ethnicity – that can be learned and effectively implemented by psychologists who do not belong to the racial/ethnic group of their clients.

Unfortunately, interventions based on these assumptions do not always reliably accomplish the miraculous outcomes as originally advertised (Isaacson, 2014; Weissberg, 2008) and sometimes lead to negative consequences (Satel & Forster, 1999). Furthermore, positive outcomes often result from clients' adherence to principles that transcend the control of applied psychologists (Wang & Wilcox, 2017), and some interventions that have nothing at all in common with the assumptions of cultural competence advocacy are nevertheless shown to be effective (Fisher & O'Donohue, 2006; Frisby, 2013; Howard, Sentell, & Gazmararian, 2006; Kountz, 2009; Saha, 2006; Whitman, 2008). Hollis (2017) writes:

> Academia is not called the 'ivory tower' for no reason. Many academics work in blissful isolation. Unlike businesses, they do not have to persuade the consuming public of the merits of their views. They themselves do not suffer the consequences of espousing false or damaging ideas. They are rarely called out for promoting failed ideologies . . . Unlike the American system of government, where political viewpoints do battle almost daily for public support, academic views suffer precious little comparable challenge; the predominance of left-wing politics in academe means that faculty tend to operate in a climate where much of what they believe is reinforced by the shared views of those around them.

This illustrates the central dilemma of fields that are dominated exclusively by the unconstrained vision. That is, those training programs most in need of exposure to research representing the constrained vision are the *same programs that are likely to be the most hostile to it.* One interviewee opines*:*

> (*Interviewee #4*) *We are supposed to be teaching young students to think critically and be exposed to diverse viewpoints. The assumption is that, if you learn these things (the nature of epistemology, critical thinking, the nature of man, etc.), you will function better in life. Unfortunately, a 19-20 year old has not grasped these things yet. When universities don't teach a classical approach to a liberal education, they are more vulnerable to superficial analyses where they see themselves as little more than members of groups and victims that need to engage in political activities to get what they want.*

Microaggressions Research: The Basis for Sound Training or Social Wreckage? Although the term "microaggressions" was first coined by Chester Pierce (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978), in contemporary times the term has been popularized by Professor Derald Wing Sue (Sue & Sue, 2016). In a presidential address to the Division 17 Society of Counseling Psychology of the American Psychological Association, Sue set the stage for the importance of microaggressions when describing "insidious, damaging, and harmful forms of 'everyday' racism perpetuated by ordinary citizens who believe they are doing right" (Sue, 2005, p. 108). More recently, Sue and Sue (2016) defined microaggressions as "brief, everyday exchanges that send denigrating messages to a target group, such as people of color; religious minorities; women; people with disabilities; and gay, lesbian, bisexual, and transgendered individuals" (Sue & Sue, 2016, p. 183). Sue and Sue (2016) describe microaggressions as displayed "automatically and unconsciously" and being "subtle in nature," which in turn can be manifested in the verbal, nonverbal, visual, or behavioral realm (p. 183). Lilienfeld (2017) reports receiving 511,000 hits from a Google search using the term "microaggression" as of November 2016. In a review of the microaggression literature up until 2013, Wong, Derthick, David, Saw, and Okazaki (2014) identified over 70 journal articles, dissertations, and theses on the topic of "racial microaggressions" that were published since Sue et al.'s (2007) seminal *American Psychologist* article. Lilienfeld (2017) reported finding over 3000 manuscripts that contained the term "microaggression" as a result of a Google scholar search from 2007 (when Sue et al.'s article was published in the *American Psychologist*). In that article, Sue et al. (2007) presented a more detailed taxonomy of, and research agenda for, racial microaggressions.

Consistent with the unconstrained vision, audiences are told that studying racial microaggressions "may open important dialogue on differences in racial realities and help to minimize race-related tension," as well as assist clinicians in "understanding how racial minorities are negatively affected at the individual level" (Wong et al., 2014, p. 192). However, Wong et al. (2014) acknowledge that, at least at the time of their review, it remains "difficult to determine whether racial microaggressions actually cause negative health outcomes and, if so, through what mechanisms" (p. 193).

According to Sue et al. (2007), microaggressions inadvertently occur within clinical practice, particularly when the therapist is white and clients are nonwhite. When this happens, microaggressions are unrecognized by white therapists. In addition, clients of color are put into a psychological dilemma that has the potential to "result in psychological harm" from "pent up anger and frustration [that is] likely to take psychological

and physical tolls" (p. 279). The purpose, therefore, of microaggressions training for cultural competence is so that whites can "accept responsibility for their behaviors and [change] them" (p. 279).

Does microaggression theorizing and research lead to a greater degree of enlightened sensitivity among clinicians and improved therapeutic outcomes for racial minorities, as predicted by the unconstrained vision? The answer appears to be more consistent with the assumptions underlying the constrained vision, in that the microaggression concept has been shown to be (1) "half-baked" conceptually, (2) insufficiently supported empirically, and (3) prone to leave social wreckage in its wake when applied to real-world situations.

First, Lilienfeld (2017) raises troubling questions about the lack of definitional clarity in the term "microaggressions," arguing that its ambiguity, subjectivity, inherent contradictions, and porous boundaries do not "permit adequate scientific progress" (p. 143). Lilienfeld provides several direct quotes, some from supporters of the concept, that this lack of conceptual clarity "[renders] it difficult or even impossible to ascertain whether they have actually occurred" (p. 144). At a deeper level of analysis, Lilienfeld argues that the microaggression research program adopts a model of racial prejudice that is widely considered to be outdated and "inconsistent with large bodies of literature in social and health psychology" (p. 147).

Second, Lilienfeld further shows that no objective evidence exists linking specific microaggressions to implicit "messages," no data exists that identifies exact proportions of hearers who interpret specific microaggressions with their presumed implicit messages, no data which verifies that microaggressive statements originate from aggressive impulses, no longitudinal data linking experiences of microaggressions with adverse mental health outcomes, and no attempts at test construction that adheres to already established psychometric principles for construct validation – among numerous other difficulties.

Despite these long-standing problems, microaggressions are accepted as a validated construct in medicine, government, business, and on college campuses (Lilienfeld, 2017). As examples, fear of microaggressions is cited as justification for why patients should choose medical doctors of their own race/ethnicity (Hardy, 2017). Workshops and lectures on microaggressions net lucrative speaking fees (Hasson, 2015), and universities offer classes that purport to teach students how to detect and respond to microaggressions (Tidwell, 2017).

The practical consequences in society that arise from belief in microaggressions have been chilling. One college encourages its students to report microaggressions to campus officials (McGrady, 2016). According to published reports, the content of microaggressions can include, but not be limited to, a white person singing a pop song originally sung by an African-American artist (Starnes, 2016), saying "America is a melting pot," "America is the land of opportunity," or "There is only one race, the human race" (Lopez, 2016). Microaggressions are thought to occur automatically when students of color walk into or sit in a classroom full of white people (Timpf, 2015).

A disc jockey was fired from his job for refusing to stop playing a song containing a lyric that upset a woman (Oehmke, 2017) – which was seen as committing a microaggression. A university approved segregated housing for black students in response to student demands to be protected from microaggressions (Beaman, 2016). A group of students at another college demanded that campus officials create a permanent resource center, create two new "diversity" administrative positions, and create a general education requirement for ethnic, racial, and sexuality theory – all for the purpose of educating the student body about "microaggressions felt by students of color" (Oh, 2015). A nationwide focus on microaggressions was offered as one of many justifications for racially and ethnically separate graduation ceremonies at one elite academic institution (Levenson, 2017). The presence of microaggressions on campus was used as one among many justifications for a racially exclusive student lounge banning whites (World Net Daily, 2017a, 2017b). A black woman in the

United Kingdom started a website where whites can offer cash and various services to people of color in order to relieve their sense of white privilege and guilt over perceived microaggressions they may have committed (Graham, 2016).

Theory Versus Reality? Failure to consider the constrained vision confirms the worst stereotypes about those who view life exclusively through the lens of the "ivory tower." Here, training programs run the risk of becoming little fiefdoms that reflect the pet sociopolitical agendas of training directors and program faculty. When preservice psychologists in training are given a choice between embracing theories from the unconstrained vision versus documented effective practices from the "real world" that may contradict principles from the unconstrained vision, they will most often choose the theoretical world of the unconstrained vision (see Frisby, 2013, Table 2.2, pp. 62–3).

Students graduate with an impressive knowledge of theory, but with no clue as to how to function in real-world environments. Practicums and internships are ideally supposed to address this issue, yet for some training programs, this is "too little too late." As one example, when graduate students in school psychology reviewed a textbook containing educational practices documenting tangible benefits and positive outcomes for minority students in schools, the textbook was mocked for not including the latest theories about minority students and schooling (Worrell, 2015).

This disconnect from reality is effectively illustrated by an iconic scene from the 1993 movie *Jurassic Park*. The movie tells the story of a wealthy industrialist who attempts to convince two skeptical paleontologists to endorse a potential theme park situated on a remote island that is stocked with real dinosaurs that have been cloned using blood extracted from fossilized mosquitos. In an epic scene, the paleontologists drive to an open field where the female paleontologist (who is a paleobotanist in the movie) excitedly discovers and gushes over a leaf on which there are imprints of small prehistoric animals. At the same time, the male paleontologist is stunned to see an approximately 70-foot-tall brontosaurus that has not yet been spotted by the female paleobotanist – who is still focused intently on the leaf. Though speechless, the male paleontologist has to physically turn the female paleobotanist's head away from her concentration on the leaf toward beholding the magnificent sight of a real brontosauras (see https://www.youtube.com/watch?v=PJlmYh27MHg).

In the same way, students enrolled in school psychology programs who are enamored with ivory tower theories about minority children must recognize that there are real-life educational environments that demonstrate clear, tangible academic results for low-income racial minority students coming from troubling and challenging backgrounds (e.g., Center for Research on Educational Outcomes, 2013; Chenoweth, 2008, 2009; Leader, 2008; Whitman, 2008). Paradoxically, most of the exemplary academic programs for minority children owe their success to principles that *contradict* the unconstrained vision of how academic success is supposed to happen. Even the most liberal/progressive cities in the country have school systems that experience serious problems with the overrepresentation of black students being suspended, embarrassing racial academic achievement gaps, and entrenched racial tensions (Dugdale, 2015; Hoge, 2005; Klein, 2009; Levin, 2009; Noguera & Wing, 2006; Oakley, 2013; Varon, 2014). In the face of these stark realities, how would knowledge of "microaggressions theory" or "cultural identity theory" enable school psychologists to understand how to approach such problems in any practical sense?

Instead of teaching students abstract theory, then hoping that it would be effective in real-life environments (consistent with the unconstrained vision), the constrained vision would favor the focused study of what appears to work (or not work) in real-world settings – *then* derive principles that can be studied in more detail in university settings. On this point, one interviewee opines:

(*Interviewee #6*) *[Clinicians who conduct research] are on the intellectual "front lines", and have clinical backgrounds that prepare them to ask relevant questions and thus they generally inspire more pragmatic research in my view. Those who don't interact with patients are coming, too often, from theory or naïve expectations and sometimes get defensive, in my experience, because they know they are at a disadvantage.*

This interviewee goes on to report how his/her experiences shaped current impressions of how opposing visions (do or do not) integrate abstract theory versus cold reality:

(Interviewee #6) I did a health policy fellowship in Washington, where you are assigned to work with someone on the Hill. At first, I never thought in terms of 'right versus left'. There were six of us, and everyone but me it seemed wanted to work with Rockefeller. Every one wanted to work with Democrats. When they asked if anyone wanted to work with a Republican, I said I would. They assigned me to a very moderate Republican – an absolutely wonderful Senator from a Midwestern state. That was the beginning of my education and my exposure to the policy culture wars. I worked on mental health legislation. Some of these people [with severe mental illnesses] are very violent, and no one wanted to hear this (for example, those on Kennedy's team). The people on the staff for the senator I worked for were just more open minded, but those on the other side of the political spectrum were much more sure of themselves and reluctant to compromise. In my personal experience during the fellowship year, those on the right were much more compassionate, whereas the people on the left were less pragmatic and more devoted to protecting civil liberties no matter the cost to real people who are suffering from psychotic illness. The staff in the Democrat's office – the ranking Senator at the time – insisted that you cannot abridge somebody else's freedoms. But when you see a mentally ill person freezing their limbs off outside in the park, what are you supposed to do? There is always going to be a certain percentage of people that are too psychotic . . . the other side believes that if we just had "enough housing", it would solve the problem. More housing is good, but there is a certain percentage of people who need more direct and coercive intervention in the short term if they are to get better. Benign paternalism, it seemed, was most acceptable to our counterparts on the left if it was in the service of nanny-state-ism. It seemed backwards: they were comfortable telling rational people how to live but reluctant to impose much-needed structure on people so vulnerable [that] they could barely protect themselves.

Conclusion

Cultural competence advocacy in applied psychology overwhelmingly reflects assumptions rooted in the unconstrained vision (Sowell, 1987). As the proverbial fish is not consciously aware that it is wet, militant cultural competence advocacy is not often consciously aware of its central guiding assumptions – most or all of which are *not* shared by many students, colleagues, or even the clients for whom they hope to serve. This vision places great faith in the deep insight, recuperative powers, and/or near perfectibility of human nature, the ability and wisdom of select experts to deeply understand social problems and how to solve them, and faith in the ability of professional organizations, task forces, and "blue ribbon panels" to create programs that would lead mankind to the promised land of social justice. Although this author is not so naïve as to expect all readers to easily abandon these beliefs, the purpose of this chapter is to sensitize readers to the existence of other viewpoints that may stimulate questions, thinking, and further debate. Improving the psychological, health, and mental health outcomes of diverse populations are certainly worthy goals; however there are a variety of paths to take that would help applied psychology to address these issues. In closing, Jussim (2012, p. 506) asks an important question, the paraphrased version of which effectively serves to challenge readers who may remain unconvinced by the arguments and observations presented in this chapter: what would *disconfirm* your belief that multicultural and cultural competence research in applied psychology are objective fields whose conclusions are entirely untainted by sociopolitical biases?

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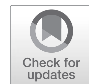
Part III

Conceptual Difficulties/Challenges from the Perspective of Related Disciplines



10 Conceptualizing Culture and Its Impact on Behavior

Helen Spencer-Oatey and Vladimir Žegarac

Introduction

This chapter explores the interconnections between culture and behavior. Although the concept of culture is intuitive, it is complex and defies definition. The complexity of culture and the importance of its role for explaining the structure of social groups – and the behavior of individuals as members of social groups – are reflected in the vast number of definitions which have been proposed (see Kroeber & Kluckhohn, 1952, Baldwin, Faulkner, Hecht, & Lindsey, 2006). However, human behavior is influenced by numerous diverse factors and, as Triandis (1994, p. 2) points out, "Although culture shapes social behavior, it is not the single most important factor." So our goal is *not* to try to use cultural factors to predict behavior; such an approach is bound to fail, because behavior will always result from numerous influences (see the seminal work of Lewin, 1935, 1951; see also Wolf, 1986) – some spontaneous and dynamic, others expected and anticipated. Despite this, at an experiential level, many sojourners report going through culture shock or having difficulty understanding "the cultural other." It is important, therefore, to grapple with this complex and challenging issue.

Of course, the interrelationship between culture and behavior can be two-way; in other words, behavior can have an impact on culture, as well as culture having an impact on behavior. To give but one example, the spreading and acceptance of the belief that fresh fruit and vegetables are healthy (a cultural beliefs) lead to the design, production, sales, and widespread use (cultural behavior) of various gadgets (such as blenders and juicers) which facilitate and otherwise enhance the consumption of fresh fruits and vegetables and contribute to the dissemination and strengthening of the belief that eating fresh fruit and vegetables is beneficial. The smaller the size of the cultural group, the greater the likelihood and speed in which this two-way impact will occur. In this chapter, however, we focus on the potential impact of culture on behavior, not vice versa.

The chapter is divided into three parts. Part I discusses how culture and behavior have been defined and conceptualized and thereby lays important foundations for the following sections. Part II turns to the main focus of the chapter: how culture may influence behavior. It examines three key perspectives on the issue: the impact of values and beliefs, the impact of norms, and the impact of schemas. Part III considers applications of the discussion. It offers

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some practical advice on interpreting culturally unfamiliar behavior. Our stance is this: while there are too many influencing factors to be able to predict the impact of culture on behavior, it is certainly possible to grow in understanding and acceptance of unexpected behavior by being sensitive to (and mindful of) the range of cultural factors that can influence ongoing interaction. We attempt in this chapter to lay that foundation. We end with a brief discussion of the challenging issues that still need further research and theorizing.

Part I: Conceptualizing Culture and Behavior

Defining Culture

"Culture" is an intuitively meaningful concept while also being difficult to define. People generally have clear judgments about whether particular objects, behaviors, relationships, beliefs, and so on are cultural, and yet the concept itself is extremely illusive. Numerous different definitions have been proposed, yet they often focus on different aspects

Table 10.1 A range of definitions of culture

Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; cultural systems may on the one hand be considered as products of action, on the other, as conditional elements of further action. Kroeber and Kluckhohn (1952, p. 181; cited by Berry, 2004, p. 168)
Man is an animal suspended in webs of significance he himself has spun. I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law, but an interpretive one in search of meaning. Geertz (1973, p. 5)
Culture is to society what memory is to the person. It specifies designs for living that have proven effective in the past, ways of dealing with social situations, and ways to think about the self and social behavior that have been reinforced in the past. It includes systems of symbols that facilitate interaction (Geertz, 1973), rules of the game of life that have been shown to "work" in the past. When a person is socialized in a given culture, the person can use custom as a substitute for thought, and save time. Triandis (1989, pp. 511–2)
To study culture is to study ideas, experiences, feelings, as well as the external forms that such internalities take as they are made public, available to the senses and thus truly social. For culture, in the anthropological view, is the meanings which people create, and which create people, as members of societies. […] on the one hand, culture resides in a set of public meaningful forms […]. On the other hand, these overt forms are only rendered meaningful because human minds contain the instruments for their interpretation. The cultural flow thus consists of the externalizations of meaning which individuals produce through arrangements of overt forms, and the interpretations which individuals make of such displays – Those of others as well as their own. Hannerz (1992, pp. 3–4)
Culture consists of the derivatives of experience, more or less organized, learned or created by the individuals of a population, including those images or encodements and their interpretations (meanings) transmitted from past generations, from contemporaries, or formed by individuals themselves. T. Schwartz (1992b; cited by Avruch, 1998, p. 17)
...the set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each individual, communicated from one generation to the next. Matsumoto (1996, p. 16)
Culture is the evolving way of life of a group of persons, consisting of a shared set of practices associated with a shared set of products, based upon a shared set of perspectives on the world, and set within specific social contexts. Moran (2001, p, 24)
Project GLOBE defines culture as "shared motives, values, beliefs, identities, and interpretations or meanings of significant events that result from common experiences of members of collectives and are transmitted across age generations." House, Hanges, Javidan, Dorfman, and Gupta (2004, p. 15)
Culture is a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioral conventions that are shared by a group of people, and that influence (but do not determine) each member"s behavior and his/her interpretations of the "meaning" of other people"s behavior. Spencer-Oatey (2008, p. 3)
Culture is always manifested in a system of orientation typical to a country, society, organization or group. This system of orientation consists of specific symbols such as language, body language, mimicry, clothing and greeting rituals and is passed on to future generations from the respective society, organization or group. This system of orientation provides all members with a sense of belonging and inclusion within a society or group […]. Culture has an influence on the perception, thought patterns, judgment and action of all members of a given society. Thomas (2010, p. 19)

of what we understand by the word "culture," thereby offering complementary rather than mutually exclusive perspectives. A comparison of some of the definitions of the term "culture," as shown in Table 10.1, illustrates this observation.

Intuitively, each of these definitions leaves something to be desired. In combination they seem to cover three or more types of definition: compositional (in that they involve listing what is part of culture, e.g., Kroeber & Kluckhohn, 1952), functionalist (in stating something about the role culture plays in society, e.g., Triandis, 1989), and theoretical (as they are given in terms of hypothetical constructs within a given discipline, e.g., Geertz, 1973). Yet each of these aspects has weaknesses. The lists in compositional definitions are almost certainly not exhaustive, because it is always possible to find something that is part of culture which has not been listed and it is not entirely clear what the criteria used for taking some aspects of culture(s) to be definitional might be. Claims about the function(s) of culture in society are not supported by observations about the mechanisms by means of which these functions are performed, and, although Geertz"s (1973) definition is theoretical, it is only implicitly so, being stated in the form of a metaphor ("webs of significance") while explicitly rejecting the possibility of a general theory of culture on the grounds that culture cannot be explained in terms of general laws. Table 10.2 illustrates how the various characterizations draw attention to these different definitional foci.

Since the focus of this chapter is the impact of culture on behavior, we start by exploring some of the key issues associated with the conceptualization of culture, inherent in definitions such as those above, that are fundamental to our subsequent discussion.

Fundamental Issues Relating to Culture

The Composition of Culture There have been numerous attempts to specify the wide range of elements that make up culture, and, as mentioned above, a fundamental problem is the exhaustiveness of their characterizations. Some people have attempted to address this issue by making broad distinctions. For example, Triandis (1972) made a fundamental distinction between objective and subjective culture: the concrete and observable elements (e.g., artifacts) versus the invisible, perceptual aspects of culture. He unpacked the latter as follows:

> Subjective culture includes how events are categorized and named (language), associations among the categories, norms, roles, particular kinds of self-concepts, and values. Triandis (1994, p. 23)

In the *World-Readiness Standards for Learning Languages*, produced by the American Council on the Teaching of Foreign Languages (ACTFL, 2015), there is a slightly more detailed grouping: culture as products, practices, and perspectives. Moran (2001) expounds on this grouping, and we provide a paraphrase of his interpretations in Table 10.3.

These three angles on the composition of culture are usually closely interrelated, as the example of food can illustrate. Different regions have local or speciality food dishes (products); customs develop around what utensils (e.g., knife and fork; chopsticks) "should be" used for eating such food (practices); people are influenced over who sits where at the dinner table, and who serves whom, by their beliefs about roles and the relative importance of hierarchy (perspectives).

According to Kecskes (2014, p. 90), most intercultural theorists are really referring to subjective culture when they talk about culture. This is a point supported by Banks (2010) who argues as follows:

> Most social scientists today view culture as consisting primarily of the symbolic, ideational, and intangible aspects of human societies. The essence of a culture is not its artifacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies. People within a culture usually interpret the meaning of symbols, artifacts, and behaviors in the same or in similar ways. Banks (2010, p. 8)

Table 10.2 Different foci of definitions of culture

	Compositional	Functionalist	Theoretical
Kroeber and Kluckhohn (1952)	✓		
Geertz (1973)			✓
Triandis (1989)		✓	
Hannerz (1992)		✓	
T. Schwartz (1992b)	✓		
Matsumoto (1996)	✓		
Moran (2001)	✓		
House et al. (2004)	✓		
Spencer-Oatey (2008)	✓	✓	
Thomas (2010)	✓	✓	

Table 10.3 Moran"s (2001) manifestations of culture

Products	These are the "concrete" or "codified" aspects of culture. They include physical objects such as buildings, clothes, furniture, and equipment and how they are arranged (e.g., interior design of a room). They also include less tangible aspects, such as the language code – the words, sounds, and grammar of a language
Practices	These are the regularities of behavior that we display, such as driving on the left side of the road and shaking hands or bowing when we meet someone new. They include our common patterns of speaking – the ways in which we use the words, sounds, and grammar of our language, such as how we typically introduce people or engage in small talk. These practices reflect the rules, conventions, and norms of the social group in which we are interacting
Perspectives	These are the deep-seated and often unconscious attitudes, values, and beliefs that we hold about life, such as respect for elders, the need for modesty, and the importance of independence and self-sufficiency

These words of Banks seem to relate subjective culture to both perspectives and practices (using Moran"s terminology). Perspectives are clearly an aspect of subjective culture, but what about practices? Cultural practices, of course, are behaviors and so of crucial relevance to the focus of this chapter. However, not all behaviors are reflections of cultural practices. As indicated in Table 10.3, the key issue here is regularities or, more specifically, the regularities that occur within a social group. This leads us to the next two fundamental issues associated with culture: social groups and sharedness.

Culture and Social Groups A thread (sometimes implicit) running through all of the definitions given in Table 10.1 is that culture "belongs" to people – both individuals and social groups/collectives. Unfortunately, culture is all too often associated only with nations, but as Avruch (1998) explains, this is much too simplistic.

> Individuals are organized in many potentially different ways in a population, by many different (and cross-cutting) criteria: for example, by kinship into families or clans; by language, race, or creed into ethnic groups; by socio-economic characteristics into social classes; by geographical region into political interest groups; and by occupation or institutional memberships into unions, bureaucracies, industries, political parties, and militaries. The more complex and differentiated the social system, the more potential groups and institutions there are. And because each group or institution places individuals in different experiential worlds, and because culture derives in part from this experience, *each of these groups and institutions can be*

> *a potential container for culture*. Thus no population can be adequately characterized as a single culture or by a single cultural descriptor. As a corollary, the more complexly organized a population is on sociological grounds (class, region, ethnicity, and so on), the more complex will its cultural mappings appear. This is why the notion of "subculture(s)" is needed. [Italics in the original] Avruch (1998, pp. 17–18)

Holliday (2000) goes a step further and argues that "the social world is made up of a seamless melange of human groupings, any of which (families, classrooms, teachers, students, schools, drinks queues) may be characterised and understood as small cultures."

Schwartz (2011) offers yet another perspective on this complex issue. He argues that every individual is exposed to the press of culture in unique ways, because of their different locations in society and simultaneous membership of different social groups. These experiential differences, combined with biological factors, give rise to noticeable individual differences even in the cultural patterning of members of the same social group. This brings us to the next fundamental question: the question of sharedness.

Culture and Sharedness One of the most challenging issues associated with conceptualizing culture is the notion of sharedness. In other words, to what extent are the various compositional elements of culture that we discussed in the section "Defining Culture" common to all members of a given social group? Several of the definitions in Table 10.1 indicate that this is a defining feature of culture. For example, the GLOBE study, which is one of the largest recent cross-cultural studies, defines culture in terms of "shared motives, values, beliefs, identities, and interpretations or meanings of significant events" (House et al., 2004, p. 15).

In contrast, a number of other researchers qualify this slightly, referring to "widely shared" (Ingelhart, 1997, p. 15) or "approximately shared" (Fischer, 2009, p. 29) elements. Recent research by Fischer and Schwartz (2011) has highlighted the importance of such qualifications. They explored the extent to which value priorities vary within and across countries and found that value ratings varied much more among individuals within a country than they did across countries. Schwartz (2014, p. 5) maintains that this poses a "serious challenge to theories that view cultures as shared meaning systems in which values play a central role," because such theories imply high levels of consensus within a social group.

On the other hand, an "epidemiological" perspective on culture, that draws an analogy between cultures and epidemics, suggests a different interpretation – that it is cultural regularity, rather than cultural diversity, that should be surprising (see Sperber, 1996). An epidemic involves a population with many individuals being afflicted to varying degrees by a particular strain of microorganisms, over a continuous time span and over a territory with fuzzy and unstable boundaries. Similarly, a culture involves a social group (such as a nation, ethnic group, profession, generation, etc.), with fuzzy boundaries, whose members share (and presume that they share) similar cultural representations that are held by a significant proportion of the group"s members. However, just as an epidemic does not affect all individuals in an area to the same extent (typically, some people are more seriously afflicted by the disease than others), so we should not expect all members of a cultural group to share all cultural representations. Rather, they reflect a family resemblance type of pattern of characteristics.

It is also important to remember that there is often a difference between understanding/knowing how to interpret a particular behavior and demonstrating it to oneself. Minkov (2013) uses the following example to illustrate this. He comments that nearly all Bulgarians know that if they see someone wearing a small black ribbon on their chest, it means that a close relative or friend of the person has died. On the other hand, not all Bulgarians would necessarily wear such a ribbon if they had lost a close relative or friend. In other words, there is an important distinction we need to make between knowing how to interpret a practice and actually performing that practice. If a person neither knows how to interpret a practice nor engages in a practice, it suggests nonmembership of that particular cultural group. The following example from Saville-Troike (1997) illustrates this vividly.

I observed the following event at a kindergarten classroom on the Navajo reservation:

> A Navajo man opened the door to the classroom and stood silently, looking at the floor. The Anglo-American teacher said "Good morning" and waited expectantly, but the man did not respond. The teacher then said "My name is Mrs Jones," and again waited for a response. There was none.
> In the meantime, a child in the room put away his crayons and got his coat from the rack. The teacher, noting this, said to the man, "Oh, are you taking Billy now?" He said, "Yes."
> The teacher continued to talk to the man while Billy got ready to leave, saying, "Billy is such a good boy," "I"m so happy to have him in class," etc.
> Billy walked towards the man (his father), stopping to turn around and wave at the teacher on his way out and saying, "Bye-bye." The teacher responded, "Bye-bye." The man remained silent as he left.
> From a Navajo perspective, the man"s silence was appropriate and respectful. The teacher, on the other hand, expected not only to have the man return her greeting, but to have him identify himself and state his reason for being there. Although such an expectation is quite reasonable and appropriate from an Anglo-American perspective, it would have required the man to break not only Navajo rules of politeness but also a traditional religious taboo that prohibits individuals from saying their own name. The teacher interpreted the contextual cues correctly in answer to her own question ("Are you taking Billy?" and then engaged in small talk. The man continued to maintain appropriate silence. Billy, who was more acculturated than his father to Anglo-American ways, broke the Navajo rule to follow the Anglo-American one in leave-taking. This encounter undoubtedly reinforced the teacher"s stereotype that Navajos are "impolite" and "unresponsive", and the man"s stereotype that Anglo-Americans are "impolite" and 'talk too much.' Saville-Troike (1997, pp. 138–9)

Conversely, a person does not necessarily have to carry out a particular practice personally in order for that practice to be part of their cultural repertoire. If they recognize it as a (relatively) common practice and also know how to interpret it, that could count as a form of cultural sharedness. This brings us to the next issue: culture and normalcy.

Culture and Normalcy Normalcy is related to the concept of sharedness, in that it refers to how "normal" or "common" it is for a particular behavior to occur in a given social group. Through our socialization, we all develop a sense of the frequency and acceptability of different types of behavior, and our evaluative judgments are based on this awareness. We typically regard large deviations from frequent or "normal" behavior as idiosyncratic or even abnormal, while we may barely notice minor deviations. However, this sense of normalcy is derived from the socialization that we have experienced within our own social groups, and so when we interact with people from unfamiliar social groups, we may have more difficulty in making normalcy judgments. We discuss this further in the section "Culture and Behavior: Schemas."

Culture and Levels of Analysis A further issue of core concern to our conceptualization of culture is level of analysis, notably, the distinction between individual-level and collective- or societal-level conceptualizations. Schwartz (2011), who has developed conceptual frameworks for both levels, explains the distinction as follows:

> I have distinguished two theories because the basic individual values that guide individual choices serve different purposes and derive from different sources than the cultural value orientations that guide societal responses to the fundamental problems societies confront. Basic values are an aspect of the personality system of individuals; cultural value orientations are an aspect of the cultural system of societies. The structure of relations that emerges among individuals" responses to value items reflects the logic of functioning as individual, psychological beings. Functional requirements that derive from our biological makeup and from the demands of social interaction determine the organization of value items into the set of (plus or minus) ten individual-level values.[1] The structure of relations that emerges among societal responses to value items (i.e., sample means) reflects the logic of societal functioning in regulating human behavior. Schwartz (2011, p. 477)

As Schwartz implies and as we discuss further below (see the section "Culture and Behavior: Values and Beliefs"), it is methodologically prob-

[1] Since 2011, Schwartz has increased the number of individual-level values to 19, as Figure 2 illustrates.

lematic to switch between levels of analysis, using, for example, societal-level concepts to explain individual-level behavior. On the other hand, individuals function within group contexts (e.g., they work in a workplace that is likely to have organizational cultural characteristics), and so somehow we need to be able to integrate the different levels. We discuss this issue further in Part II of this chapter.

Conceptualizing Behavior

A very informal definition of "behavior" might be that it is everything people do. This would include spontaneous actions, such as "breathing," deliberate ones, such as "running," and voluntary psychological–cognitive processes, such as "listening to music" or "thinking about a problem." A somewhat more formal definition is that behavior is any state of an organism which can be explained at least in part as a response to the environment. In the context of culture, it is important to note that the concept of environment should be conceptualized as including the physical, cognitive (i.e., cognitive-psychological), and/or affective-emotional (as emotions are among the causes and among the effects of behavior) elements.

People generally make sense of behavior by interpreting it in terms of its causes and effects. For example, a perceptible change in the eye region of the face is described as a "twitch" if it is assumed to be involuntary and as a "wink" if perceived as intentional and directed at one or more people. Similarly, various facial expressions are conceptualized in terms of the emotions they express (e.g., a genuine, sincere, smile expresses a positive emotion, such as joy; a blushing face expresses embarrassment, etc.).

Humans have a natural disposition to make sense of their own or others' behavior by explaining it in terms of its causes and its actual or merely potential effects. Thus, we do not describe people we see in the street as "moving their legs along the surface underneath them while in an upright position." Rather, we describe them as "walking" or "going to work" or "going shopping" or "sightseeing" or whatever. The point is that we tend to conceptualize behavior in terms of its presumed causes and functions or effects. For this reason, the theory which investigates how we make sense of behavior is called "attribution theory" (Kelley, 1967, 1971). We explain (i.e., make sense of or conceptualize) human behavior in terms of two types of cause: external and internal. In other words, we make "external attributions" and "internal attributions." The explanation of a particular behavior by attributing it to an external cause (in other words, an agent or a force external to the person who is exhibiting the behavior) is called "external attribution." An example of an external attribution might be the twitch of the eye caused by dust. When a behavior is explained by some cause internal to the person who exhibits it, this explanation is described as an "internal attribution." For example, a "wink" is explained in terms of the winker"s intention to communicate something (perhaps an informal greeting, acknowledgement, agreement, etc.) to the person at whom the wink is directed.

It should be noted that "attribution theory" does not deal only with the way we explain behavior but events in general. For example, a person"s failure at an examination may be explained in terms of an external attribution (the student"s beliefs that he has failed because the teaching on the course was poor) or an internal attribution (the student"s belief that he or she lacks the academic ability to learn). It is often observed that people generally tend to explain successes in terms of internal attribution (as evidenced by the true anecdote about a person who said in a television chat show program that she was proud of herself because she had won the national lottery jackpot), while failures are typically explained by external attributions (e.g., the failure in an examination is explained by the poor quality of the teaching on the course leading up to the examination). Research also shows that there is a general bias toward explaining the behavior of other people in terms of internal attributions and one"s own behavior in terms of external attributions (see Ross, 1977).

People are generally assumed to be consistent, and in this sense rational, in making attributions and interpreting behavior. For example, the same type of event is not assumed to be a "football match" on one occasion and a "Christmas party" on another. Rationality is an important feature of our social actions (in other words, of the things we do as members of a society, who are aware of and take account of the perceptions and responses of others).

Human rationality is a very complex topic, and its consideration falls outside the scope of this chapter, but it needs to be mentioned here, because it is important for understanding the most fundamental aspects of the behavior of people as members of cultural groups and of the way they make sense of their behavior. We live not only surrounded by material things but also by mental representations of those things, and these are central for defining and describing cultural categories (see the section "Culture and Behavior: Schemas"). For example, the concept of "university" cannot be exhaustively defined in terms of the physical characteristics of a location or the people who are associated with it. In order to grasp the concept of "university," one needs to have some mental representations which are shared by members of society about places which are called universities. To give another example, consider the social institution of "marriage." Under what circumstances can two (or, in some cultures, more than two) people be described as married to each other? The representations about which social relationships fall under the label "marriage" vary widely across cultures. In all cultures, "marriage" is considered a relationship between people which is in some sense "special," but the particular representations about the nature of this relationship (e.g., as between two or more people, as between people of different sexes or possibly also of the same sex, etc.) vary widely, as do the representations about the respective rights and obligations of those who enter into "marriage." So, the conceptualization of the behavior of people (as members of sociocultural groups) tends to include the ways in which they participate in the life of social institutions such as a "university" (e.g., as students, lecturers, researchers, etc.) or the bond of "marriage" (such as assuming, through taking part in a culturally appropriate ritual, the role of "spouse" with whatever rights and obligations the role entails).

Consider a simple utterance, typical of many ordinary, everyday conversations: James: I am going to university in September.

Even if we know very little about the speaker (say, the speaker is 18 years old and has just passed his entrance examinations), we would most likely conclude with confidence that he is going to university in order to study, because the expression "go to university" has been used often enough and long enough to acquire the conventional meaning: "go to study at university." Many other assumptions will also become very salient to us. These might include the following: "James will, or at least, he intends to, spend several years as a university student," "James will need to attend classes, do coursework and take examinations as part of his programme of university studies," "James will obtain a degree qualification when/if he completes his programme of studies at university," "James may be moving away from home" and so on. These and other assumptions are made almost instantly available to us on the basis of what we know about the meaning of the word "university," the standardized meaning of the phrase "go to university" and about young people of James" age and education.

It should also be noted that a slight change in our background knowledge may make a big difference to the way we interpret a communicative act. For example, if we know that James is 18 years old but that he has failed all his entrance examinations, we may be puzzled by his utterance, because, in this circumstance, it would be irrational for James to utter truthfully and seriously the words: "I am going to university next year." We might think that he is joking or that he has applied for a nondegree course at university. If James intends to communicate that he will go to university without committing himself to all of these assumptions, he should indicate this clearly (e.g., by saying: "I am going to university to do an access course"); otherwise he will fail to be adequately informative as his utterance will be unnecessarily difficult to interpret in the context

available to the hearer who is left wondering what exactly James intends to do at university, given that he does not qualify for enrolling on a bachelor degree. In other words, it would be irrational for James to produce this utterance seriously and truthfully under these circumstances.

This simple example illustrates an important point: the way we make sense of the world in a systematic and relatively reliable way requires us to draw on our background knowledge. So when we hear an utterance in which a particular word, say "university", is used, we draw on our knowledge about this word to figure out what the speaker intended to communicate by using that word because that particular attribution is the most rational we can make (assuming that he/she has also acted rationally in producing the utterance). In other words, when we make sense of people's behavior, including their communicative behavior, we presume that their behavior is rational in that it can be explained in terms of systematic and predictable cause-consequence relations, in line with our background knowledge.

When somebody utters a string of words, such as "I am going to university next year," we explain the speaker"s production of these words by attributing to the speaker some intentions. Developing the ideas of the philosopher of language H.P. Grice (see 1989), Sperber and Wilson (1995) describe the comprehension of communicative behavior in terms of intentions. Communicative behavior is explained by attributing to the speaker the intention that the hearer should recognize the act as communicative. So what distinguishes communicative acts from other forms of social behavior, and behavior in general, is the way we explain it to ourselves. In other words, communicative behavior differs from other forms of behavior in terms of the attributions we make. Crucially, we attribute to the person who produces a communicative act the intention to convey a message. This guides the process of making inferences in order to figure out the message. For example, when your friend"s son James says "I am going to university next year," we pay attention to his words because we attribute to James the intention that we should realize that he has produced those words because he intends to inform us of something. We then figure out by drawing on our knowledge (which is largely sociocultural) what it is that James intends to inform us of.

It should be clear from these arguments that cognitive representations play an important role in making sense of human behavior. It should also be clear that the knowledge of these representations, including culturally based elements such as beliefs, values, and norms, is an important part of communicative competence. The interpretation of communicative behavior depends on rational attributions, and these can be made (adequately) reliably only provided they are informed by culture-specific representations which are embedded in our cognitive makeup. So in the next section, we explore the ways in which culture-specific knowledge has been conceptualized and how it may impact on behavior.

Part II: Exploring Interconnections Between Culture and Behavior

Having examined in the first part of this chapter how culture and behavior can each be conceptualized, we now turn to the interconnections between the two. We explore three main elements of cultural cognition – values and beliefs, norms, and schemas – and for each in turn we consider how they may impact on behavior and interpretations of behavior.

Culture and Behavior: Values and Beliefs

Some of the most extensive research into culture and its (potential) impact on behavior has been carried out by anthropologists and psychologists who have tried to identify people's primary values and beliefs. These deep or "hidden" aspects of culture ["perspectives," in Moran's, (2001), terms – see the section "The Composition of Culture"] include the fundamental assumptions, basic values, and core beliefs that may underlie people's

Table 10.4 Probabilistic responses regarding the importance of religion in the respondents" lives (World Values Survey data)

	Total	Country code			
		China	Germany	Iraq	United States
Very important	28.9%	2.6%	13.1%	84.7%	40.4%
Rather important	18.9%	8.0%	24.9%	12.8%	28.0%
Not very important	23.8%	29.6%	36.1%	2.3%	18.2%
Not at all important	25.1%	49.8%	25.6%	0.2%	12.7%
No answer	0.5%	0.8%	0.1%	–	0.7%
Don"t know	2.8%	9.2%	0.2%	–	–
(N)	(7778)	(2300)	(2046)	(1200)	(2232)

Selected samples: China 2012, Germany 2013, Iraq 2013, United States 2011

practices (or behavior). A crucial and highly controversial issue is whether and/or how these deep-seated perspectives influence behavior. According to Minkov (2013), this is partly dependent on the way in which the elements are measured. If the measurement is done at the societal or collective level, predictions about individual behavior are highly problematic. In fact, much research, including that of Hofstede (1980/2001) and the GLOBE study (House et al., 2004), focuses on comparisons of societies not individuals, and that makes predictions about individual behavior highly dubious for two reasons. Firstly, as Schwartz (2011) explains, the constructs that operate at societal level are not necessarily the same as those that function at the individual level. Thus it is inappropriate to apply one to the other. In fact, if this is done, this is known as the ecological fallacy – a danger that Hofstede himself warned against but that many people have ignored. Secondly, even if the constructs exist at both levels, applying average country-level scores to individuals typically results in stereotyping, because the mean score is a statistical average that offers no information about degree of variability across the population. It may therefore be unrepresentative of large numbers of individuals or even may represent no specific individual at all. According to Minkov (2013), the only potentially helpful measurement is one that provides distribution information about a single cultural variable across the chosen population. However, this type of information is rarely available. An exception is that provided by the World Values Survey.[2] This is a major longitudinal study in which representative samples of people from a wide variety of countries (1000 per country) are interviewed on a range of issues. For example, Table 10.4 shows the responses from interviewees in China, Germany, Iraq, and the United States of America to the question: *How important is religion in your life? Would you say it is:*

However, even probabilistic data of this kind is still just that – probabilistic – and thus cannot be used to predict behavior. Moreover, it cannot take into account contextual factors or any situational dynamics.

Yet our goal may not be to predict behavior but rather to anticipate different possibilities or to understand and/or accept unexpected behavior. In these cases, insights into likely ways in which people"s basic values and core beliefs may vary can be useful, enhancing our schematic knowledge (see the section "Culture and Behavior: Schemas") and/or helping us think through unanticipated occurrences after they have happened (see the section "Culture and Counselling Theory"). In this section, therefore, we consider some classic frameworks that identify fundamental values.

[2] See http://www.worldvaluessurvey.org/

Table 10.5 Kluckhohn and Strodtbeck"s (1961) cultural orientation framework

Core issue	Possible solutions		
Primary orientation to time	Focus on the past (emphasis on maintaining traditions)	Focus on the present (emphasis on achieving best solution for current situation)	Focus on the future (emphasis on planning ahead)
Relationship to the environment	Subjugation to nature (belief that humans should submit to higher forces and not try to control them)	Harmony with nature (belief that humans should control what they can but also live in harmony with nature)	Mastery over nature (belief that humans can and should control the forces of nature)
Quality of human nature	Basically evil	Mixture of good and bad	Basically good
Relationship among people	Lineal (preference for hierarchical relations)	Collateral (emphasis on consensus within extended group)	Individualistic (emphasis on the individual or individual families within the group who make decisions independently from others)
Mode of human activity	Being (acceptance of the status quo)	Being-in-becoming (preference for transformation)	Doing (preference for direct intervention)

Fundamental Assumptions and Basic Values The anthropologists Kluckhohn and Strodtbeck (1961) argued that all social groups throughout the world face a number of core human issues that they need to resolve and that there is a limited range of solutions to these problems. Preferred solutions will emerge within each cultural group, although there will always be people who hold different viewpoints. The five core problems that they identified, along with the range of possible solutions, are shown in Table 10.5 (see Hills, 2002, for a helpful account).

Other key figures who have researched basic values are Hofstede (1980/2001), House et al. (2004), Trompenaars and Hampden-Turner (1997, 2012), and Schwartz (e.g., 2011). However, Schwartz is the only one who has developed an individual-level framework (in addition to a societal-level one), and so we consider his work in more detail here.

Schwartz"s research has been voluminous for over 20 years (e.g., see Schwartz, 1992a, 1992b, for two of his earlier works), and it has spawned literally hundreds of studies by a wide range of academics. Schwartz defines basic values as "trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or a group" (Schwartz et al., 2012, p. 664). He maintains that the values he proposes are likely to be universal because they are grounded in one or more of three universal requirements of human existence: human needs as individual biological organisms, human needs for coordinated social action, and the needs of groups for survival and welfare.

Schwartz"s conceptualization is unique, not only in that it identifies different (albeit related) values at the individual level as well as at the society/group level, but also in that the values he proposes are represented not as a set of discretely different values but rather as circular continua of related motivations. An analogy with colors may help explain this: just as one color merges into another, so one value gradually shifts to another. Figures 10.1 and 10.2 show this circular continuum for the values he has identified at societal and individual levels, respectively.

To gain a clearer idea of how Schwartz"s values are to be interpreted in more concrete terms, it is helpful to look at the items that Schwartz uses to probe these values. Table 10.6 illustrates some of these for each of his individual-level conceptualization. They are taken from Schwartz"s PVQ5X value survey (Schwartz et al. 2012).[3]

[3]Schwartz uses different versions for male and female respondents. Here a mixture of his male and female items has been presented.

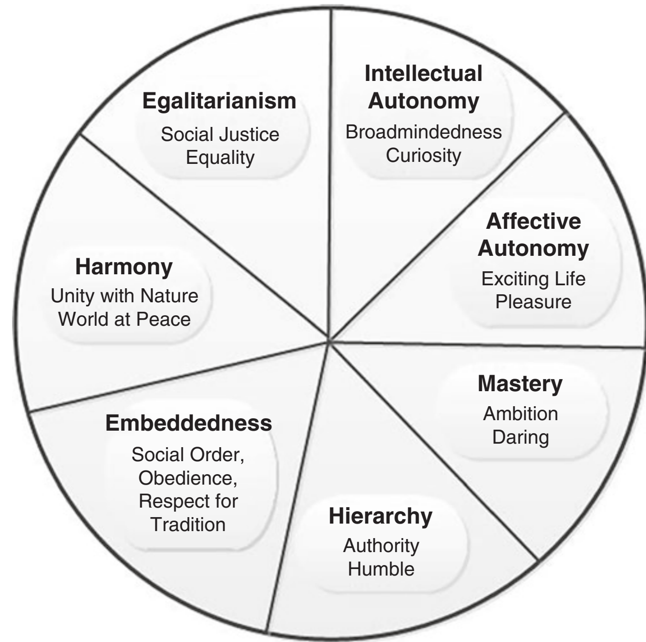

Fig. 10.1 Schwartz''s circular motivational continuum of seven societal-level values. (Based on Schwartz 2011)

Fig. 10.2 Schwartz''s circular motivational continuum of individual-level values. (Based on Schwartz et al. 2012)

A quick scan of these sample items illustrates how each of these values could influence not only people''s interactions with others but could also underpin their evaluations of other people''s behavior. We use the following authentic example to show how this could play out in real life.

At the beginning of July, a new Finance Officer took up a post in a university department. Her line manager was the head of that department (HoD), but she had dotted line reporting to a manager in the university''s central finance team. Since the financial year was ending on 31 July and since she was new to the university, a senior member of staff

Table 10.6 Schwartz"s individual-level values and sample items for probing them. (Schwartz et al. 2012)

Value	Sample item
Self-direction – thought	It is important to him to form his own opinions and have original ideas
Self-direction – action	Doing everything independently is important to her
Stimulation	He thinks it is important to have all sorts of new experiences
Hedonism	Having a good time is important to her
Achievement	Being very successful is important to him
Power – dominance	She wants people to do what she says
Power – resources	He pursues high status and power
Face	It is important to her that no one should ever shame her
Security – personal	He avoids anything that might endanger his safety
Security – societal	Having order and stability in society is important to her
Tradition	It is important to him to maintain traditional values or beliefs
Conformity – rules	She believes she should always do what people in authority say
Conformity – interpersonal	He always tries to be tactful and avoid irritating people
Humility	She tries not to draw attention to herself
Benevolence – dependability	He goes out of his way to be a dependable and trustworthy friend
Benevolence – caring	She always tries to be responsive to the needs of her family and friends
Universalism – concern	He wants everyone to be treated justly, even people he doesn"t know
Universalism – nature	She strongly believes that she should care for nature
Universalism – Tolerance	Even when he disagrees with people, it is important to him to understand them

in Central Finance promised the HoD that they would provide the new Finance Officer with the help she would need to carry out all the financial year-end procedures, as well as give her the training she would need to become familiar with the university"s financial systems and procedures (things that the HoD, as an academic, knew little about).
A week or so after the new Finance Officer started her role, she expressed concern to the HoD that she was not receiving sufficient support from Central Finance. The HoD offered to contact the senior member of staff about it, but she refused quite sharply, saying that she was perfectly capable herself of requesting any help she needed. The HoD wondered how things would turn out because she knew that the university operated in an extremely hierarchical manner, despite superficial appearances of being an egalitarian organisation (e.g. first name terms with senior management). However, since the Finance Officer was so adamant, she said no more.

About one month later, when the HoD was overseas on leave, the Finance Officer sent her an "emergency email" – apologising for disturbing her – saying that she was not getting the support she needed from Central Finance and that she was afraid she would not be able to finish the year-end accounts (due in a week"s time and extremely important to both the university and the department). The HoD then contacted the senior member of staff in Central Finance and asked him to intervene, since the manager in Central Finance who was responsible for providing help and ensuring her training had (for reasons unknown) not given her sufficient help. That senior manager did so.

How, then, can Schwartz"s conceptualization of values help us understand this incident? First, we need to ask why the Finance Officer refused the HoD"s initial offer to contact Central Finance. It seems likely that two individual-level values were having a particularly strong influence on her: self-direction (working independently and demonstrating self-sufficiency) and achievement (capable and successful) (e.g., see Table 10.6). Her current context (a new member of staff who presumably wanted to make a positive impression on the HoD, her main line manager) and her recent history (having experienced redundancy in her previous job) probably made these values particularly salient and important to her.

However, the university was a hierarchical organization, with a strong organizational-level value of hierarchy (authority – see Fig. 10.1), and it would have been completely "normal" for the HoD to ask the senior member of staff in Central Finance to increase their level of support. That would have been more effective than a more junior person asking an extremely busy finance manager, with only dotted-line responsibility for her, for additional help. So if the Finance Officer had been able to put aside her own personal values of self-direction and achievement, including her concerns about appearing to her HoD as capable and self-sufficient, and had allowed her HoD to take the hierarchical route that was typical of the university, she would not have found herself in the crisis situation, and the HoD would not have had to deal with the issue while on leave. Equally, one could argue that the HoD should have contacted the senior member of Central Finance when her Finance Officer first expressed her concerns, since she knew how best to achieve things within the university context and could have explained this to her Finance Officer.

From this particular example, then, we can infer that when someone moves into an unfamiliar societal/organizational culture, they need to be able to handle strategically the interface between their own individual-level values and those of the society/organization that they find themselves in and be willing to make adjustments. If they do not, they may well have difficulty achieving their goals, especially when there are some incompatibilities in values. Similarly, members of the dominant community need to be aware that newcomers or members of other communities may be unfamiliar with the prevalent values that themselves may have become used to and will need additional help in making adjustments.

So this raises the question of how can we handle the interface between societal-level values and individual-level values. We use an incident that the first author personally experienced in order to help us explore this issue further.

This incident took place in the 1980s, when Helen was working in Shanghai. It was a time when many goods were in short supply. One Saturday morning Helen went to a local store to buy some yoghurt and some milk. There were two long queues for each of these items and she joined the queue for yoghurt. As she gradually waited her turn, she began to realise that by the time she had bought her yoghurt and lined up again for milk, the milk would all have been sold out. As it came almost to her turn to buy her yoghurt, she noticed that one person ahead of her had bought both yoghurt and milk – the assistant had simply reached over for a bottle of milk. So when Helen was served, she also asked for a bottle of milk in addition to the yoghurt. Immediately the assistant shouted at her, clearly unwilling to sell her the milk. Others in the queue started shouting back and there was a great commotion. Eventually the assistant reached for a bottle of milk and sold Helen both the yoghurt and the milk. However, when she was about to give Helen her change, she looked at Helen in disgust and then deliberately threw her change on the floor.

How can we interpret this incident? Was the shop assistant simply being rude – her behavior a reflection, perhaps, of a difficult temperament? Or did she and Helen hold different values, or different interpretations of the same values, that contributed to the incident?

Helen assumed that in a service encounter context, such as a shop, the equality component of the universalism value would prevail – that all customers would be entitled to equal treatment in terms of sales of goods. So when she saw another customer being sold milk, she assumed that she would be entitled to buy milk. However, the sales assistant did not share that assumption, so the key question is why. Following discussion with Chinese students and colleagues, the most likely explanation seems to be as follows. Helen, the sales assistant and the Chinese customers in the queue probably all believed that it was fair for people to line up in the appropriate queue – for yoghurt if they wanted yoghurt and for milk if they wanted milk. When the assistant sold the milk to the person in the yoghurt queue, she was most likely selling it to a personal friend. In that case, the assistant"s benevolence value (caring – being responsive to the needs of family and friends; see Table 10.6) was of greater importance to her than her universalism equality value, and so she had no hesitation in selling the milk. Others in the queue understood and accepted this

and realized that they would not be entitled to ask to buy milk. Helen, on the other hand, was completely oblivious to this in-group/out-group distinction. When she asked the assistant for milk, it put the assistant into a difficult position, because if she served an obvious stranger, it would contravene the values that she and the local people in the queue accepted: that the universalism value of equality of opportunity for all customers could be overridden only if requested by a close friend. If she did so, it could open a floodgate of requests and undermine the fairness of queuing appropriately. However, the others in the queue persuaded the assistant that she could make an exception, by treating Helen as a foreigner, and thus entitled to high levels of hospitality and "special favors."

Schwartz (2007) explains that benevolence values are concerned primarily with the welfare of close others (i.e., members of the in-group), while universalism values can apply to both close others and to those beyond the in-group. In his 2007 study, he calculated a measure of "moral inclusiveness" by examining people"s benevolence and universalism value ratings, and he listed the scores for the 66 countries in his sample. He showed China as having a low score and the UK as having a high score. This could be seen to support the explanation given above for the sales assistant"s behavior and subsequent reaction of other people in the queue. The sales assistant"s sense of moral inclusiveness was much narrower than that of Helen"s, leading her to treat a friend differently from other customers in a public service encounter context. Other people in the queue seemed to hold a similar breadth of moral inclusiveness, except that they thought Helen"s status as "foreign guest" entitled her to another form of special treatment.

So in one sense, Schwartz"s distinction between the "caring" values of benevolence and universalism is helpful for understanding this incident. Yet it also raises some conceptual issues. Schwartz (2011, p. 477) maintains that individual-level values reflect "the logic of functioning as individual, psychological beings" while societal-level values are derived from the "demands of social interaction." This incident is obviously an interactional one, involving a number of different people who all, apart from Helen, seemed to "understand" what was happening, and yet the distinction between benevolence and universalism does not appear in Schwartz"s specification of societal-level values (see Fig. 10.1).

In our view, people are constantly engaged in social interaction and so form their own values or interactional principles (cf. Spencer-Oatey & Jiang, 2003) with respect to this. We would argue, therefore, that these interactionally relevant values need to be incorporated conceptually into individual-level conceptualizations of culture. This is true not only for the in-group/out-group distinction we have discussed so far but also to other interactionally relevant values such as hierarchy. For example, Schwartz (2009, p. 129) points out in another paper that "people are socialized to take the hierarchical distribution of roles for granted, to comply with the obligations and rules attached to their roles, to show deference to superiors, and to expect deference from subordinates." We would maintain that individuals not only hold individual-level values relevant to superordination/subordination – the values of power (pursuit of status and power is a personal goal – see Fig. 10.2 and Table 10.6) and of conformity (obedience to people in authority – see Fig. 10.2 and Table 10.6) but also hold individual-level values relating to hierarchy – beliefs about how hierarchy should operate in the contexts in which they live. Somewhat strangely, Schwartz only identifies this value at the societal-level, and yet it clearly operates at the individual and interactional level.

Core Beliefs The vast majority of intercultural research has focused on the impact of basic values. However, during the last 10–15 years, a number of cross-cultural psychologists have become increasingly concerned that this focus has been too excessive. Some, therefore, have turned their attention to a related phenomenon: beliefs or, more specifically, social axioms. Leung et al. (2002) argue that this is important because it may reveal information about cultural

variations that have not emerged from the research on basic values. They set themselves this very specific objective:

> The primary objective of the present research is to explore whether a common set of beliefs can serve as a basis for understanding individuals in all cultures and understanding cross-cultural differences in behavior. Leung et al. (2002, p. 287)

They point out that beliefs can vary enormously in their level of specificity. Some can be very context- and/or person-specific; others can be very broad and viewed as "generalized expectancies." They focused on the latter, as their goal is to identify beliefs that function at a high level of abstraction and apply to social behaviors across a wide variety of contexts, individuals and time periods.

They define social axioms as follows:

> Social axioms are generalized beliefs about oneself, the social and physical environment, or the spiritual world, and are in the form of an assertion about the relationship between two entities or concepts. […] For instance, "good things will happen to good people" is a typical example of an axiom, and people may endorse this belief to a different degree. Leung et al. (2002, p. 289)

They go on to point out that social axioms are different from values, in that the latter are evaluative beliefs about something, while social axioms are normative beliefs about how the world operates. They use the following examples to illustrate this: they regard "good health is important" as an evaluative belief, while they see "good health leads to success at work" as a social axiom, in that the former makes an evaluative judgment, while the latter makes a claim as to how the world works. They thus associate social axioms with norms and expectancies and values with moral prescriptions.

Through this and a range of studies (e.g., Bond et al., 2004; Leung et al., 2002), they identified five core social axioms, with indications of a sixth:

- Cynicism: a view that life produces unhappiness, that people exploit others, and a mistrust of social institutions
- Social complexity: a belief that outcomes can be achieved in multiple ways and that human behavior is variable across situations
- Reward for application: a belief that effort, knowledge, and careful planning will lead to positive results
- Spirituality (also called religiosity): a belief in the reality of a supreme being and the positive functions of religious practice
- Fate control: a belief that life events are predetermined but that people can influence these fated outcomes
- Interpersonal harmony: a belief that social harmony is the basis or antecedent of positive interpersonal relationships

Using a range of items to probe each of these axioms, individuals are asked to rate the extent to which they agree with the above core axioms.

Leung et al. (2002) end their article by suggesting that a fruitful line for future research would be to examine how these social axioms relate to social behavior, especially with respect to expectations. Two studies indicate that this could be a potentially rewarding direction. Kurman and Ronen-Eilon (2004), in a study of immigrants to Israel, found that the more familiar the immigrants were with Israeli social axioms, the better adapted they were. They also found that the immigrants" knowledge of prevailing Israeli social axioms (which the researchers investigated separately) contributed more to their sociocultural adaptation than proximity to their own social axioms. Kuo, Kwantes, Towson, and Nanson (2006) examined the impact of social axioms on the attitudes of ethnically diverse university students toward seeking professional psychological help. They found a significant effect, with cynicism and interpersonal harmony having the greatest influence. Individuals with high social cynicism scores exhibited negative views about seeking help, and individuals holding strong beliefs about interpersonal harmony displayed positive views.

Other researchers have looked at more specific beliefs: religious beliefs. Tarakeshwar, Stanton, and Pargament (2003) argue that religion is an

overlooked dimension in cross-cultural psychology and propose a five-dimensional framework for studying the interconnections between religion and culture: ideological, ritualistic, experiential, intellectual, and social. The importance of researching religious beliefs is supported by a large-scale study by Saucier et al. (2015). They conducted a "survey of world views," collecting data from nearly 9000 respondents in 33 countries and incorporated measures of a very wide range of variables, including values, social axioms, and religious beliefs and practices. They found that some of largest variations across nations in effect size were for religious beliefs and practices and recommend that it would be particularly helpful for future studies to "focus on beliefs connected to religion (or the metaphysical), and especially on practices and behaviors that reflect the everyday impact of religion on persons" (p. 63).

Interestingly, and in line with this, the British Prime Minister, David Cameron, referred to Christian values in his Christmas message in December 2015, encouraging the British people to reflect on them and the way in which they link to welcoming migrants.

> As a Christian country, we must remember what his [Jesus"] birth represents: peace, mercy, goodwill and, above all, hope. I believe that we should also reflect on the fact that it is because of these important religious roots and Christian values that Britain has been such a successful home to people of all faiths and none.[4]

Culture and Behavior: Norms

As the length of the previous section implies, the majority of the research in cross-cultural psychology has focused on the deep manifestations of culture, especially people"s basic values. However, as Gelfand, Nishii, and Raver (2006) explain, there is growing skepticism of the merits of such a focus, and there is increasing recognition that new approaches are needed (e.g., Caprar, Devinney, Kirkman, and Caliugi, 2015). One such new focus is that of norms (e.g., Leung & Morris, 2015; Morris, Hong, Chiu, & Liu, 2015), which is related to a practices interpretation of culture, in that regularities in practices are taken as reflections of underlying cultural norms.

The social psychologist, Robert Cialdini (2012), has drawn an important distinction between two types of norms: descriptive norms and injunctive norms. Descriptive norms refer to what is typically done or what is "normal", while injunctive norms refer to what is typically approved of or disapproved of by members of a social group. He maintains that descriptive norms can provide a decision-making shortcut in that they are likely to be effective and adaptive actions for a given situation, and so people may follow them for this reason. Injunctive norms, on the other hand, constitute the moral rules of the group, and people may follow them to avoid social disapproval.

Gelfand and her colleagues (2006) offer a cross-cultural perspective on norms that is potentially compatible with Cialdini"s theorizing. They argue that social groups differ both in how strong their social norms are and in how much tolerance members have for deviation from the social norms. They label this "cultural tightness–looseness." They maintain that variation in tightness–looseness occurs at multiple levels, including the societal level, the organizational/group level and the individual level, and they point out that academics in both anthropology (e.g., Pelto, 1968) and psychology (e.g., Berry, 1967; Triandis, 1989) have long argued that this is an important concept. Nevertheless, they say that there has been little follow-up research on it, and, in developing their theory, they put forward a number of propositions, a selection of which is shown in Table 10.7.

Gelfand and a large group of colleagues (Gelfand et al., 2011) then carried out a 33 nation study to explore their hypotheses. In line with their predictions, they found that there was high within-nation agreement in each country and high between-nation variability. They conclude that "Understanding tight and loose cultures is critical for fostering cross-cultural coordination in a world of increasing global interdependence" (p. 1104).

[4] The full message is available at https://www.gov.uk/government/news/christmas-2015-prime-ministers-message

Table 10.7 A selection of propositions associated with tightness–looseness put forward by Gelfand et al. (2006)

1.	Tightness–looseness consists of the strength of social norms (number and clarity) and the strength of sanctioning (tolerance for deviance from norms)
2.	Societal institutions in tight societies generally foster narrow socialization, whereas societal institutions in loose societies generally foster broad socialization
3.	Societal tightness–looseness affects variance across individuals in individual attributes (e.g., attitudes, beliefs). There is generally less variance across individuals in tight versus loose societies
4.	Societal tightness–looseness has cross-level effects on individual behavior as mediated by felt accountability psychological attributes. Individuals in tight societies tend to enact behaviors characteristic of conformity, risk avoidance, and stability seeking, whereas individuals in loose societies tend to enact behaviors characteristic of deviance, risk seeking, and openness to change
5.	Through bottom-up processes, psychological felt accountability characteristics (e.g., accessibility of normative requirements, regulatory focus, and strength) influence the level of tightness and looseness in organizations
6.	A lack of fit between individuals and groups/organizations produces more negative consequences for individual in tight as compared with loose societies

This is clearly an extremely important finding, but to take it further, we need to gain more information about the nature of the norms and the contexts in which they apply. Gelfand and her colleagues asked respondents to make judgments about norms and deviance in general (e.g., "In this country, there are very clear expectations for how people should act in most situations") rather than in specific contexts. So, as Minkov, Blagoev, and Hofstede (2012, p. 1096) point out, this "does not reveal what norms the respondents had in mind when they answered the questions." Different people might have been thinking of different types of norms in different types of contexts, and this could fundamentally undermine their findings. Clearly, much more research is needed on the issue.

This brings us to another key question: are there any frameworks for conceptualizing different types of norms? Unlike for values, there are no established frameworks, except for the work of the anthropologist E.T. Hall. We explore some of his key ideas in the next three subsections.

Cultural Norms Regarding Time Management
Hall (1959, 1976) drew attention to several differences across cultures in the management of time. Probably his best known is the distinction between monochronic and polychronic time. Monochronic (M) time is characterized by the handling of one thing at a time, an emphasis on schedules and promptness, and activities that are compartmentalized and treated in a linear fashion. Polychronic (P) time, on the other hand, is characterized by doing many things at a time, an emphasis on involvement with people and completion of transactions rather than adherence to preset schedules.

Hall does not provide clear empirical evidence for this distinction; rather he presents somewhat anecdotal descriptions of difference, as the following quotation illustrates:

> Americans overseas are psychologically stressed in many ways when confronted by P-time systems such as those in Latin America and the Middle East. In the markets and stores of Mediterranean countries, one is surrounded by other customers vying for the attention of a clerk. There is no order as to who is served next, and to the northern European or American, confusion and clamor abound. … In contrast, within the Western world, man finds little in life that is exempt from the iron hand of M-time. In fact, his social and business life, even his sex life, are apt to be completely time-dominated. Time is so thoroughly woven into the fabric of existence that we are hardly aware of the degree to which it determines and co-ordinates everything we do, including the modelling of relations with others in many subtle ways. Hall (1976, pp. 17–18)

Despite the possible ethnocentrism and overgeneralization of an account such as this, differences in people"s preferences for the handling of time do often present challenges when people are living and working in culturally unfamiliar environments. In professional contexts, this often relates to last minute or advanced scheduling. The following example from an interview with some very senior and highly experienced international managers illustrates this issue:

RS: *Uh we were launching a new programme [in Tanzania] uhm […] and after much debate we decided that as part of our launch activities we were going to challenge parliament to a football match, which we did. Uh and there was a lot of behind the scenes stuff going on, uhm and we knew that this was going to take a long time to materialise. The date was set for the uhm 5th August, to have this football match, and there were various things happening around it, uhm but the colleague who was in charge of doing all this didn"t actually approach parliament until the beginning of July. And I"m tearing my hair out at this, you know. I was getting to the stage of "Have you done it yet?" and standing over him whilst he made the calls. Uhm and that was, I recognised, because I was so worried and stressed about the event that I wanted it to be correct, and you know I wanted it all to go well. But for him, he- it wasn"t that he wasn"t interested, you know, this was his primary activity, this was the one thing that he had to deliver, and he was very very engaged in it, but he didn"t see the need to make those calls until you know 3 weeks before.*

KE: *He didn"t see the need or he thought that was a bad strategy to call them at the last moment?*

RS: *He didn"t see the need.*

WM: *People don"t have confidence that they can influence the future. So they"re (.) the attitude that I have to planning, having been brought up in a sort of scientific discipline and tradition and believing in cause and effect, and believing that I can influence the future, that you make a plan and it"s contingent, you think that things that happen tomorrow are contingent on things you do today. Uhm colleagues in the team that I worked with in India just did lack that fundamental belief. And if it was going to happen, it was going to happen, it was not strongly influenced by their own actions. And throughout the Middle East you get uh the common response when you say "let"s do this", they say "yes, inshalla, God willing this will happen". And that is, it"s God"s will rather than our will that will influence what will happen.* [Spencer-Oatey, unpublished research data]

Time management practices are clearly influenced by a range of personal and contextual factors, but cultural norms may also play a role. Moreover, as can be seen from WM"s comments in the interview extract above, cultural differences may not occur simply because of interactional preferences but may also be influenced by deeper aspects of culture, such as religious beliefs.

Cultural Norms Regarding Space Management Another cultural practice issue that Hall (1959, 1976) drew attention to was space management. This includes a range of aspects. It can be personal space: how close we normally stand to another person in different contexts – intimate, personal, social, and public. If someone moves closer to us than our norm, we tend to feel uncomfortable and back off. Yet Hall argued that norms as to how far, literally, that "comfortable distance" is can vary across cultural groups. He suggested a scoring system that could be used in observational studies, ranging from 1 (within body contact distance) to 4.5 (just outside touching distance by reaching). This was used by Watson and Graves (1966) in a study of 38 proxemics behavior among American and Arab friends, who were asked to chat informally in a room. They found that the mean for the Arab group of friends was 1.05 while for the American group of friends it was 2.85.

Other aspects of space management that Hall (1959) drew attention to relate to buildings rather than people. They include the direction that doors face as well as the arrangement of furniture. As was the case for time management, preferences can relate to (religious) beliefs, as, for example, the orientation of mosques for Moslems or architectural decisions that are based on *feng shui* in Chinese cultures. As with time management practices, space management behavior is clearly influenced by a range of personal and contextual factors, but cultural norms may also play a role.

Cultural Norms Regarding Communication Style A third difference in cultural practices that Hall (1976) identified was differing preferences for low-context and high-context communication. Low-context communication refers to patterns of communication that use explicit verbal messages to convey meaning. High-context communication, on the other hand, refers to communication patterns that draw heavily on the context to convey meaning. The context can embrace many elements, including conceptions of social roles and positions, shared knowledge and experience, and the use of non-verbal channels such as pauses, silence, and tone of voice.

This is a difference that has often been referred to in interactional studies (e.g., Miller, 2008; Tyler, 1995) as well as mentioned very frequently by people working in culturally unfamiliar contexts. It can be a communication issue that even highly experienced leaders can find difficult to handle, as the following interview comment from a senior international manager makes clear:

> *[Something] I don"t have the answer to yet but I"ve talked to several people is: How do I demonstrate relatively early on that although I"m not openly addressing this issue, that I"m not a fool, that I"m aware of the issue, do you know what I mean? That there is a level of sophistication at least in terms of a knowledge, without actually openly saying, you know, "I understand this issue and I understand that it"s going to be difficult for us to talk about it openly." That"s a challenge. I don"t have the answer yet, but I"m clear about attempting.* (Spencer-Oatey, unpublished research data)

This leader was aware of the need to use a more high-context style than he would normally do but clearly had difficulty performing in this way.

Other theorists (e.g., Ting-Toomey, 1999; Molinsky, 2013) have proposed other ways in which communication style may vary. For example, Molinsky (2013, p. 14) identifies the following six:

Directness:	How straightforwardly am I expected to communicate in this situation?
Enthusiasm:	How much positive emotion and energy am I expected to show to others in this situation?
Formality:	How much deference and respect am I expected to demonstrate in this situation?
Assertiveness:	How strongly am I expected to express my voice in this situation?
Self-promotion:	How positively am I expected to speak about my skills and accomplishments in this situation?
Personal disclosure:	How much can I reveal about myself in this situation?

He argues that within each cultural group, there is a range of appropriateness for each of the above dimensions, which he labels the "zone of appropriateness." This is an important notion from the point of view of cultural adaptation, especially if combined with a dialectic approach (e.g., Spencer-Oatey, 2013).

Cultural Norms: Others The range of norms that can affect behavior is almost endless. Here, though, we briefly touch on one that interrelates with both cultural products and cultural perspectives and that can be highly contentious: the issue of people"s dress. For example, the wearing of the burka in the UK or France is a subject of current debate and different opinions, and "inappropriate" choices of dress can cause a number of problems, as the following interview extract from an Omani leader illustrates.

> *… a UK colleague came to Oman and we had this meeting with ministries, […]you know they are highly ranked number one partners, and she was not dressed properly. […] But anyway we had to take her to the meeting as she was, so we had to cover her, tell her bring a shawl with you because in the ministries usually you"ve got uhm the minister could be there or the under-secretary could be there, and they"ll be expecting [name of organisation] to present themselves you know in a more professional way. But she couldn"t understand, why are you making me cover up, I"m hot. […], but when we were in this meeting it came across that she"s rude, we are partners, you can"t be that*

rude. So we had to deal with that situation, both ways. We had to talk to the ministry and tell them that […] she"s coming from UK and she was not expecting that she"s going to be in this meeting, uh so we just dragged her with us, so it"s OK. And we had to speak to the UK colleague and tell her when you come to the Middle East, first thing you have to have in mind is the dress code. Especially if you are visiting VERY important partners or government body, it"s very important to do that. But she was not really happy about it, but then she settled, she was OK. (Spencer-Oatey, unpublished research data)

Culture and Behavior: Schemas

In the last two main sections, we have explored two types of cultural knowledge that may influence our behavior: (a) values and beliefs and (b) norms. But of course our behavior is influenced by all types of knowledge – in other words, by our schemas. Fiske and Taylor (1991, p. 98) define a schema as "a cognitive structure that represents knowledge about a concept or type of stimulus, including its attributes and the relations among those attributes." Our schemas allow us to make sense of situations and events, including the behavior of others, and we use them to predict situations, events, and behaviors in the relatively near or distant future.

In everyday life situations, we do this reasonably reliably, spontaneously, and fast. Two features of human cognition explain how this is possible. First, we do not allocate our cognitive resources equally to everything that happens to be in our environment. Rather, we tend to pay attention to something when it seems interesting, in other words, when we have reason to believe that paying attention to it and thinking about it is or will turn out to be worth our while. Second, we make sense of the things around us in terms of the information stored in our memory which is readily available to us. This knowledge directs the inferential process of making sense of various situations and events in particular directions. By and large, the more often we draw on some belief assumptions in our general world knowledge store, the more accessible (i.e., cognitively salient) they will be. Some of the most salient assumptions are universal, but others are culture-specific. The highly salient knowledge which is activated automatically when we pay attention to particular phenomena in our (physical or cognitive) environment has been termed "Background":

> We might usefully think of the Background as a set of assumptions and practices that maintain a fairly steady degree of not very high manifestness, across time, in an individual"s cognitive environment. A subset of the Background consists in assumptions/practices which make up the mutual cognitive environment of all (non-pathological) human beings – the deep Background; other subsets are the mutual cognitive environments of what can be loosely termed culturally defined groups of human beings – local Backgrounds. Carston (2002, p. 68)

It stands to reason that the assumptions/practices which form the "deep Background" of individuals are incorporated, as it were, in the heuristics for processing regularities in the perceptual environment. For example, our naïve physics knowledge keeps us alert to investing proximal events of particular types with a cause-consequence relation (often going beyond the evidence). Our face recognition mechanism guides us to analyze as faces even those configurations of features which bear only a very vague resemblance to human faces. The assumption that we have special cognitive mechanisms for analyzing input stimuli as faces, for cause–consequence attributions, etc. is fairly uncontroversial. If, by analogy with the deep Background, there are subsets of assumptions/practices which are specific to particular individuals as members of cultural groups ("local Backgrounds"), then it seems worth considering the possibility that we have developed sub-procedures for processing environmental inputs which incorporate the regularities in these local (or cultural) Backgrounds (see Augustinos, Walker, & Donaghue, 2014; Ringland & Deuce, 1988).

These underlying structures of knowledge, or schemas, which act as Background, can be of various types. Some may have fixed, stable, contents, in which case they are called "frames." For example, the frame associated with the word "car" includes the information that it has a steering wheel, an engine, and so on. Other schemas store information about types of events and are known as "scripts" (Schank & Abelson, 1977). For example, the

scripts for "going to a party" and "taking part in a business meeting" or "going to the restaurant" include assumptions about the typical parts of these events and things involved in them. Yet other schemas store information about roles and are simply called "role schemas" (Fiske & Taylor, 1991). They comprise the set of behaviors expected of a person in a given role, for example, the rights and obligations of a doctor in questioning a patient or of a lecturer in teaching a class of students. Two other types of schema identified by Fiske and Taylor (1991), which are also relevant to culture and behavior, are person schemas and self-schemas.

Since mental schemata are knowledge structures which provide the basis for forming expectations about new situations, they can be said to be theories that people have, systems of hypotheses which we expect to be true. As Sternberg (1990, p. 133) observes:

> Intelligent systems rely to a great extent on problem patterns when they face a familiar task. Instead of creating solutions from scratch for every problem situation, they make use of previously stored information in such a way that it facilitates their coping with the current problem.

As we illustrate below, differences in people"s schematic knowledge can lead to miscommunications and misunderstandings.

Culture and Frames Blass (1990, p. 15) considers the relation between culture-specific schemas and comprehension. She gives the example of the following report made by a member of a local cultural group in the Niger-Congo region of Africa: "The river had been dry for a long time. Everybody attended the funeral." She makes the point that although the report is easily understood by members of the local culture, it can seem incoherent to a hearer who does not have the appropriate cultural knowledge, because the local cultural knowledge includes the belief that when the river dries up, the river spirit dies, and that a ritual of burying the river spirit is then performed in order to improve the chances of the drought ending. This culture-specific schema is very salient to the members of the speaker's local culture, and in the absence of such knowledge, this communicative act seems incoherent.

In fact, miscommunication may occur even when the required schema is stored in the memory of all the participants, because it is insufficiently salient and accessible in the particular context. The following example illustrates this point:

> A British family had lived in an African country for several years. They had become familiar with the local language and culture. After the break-out of civil war in the region, they were forced to leave the country. Before leaving, they accepted the local people"s offer of help and asked them to try and "rescue" some of their "special things". Quite some time later, they were somewhat surprised to find that their TV set and video recorder were the main rescued items.

In this situation, miscommunication was caused by the British family members" failure to access and act on their cultural knowledge about the sorts of things that are considered prized possessions in the local culture. The phrase "special things" had the same literal meaning for both the British family members and for the local people: "things which are particularly dear to their owners." However, the local people"s schema associated with this expression included beliefs about technical goods as prized possessions, whereas the British family members' schema included objects which had some personal value, such as letters, photographs, books, and various personal belongings with sentimental rather than material value. Having lived for several years in the local community and being familiar with the local culture (and language), the British people knew that the local people considered technical goods prized personal possessions. However, the threat of being caught up in a civil war, their home culture schema for "special things" was more cognitively salient, and they failed to take account of the local cultural schema associated with the expression "special things." So, the organization and storage of knowledge into schematic frames make people susceptible to interpreting sociocultural categories, situations, and events incorrectly due to their automatic,

intuitive, reliance of their own cultural schemas.

Culture and Scripts Scripts contain information about common and appropriate sequences of events in well-known situations. They include language sequences as well as broader behavioral sequences. For example, scripts for greeting people can be very different across cultural groups as the following comments from international students studying in the UK illustrate:

> *When you are in a store or any form of service encounter, the staff is always very nice to you, usually saying: "Hi, how are you love, you all right?" , which is really nice, but I started wondering what I was supposed to answer to this. Should I just say: "I"m fine thank you!" Or should I also add: "and you?" Is that strange? All of these thoughts went through my mind the first few days in the UK, before I started thinking of ways to respond to this polite small talk. In Norway I am not used to a lot of conversation with the people I do my shopping with, it is usually just the few common phrases of: "Hello, that is 120 kroner, do you need a bag, thank you, bye". Nothing that invites a conversation like the English seem to do with their small talk in the same context.* (Female Norwegian postgraduate student)
>
> *One thing I have struggled with for quite a long period and am still working on is a very basic thing that happens almost every day – that is, greetings. In China, when we meet an acquaintance, we"ll say "hi/hey/morning", then the others will respond the same. If I still want to talk, I"ll do some small talk such as "what a coincidence to meet you here/ long time no see/ I miss you a lot", things like that. However, the greeting in the UK is different. People use "how"s it going/how are you?" instead of a single "hi", sometimes making me feel at a loss and don"t know how to respond.* (Female Chinese postgraduate student) (Spencer-Oatey, unpublished research data)

Numerous other types of scripts can be subject to significant cultural variation; a few examples are buying tickets for the bus or train, managing and chairing meetings, introducing a guest speaker, giving a presentation, and answering the telephone (e.g., see Pan, Wong Scollon, & Scollon, 2002). Some have interrelationships with another type of schema, role schemas, in that what people say or do can be influenced by their perceptions of participant roles.

Culture and Role Schemas Like scripts, role schemas can be subject to significant variation across cultural groups. This variation can include differences in relational framing in terms of the typical levels of hierarchy and distance–closeness perceived for the role partners (e.g., between teacher–student, doctor–patient, boss–subordinate). In addition, there can be noticeable differences in people"s beliefs about the rights and obligations associated with a given role.

Spencer-Oatey (1997), for example, found significant differences between British and Chinese conceptions of the tutor–student relationship. She found that both Chinese tutors and students perceived the role relationship to be more hierarchical than British tutors and students did. She also found that for British respondents, there was a negative correlation between hierarchy and closeness, in other words, the greater the perceived hierarchical gap, the lower the perceived closeness. For Chinese respondents, on the other hand, there was no significant correlation between the two variables, level of hierarchy and degree of distance–closeness.

The following comments from international students studying in the UK illustrate the ways in which different role schemas can cause people adjustment problems:

> *On the first day of the introduction week, a lecturer mentioned that students can address lecturers by their first names. I was surprised and felt uncomfortable. In Thailand, calling someone with higher positions directly with their names is inappropriate, lecturers in particular*. (Female Thai postgraduate student)
>
> *During my first term of study, I could not help noticing the major difference between the two countries" ways of learning. […] Professors are more like guides instead of instructors who tell me what to do. At first, I felt a little lost for the reason that it was the first time in my academic life without professors telling me to do the exercises on a certain page of the textbook.* (Male Chinese postgraduate student)
>
> *"If I don"t criticise you, it is praise enough" – This is a saying from the region in which I grew up, where people rarely give compliments. When a task is done well, it often remains uncommented, although people can be pleased with you. People*

> *also tend to focus on negative aspects and express negative feedback in a relatively straightforward and precise manner. […] In my current course, I noticed that lecturers" behavior differed. When an answer of a student was wrong, the lecturer did not say "No, that"s incorrect". Instead she asked the group if there are any other ideas. […] When I actively asked for feedback after a presentation, the professor focused on positive aspects rather than on negative ones. Additionally, he mitigated weaknesses by saying "other people also have problems with it". On the other hand, if students" answers were right or tasks done correctly, students got positive feedback which often was not my expected "well done" or "good" but an enthusiastic "brilliant", "very good" or "excellent". […] The differing behavior made me feel uncomfortable, because it did not comply with my usual pattern of getting or giving feedback and I did not expect it. It was also partly in conflict with my beliefs. I thought an honest and precise feedback is the basis on which to improve your performance. I could not understand why it is necessary to beat around the bush as we are adults and should see constructive criticism as a good thing. Furthermore, direct feedback saves time.* (Female German postgraduate student) (Spencer-Oatey, unpublished research data)

Schemas and Overgeneralization As the examples above imply, when we are in culturally unfamiliar contexts, we tend to apply our existing schemas in comparable contexts. Our implicit beliefs, assumptions, and expectations are often intuitive and not easily amenable to conscious reflection, and they influence our actions. The following exchange illustrates this point:

> A French person is at a restaurant. An Indian colleague arrives late. The French person does not know his Indian colleague well. He has tried to make a best guess about the type of drink the Indian person likes and has put in the order. The Indian colleague has arrived in the restaurant.
> French person: We ordered wine for the table and ordered you a soft drink.
> Indian person: Okay, I"ll drink both.
> French person: [surprised] Oh, good. (Example contributed by Kate Berardo)

The French person"s decision to order a soft drink for his Indian colleague is based on his schema for "Indian person" which includes the assumption: "Indian people do not drink alcohol because their religion prohibits it." In the context of the assumption: "My colleague is Indian," this schema, associated with "Indian person," makes highly salient the hypothesis:

"My colleague does not drink alcohol," and this hypothesis is the basis for the French person"s decision to order a soft drink for his Indian colleague. In light of the Indian participant"s reply, the French participant will most likely revise his schema for "Indian person." He can do this in a superficial way, by forming the assumption like: "Some Indian people drink alcohol." However, this revision of his "Indian person" schema would not be very useful, because it would include incompatible assumptions: "The religion of Indian people prohibits drinking alcohol" and "Some Indian people drink alcohol." If a schema includes contradictory assumptions, then it is very likely that it will give rise to conflicting predictions in a given situation. For this reason, the French person will be better off if he revises his "Indian person" schema by finding out more about the reasons why some Indian people drink alcohol, as this may be useful on similar future situations. We could say that the French person made the mistake of acting on a stereotype of "Indian person," which raises the question of the relation between schemas and stereotypes (see Hinton, 2000 for a detailed account of stereotypes in the context of human cognition and culture). Essentially, stereotypes are schemas which, though very general, are held with great conviction, so they provide the basis for unwarranted predictions about members of the stereotyped category (which may be defined in terms of culture, race, profession, age, sex, religion, etc.). These examples lend some intuitive support to the view that an important goal of research into culture, behavior, and intercultural communication is to examine cultural schemas and describe the similarities and the differences between them.

Part III: Applications

Having explored three important types of cultural influences on behavior, this final part of the chapter considers the implications and applications for counsellors.

Culture and Counselling Theory

It is important that the insights into culture and behavior that we have presented in this chapter are applied in practice, and we use therapeutic counselling as an example of applied psychology to highlight some ways in which current counselling theory and practice are found to have traditionally fallen short of doing justice to the role of culture.

Counselling can be described as a type of more or less formally institutionalized cultural activity in which communication between a skilled professional and a client aims to lead the client to develop a more positive sense of himself or herself in the context of their personal needs and aspirations and of the ways they function as members of society. A cursory survey of the literature (such as the one presented in Mollen, Ridley, and Carrie, 2003) points to the conclusion that current counselling theory and practice can benefit from the aspects of and theoretical perspectives on culture outlined in this chapter in respect of (a) the place of culture in counselling theory, (b) the conceptualization of a person"s cultural identity, and (c) the ways the study of culture should inform counselling practice.

The lack of adequate attention to culture in counselling theory and practice has not remained unnoticed. Thus, Mollen et al. (2003) claim:

> Although the multicultural movement has gained considerable momentum, some professionals–especially those trained years ago–continue to rely almost exclusively on standard person-centered, cognitive-behavioral, and behavioral approaches in their practices. The primary assumption implicit in this model is that multicultural competence derives from training in the use of conventional psychotherapies. Three secondary assumptions logically follow: (a) Major psychotherapies are universally applicable and robust enough to account for cultural variation among clients, (b) no additional systematic training is necessary, and (c) counselors" cultural group membership is unimportant. (Mollen et al., 2003 p. 15)

In one respect, this criticism is misplaced: reliance on a standard approach to counselling does not in and of itself preclude the appropriate use of multicultural competence. On the other hand, in this chapter, we have highlighted the multifaceted nature of both culture and culture research, which suggests that plausible models of counselling need to integrate insights into culture from various theoretical perspectives and to spell out the ways in which these insights should inform counselling practice. In this respect, these authors" criticism is justified: culture is generally not integrated with the standard approaches to counselling psychology in a systematic, sufficiently explicit, and theoretically plausible way but tends to be added on, as it were (a good example is McLeod, 2013). This leads to two problems.

Firstly, as Mollen et al. (2003, p. 2) observe, considerations of culture within counselling theory and practice tend to focus mainly, often exclusively, on ethnicity and race, ignoring other variables such as gender, religion, profession, or age. To be sure, in everyday usage, the concept of "a culture" typically (more or less implicitly) overlaps with nationality, ethnicity, or race (though it is worth noting that "youth culture" is a fairly well-established collocation). In line with our consideration of culture and social groups (see the section "Culture and Social Groups"), the cultural identity of an individual is better described as a complex system of different group memberships each of which is defined in terms of a different variable. Therefore, counselling theories and practices should take account of the complexity of cultural identities of individuals rather than deciding on a single defining variable of culture by stipulation.

Although our day-to-day social interactions are processes which take place in the context of culture, academic descriptions and explanations of culture(s) are all too often static. In the section "Conceptualizing Behavior," we tried to show how culture is reflected in behavior and the interpretation of behavior in a systematic way, and how our interpretations of behavior – which are holistic – are products of the integration of diverse items of information from various sources, including culture. Moreover, our cultural values, core beliefs, and norms are themselves organized into consistent (and at least to that extent rational) systems. An implication for counselling practice is that the counsellor"s sensitivity to and awareness of (their own and the client"s) cultural values, core beliefs, and norms, as well as of their more or less culture-

specific schemas, frames, and scripts are of vital importance for their ability to monitor the counselling process, to explore their interpretations of the client''s communicative contributions and make correct and relevant interpretations conducive to desired therapeutic outcomes.

Secondly, greater conceptual interpretation of culture is needed. All the key culture concepts, including those explored in this chapter, need to be examined in some detail, as each has the potential to lead to a different relevant insight into the counselling clients'' presenting issues. For example, we have pointed out that cultures are shared, but that they are not shared in identical ways by all members of sociocultural groups (see the section "Culture and Sharedness"), that cultures can be investigated both at the collective, group, level (e.g., Hofstede 1980, 2001) and at the individual level (e.g., Schwartz, 2011). However, the implications of these, as well as other, approaches to culture for different approaches to counselling remain underexplored (despite a growing body of work including McAuliffe & Associates (2008) and Cornish et al. 2010). Our consideration of attribution theory in making sense of people's behavior, in general, and communicative social interaction, in particular, suggests that individual-level and group-level characteristics of individuals influence the attributions that they make and need to be taken account of in counselling practice (which is itself a type of communication situation) to ensure that counsellors make as correct relevant attributions as is possible. For example, it is not clear how such attribution can be made without taking account of the concept of "normalcy" (see the section "Culture and Normalcy"), because the way a particular behavior is interpreted as socially appropriate or inappropriate, assigned meaning by the counsellor and explored further in the counselling process, depends on whether it is normal in the client''s culture. At the very least, each approach to counselling should incorporate a model of the way the counsellor''s and the client''s cultural values, core beliefs, and norms impact on the therapeutic process and how they can be fruitfully brought to bear on and integrated with this process. It stands to reason that this can be achieved only provided a person''s cultural identity is conceptualized in a plausible way.

Culture and Behavioral Change

Much work in the intercultural field has traditionally attempted to explain or even predict behavior on the basis of the core values that members of a cultural group are thought to hold. Yet, as explained in the section "Culture and Behavior: Values and Beliefs," there are fundamental problems with doing this, not least because there is no one-to-one link between behaviors and values. The same values can map onto a range of attitudes and behaviors, while the same attitudes and behaviors can be influenced by different values. Fischer and Schwartz (2011) illustrate this with the following example:

> Kissing a nonrelative on the cheek when meeting in public may be construed as showing "respect", "friendship", and "equality" or as violating "tradition", "decency" and "honor". Which mapping occurs depends on the social and cultural context. Fischer and Schwartz (2011, p. 1140)

In other words, context is of crucial importance, and this is being increasingly acknowledged by intercultural theorists (e.g., Leung and Morris, 2015; Morris et al., 2015). As Morris et al. (2015, p. 1) point out, "cultural influences on individual judgment and behavior are dynamic and situational rather than stable and general, especially as people span multiple cultures." Moreover, as applied linguists explain, communicative interaction is by nature dynamic and entails the co-construction of meaning on the part of all the participants. So then, if behavior is so dynamic and unpredictable, how can we best help people handle the challenges of adapting to culturally unfamiliar behavior? In our view, the only feasible ways are, on the one hand, to enhance their awareness of possible areas of difference (i.e., like the ones we have explored in Part II of this chapter) and, on the other hand, to help them develop self-management strategies.

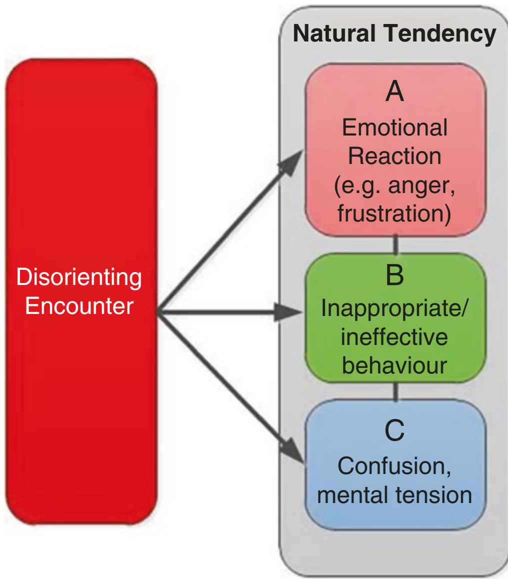

Fig. 10.3 Natural tendency when experiencing a disorienting encounter. (Spencer-Oatey, personal communication)

A number of theorists (e.g., Anderson, 1994; Ward, Bochner, & Furnham, 2001) have pointed out that adaptation entails three elements: affective (A), behavioral (B), and cognitive (C) (cf. Ward, Bochner, & Furnham (2001), ABCs of culture shock). People need to pay attention to all three of these elements, making adjustments in any or all of them when necessary. Figure 10.3 illustrates people's natural tendencies when experiencing a disorienting encounter, such as may occur in culturally unfamiliar contexts. People tend to react emotionally (e.g., with anger, frustration, embarrassment, etc.), they may feel confused because they cannot give it a rational interpretation, and they may respond in an ineffective or unhelpful manner.

To overcome these ineffective reactions, people need to monitor, reflect on, and adjust their ABC elements, as illustrated in Fig. 10.4.

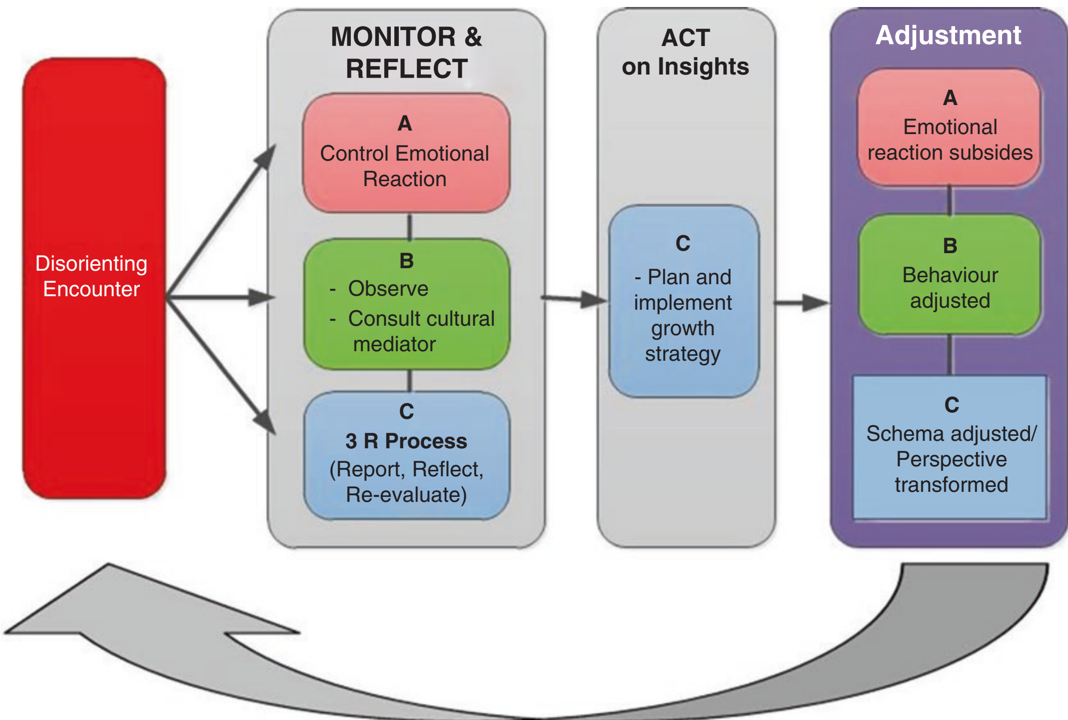

Fig. 10.4 Intercultural learning cycle. (Spencer-Oatey, personal communication)

As Storti (1991) points out, the key is to deal with our emotions as they arise and the best way of controlling our emotions is to reflect on why we are experiencing them. The 3R tool developed by Spencer-Oatey and Davidson (2015) provides a set of helpful steps for this reflection process. Moreover, as part of this reflection process, it is often helpful to consult a cultural insider/mediator to find out their interpretation, explanation, and insights, in order for us to achieve an effective re-evaluation. Observing comparable encounters will also build up our normalcy awareness and help us identify how cultural insiders act in these contexts.

These three-pronged steps, then, can form the foundation for our strategies and plans for our personal growth and our ultimate adjustment. Space does not allow us to go into detail on this growth and adjustment process, but we have found Molinsky"s (2013) "global dexterity" framework particularly helpful in this respect. Our students have found it extremely beneficial in helping them in their intercultural adaptation endeavors, and we recommend it highly.

Conclusion

Morris et al. (2015, p. 1) argue as follows:

> In this era of globalization, the models of culture in terms of value orientations […] that have traditionally dominated organizational behavior research increasingly appear incomplete. […] cultural influences on individual judgment and behavior are dynamic and situational rather than stable and general, especially as people increasingly span multiple cultures. Managers today switch between cultural codes from one interaction to the next to mesh with different audiences.

Concerns over the way in which culture is conceptualized and how its interrelationship with behavior can be understood have recently led to a special issue of the *Journal of International Business* (Caprar et al., 2015). The stated aim of that special issue was to find new and better ways of conceptualizing and measuring culture – with an implicit aim of offering new insights relevant for those working in international business. The jury is still out, and it seems the field is at a critical developmental point. The limitations of an explanatory reliance on cultural values are increasingly being acknowledged, and attention is turning to "new" (yet old!) concepts such as norms. Yet as Leung and Morris (2015) argue, multiple concepts are needed. The complexity of explaining how culture can impact the dynamics of interaction is too great to be accounted for by a single concept. In this chapter, we have explored some of the most important concepts and drawn attention to some of the conceptual difficulties associated with the issue.

In particular, we have tried to show that acceptance and understanding of different cultures in social interaction are made possible by sensitivity to a wide range of factors which influence social interaction, including the differences in cultural backgrounds, which can be related systematically to values, beliefs, norms, and schemas (frames and scripts). Therefore, awareness of values, beliefs, norms, and schemas can be regarded as a key foundation to multicultural competence and thus helpful for its development. The examples of intercultural interactions we have considered and our brief discussion of the application of our approach to therapeutic counselling as a field of applied psychology point to the conclusion that multicultural competence can be described, explained, and developed even in the absence of definitive answers to otherwise interesting and important questions which call for a detailed theory of culture, such as the one Blommaert (1991) posed many years ago: "How much culture is there in intercultural communication?"

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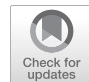

11 Culture: The Use and Abuse of an Anthropological Concept

Raymond Scupin

Introduction

The concept of culture as developed within the discipline of anthropology has had a significant influence on Western understandings of humanity for over a century. This concept percolated widely into the discourse of the Western world as an alternative to explaining human differences as a result of racial or biological factors (Brumann, 1999; Richerson & Boyd, 2005). The concept of culture is thought to be one of the signal achievements of the field of anthropology. Although the concept is foundational for modern Western thought and has been widely dispersed, it has also gone through considerable changes over the last century. At times the concept was used and abused by practitioners and academics in many disciplines and arenas, including politics, economics, and in corporate settings. The concept was loosely employed by many within academia and elsewhere as a major autonomous variable and determinant of individual, ethnic, national, and sometimes civilizational group behavior. Simultaneously, the reliance on the culture concept to explain and characterize individual and group behavior resulted in a separation between the disciplines of anthropology and psychology. More recently, following groundbreaking research within both cognitive psychology and cognitive anthropology, there is a growing recognition that these disciplines need to combine understandings of the inner workings of the individual mind as well as the cultural context. The merger of these disciplines with a nuanced understanding of the culture concept can provide a foundation for improvement in dealing with the practical issues in counseling, social work, and other related applied psychology fields.

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Culture: Early History of the Concept in the West

The concept of culture emerged early in classical antiquity in Western society with the writings of the Roman philosopher and orator Cicero. Cicero used a Latin agricultural metaphor with the phrase *cultura anima* in his *Tusculanae Disputationes* (Tusculan Disputations), a work devoted to Stoic philosophy in 45 BC to refer to the "cultivation of the soul (mind)" (Panoussi, 2009, p. 518). The term culture resurfaced once again in Europe by Enlightenment philosophers such as Jean Jacques Rousseau and later Immanuel Kant related to the progress or "perfection" of the individual especially through education. Similar to Cicero's original meaning, the Enlightenment philosophical discourse emphasized that humans could overcome their original

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immaturity and "barbarism" through the attainment of culture through education. During the Enlightenment, the term culture frequently interconnected with particular theories of history. For example, French writers in the Enlightenment tied the term culture to "civilization," which represented a cumulative, progressive form of human achievement (Kuper, 1999). The French social contract theorists such as Rousseau argued that civilization had emerged from an original lower "state of nature" and evolved toward more refined and higher forms of culture. Like the French usage of culture, the British in the nineteenth century linked culture with civilization, usually to indicate a superior form of "British civilization." For example, the British poet and essayist Matthew Arnold used the term culture to refer to an ideal of individual human refinement, of "the best that has been thought and said in the world." He contrasted culture to anarchy and believed that it needed to be defended from those who were not refined and educated (Super, 1965).[1]

A Counter-Enlightenment, Romantic, and nationalist discourse emerged in Germany during the eighteenth century with thinkers such as Johann Gottfried Herder who proposed a more collective conception of culture (*Kultur)* based on language, customs, and traditions that provided coherent identities of humans in different geographical regions ([1800] 1967; Shweder, 1984; Stocking, 1968, 1996; Zammito, 2002). In contrast to the abstract and historic ideals of progress and perfectibility of most Enlightenment thinkers, Herder maintained that human societies and "cultures" (plural) develop in relationship to the particular historical constraints and challenges of specific time periods. Herder argued that each culture is unique and provides a *Weltanschauung* (worldview) or *Geist* (spirit) intimately connected with the various languages, histories, and geographical location of different groups of *Völker* (peoples).[2] Concepts, meanings, and inner thought were completely dependent on the language of the speaker. Additionally, in Herder's conception of cultures, one could not produce cross-cultural generalizations. Cultures were incommensurable and could not be compared with one another. In Herder's view, the culture of a particular group of people was not only a cognitive component—rather it had a predominant affective or emotional aspect. People were emotionally connected with their particular ancestral roots, languages, and territories. Herder's concept of culture[3] was developed in Germany and elsewhere to connect with the embryonic ideals of nationalism that were spreading throughout Europe during the Romantic period. For example, the famed composer Richard Wagner drew on the *kulturvolk* (folk culture) of the ancient religions of Europe in writing operas to express the nineteenth-century nationalistic sentiments emerging in Germany.

Within Germany, two leading philosophers Wilhelm von Humboldt (1776–1835) and Adolf Bastian (1826–1905) attempted to synthesize some aspects of the Enlightenment and Counter-Enlightenment thinking expressed by Kant and Herder. Humboldt was a linguist who had studied the Basque language in Spain along with other languages and pioneered the idea that languages were rule-governed rather than just being a

[1]The view of culture expressed by Arnold became widely incorporated into common parlance that "culture" was associated with elite ideals of classical literature, art, aesthetics, music, elegant fashion, or haute cuisine. This is not the view of culture that became prevalent in anthropology.

[2]Although Herder emphasizes the particularity of cultures in the plural, his break with the Enlightenment ideals were not consistent. In some of his writings, Herder espoused views that confirmed that progress did take place within specific cultures as a result of historical interconnections among societies. However, Herder maintained that cultural differences were overlooked by most Enlightenment thinkers (Denby, 2005; Zammito, 2002).

[3]In Herder's discussion he used the term *Gestalt* (shape or form) to refer to perceptions that people had based on their particular language and cultural environment. It assumed that the human mind perceived the empirical world as configurations or wholes, rather than as independent parts. Of course, the concept of *Gestalt* led to a movement in German psychology and therapeutic circles in the late nineteenth century. Herder's conceptions of plural cultures had a deep influence on the origins of psychology in Germany. He influenced Wilhelm M. Wundt who published his *Völkerpsychologie* in 1900 and was the father of experimental psychology.

collection of words that had meaning. He argued that the structure of a language expressed the inner life and knowledge of the speakers (von Humboldt, [1836] 1999). Humboldt believed that each language had a structure and form that resulted in particular forms of *Weltanschauung,* a view reflecting Herder's influence. However, he also maintained that there were linguistic universals based on the mental categories of the human mind. Humboldt thought that there was a common "human nature" among all members of humanity (*Gattungs-Charakter)* and that all human cultures shared basic similarities, including the universal characteristics of language and reasoning (Bunzl, 1996, pp. 22, 31). Similarly, Adolf Bastian in 1860 argued for "the psychic unity of mankind." He proposed that a cross-cultural comparison of all human societies would reveal that distinct worldviews consisted of the same basic elements. He maintained that all human societies share a set of "elementary ideas" (*Elementargedanken*), but like Herder, he held that the world consisted of many different cultures based on geographical locales and historical circumstances that resulted in various "folk ideas" (*Völkergedanken*) that were local modifications of the elementary ideas (Bunzl, 1996; Koepping, 1983).

Culture: A Key Concept in Anthropology

Both the Enlightenment and Counter-Enlightenment conceptions of culture had definitive influences on the discipline of anthropology. The predominant explanation that nineteenth-century anthropologists offered to explain the differences and similarities among human societies and cultures became known as unilineal *evolution.* Charles Darwin had developed his theory regarding the evolution of life in 1859, with the publication of his book *The Origin of the Species.* Many anthropologists of the nineteenth century were influenced by Darwin's thesis and attempted to apply these evolutionary concepts to the study of human societies, cultures, and "races." These nineteenth-century anthropologists' evolutionary approaches influenced their view of culture. In the British Victorian tradition of anthropology in the nineteenth century, Sir Edward Burnett Tylor proposed a definition of culture in his two volume work entitled *Primitive Culture* that includes all of human experience:

> Culture…is that complex whole which includes knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. (1871, p. 1)

His usage of the term culture referred to a fundamental universal human cultural capacity that all humans shared. Like the Enlightenment thinkers, he connected "culture" to "civilization." In dealing with the specific societies, he was influenced by Herder's notions of cultural differences. However, like most other nineteenth-century anthropologists, he maintained that there was an evolution of varying stages of society: savagery, barbarianism, and civilization.

Although Tylor accepted a form of the "psychic unity of mankind," he believed that cognitive abilities were closely linked with the varying stages and levels of societal evolution and development. Like other nineteenth-century evolutionists such as Herbert Spencer, Tylor assumed that a savage or barbarian mentality was associated with early stages of evolution. He suggested that there was a corresponding progress in mental ability in morality, religion, economic, and social institutions and confidently assumed that British culture was the pinnacle of civilization. Like many of the other Enlightenment thinkers, Tylor maintained that human use of reasoning capacities resulted in the progression of civilization. For example, Tylor believed that language evolved from early origins in gestures to the more abstract signs of civilized discourse. Thus, according to Tylor, culture, "that complex whole," was associated with the evolution of "civilized societies," which were superior to the lesser stages of development. He was referring to the *culture of all humanity* as evolution progressed rather than Herderian unique cultures of specific peoples in various geographic and historical locales (Stocking, 1968). Yet, unlike many of the other anthropologists of the nineteenth century, Tylor's

definition of culture implied a separation of culture and biology (genetics) or "race," a development that was to become important in the twentieth century and contemporary anthropology.

One of the major anthropological projects that criticized these Victorian views of culture and unilineal evolution was associated with the efforts of Franz Boas (1858–1942), who was born in Germany, where he was also educated and trained in physics. Later, he became interested in geography and culture, and after research among the Eskimo (Inuit) in the Canadian Arctic, he worked closely with Adolph Bastian and others in the Royal Museum of Berlin. Immigrating to the United States in 1887, Boas eventually became a highly significant anthropologist, establishing the first PhD program in anthropology in the United States at Columbia University. While at Columbia, Boas and his students carried out extensive research in physical anthropology, archaeology, linguistics, and cultural anthropology, providing the contemporary foundations for the systematic investigation of such topics as race, culture, and ethnicity (Degler, 1991; Stocking, 1968). He trained many of the early American anthropologists such as Ruth Benedict, Margaret Mead, Edward Sapir, Alfred Kroeber, and others who promoted his views on culture and human behavior.

Boas' conception of culture drew on the "psychic unity of mankind" ideas of Bastian, along with inspiration from Herder, Kant, and other German thinkers. Although accepting Darwin's contributions, he rejected the use of evolutionary models when applied to society. Theorists like E.B. Tylor had assumed that hunter-gatherers and many other non-Western societies were living at a lower level of existence than were the "civilized" societies of Europe. Boas' ethnographic research among the Inuit of the Canadian Artic convinced him that these people were not the "savages" as depicted in these nineteenth-century models of cultural evolution. Boas' fieldwork experience and his intellectual training in Germany led him to conclude that each society has its own unique historical development. This Boasian perspective informed by Herder's conceptions of culture maintains that each society must be understood as a product of its own history and geographical features (Boas, 1911, 1940). Boas advocated close-up ethnographic fieldwork for cultural anthropologists in order to provide detailed descriptions of specific cultures.[4] In his teaching and research, Boas emphasized the recognition and importance of culture on the conscious and unconscious mind for individuals within specific regions of the world. This view led Boas to adopt the notion of cultural relativism, the belief that each society should be understood in terms of its own cultural practices and values. Further, in contrast to the Victorian anthropologists, he held that although some societies had more effective food production techniques than others, no one cultural group is more advanced in mental abilities than another.

Culture and Personality: Early Approaches

A direct outgrowth of the Boasian approach was the emergence of *culture-and-personality theory* in American anthropology. Boas trained two noteworthy students, Ruth Benedict and Margaret Mead, who were early pioneers in the study of enculturation, which is the link between individuals and the specific culture to which they are exposed. Influenced by Boas and also Freud and Jung, Benedict and Mead maintained that immediately after birth, infants begin to absorb language and culture—the etiquette, mores, values, beliefs, and practices of their society—through both unconscious and conscious learning. According to Benedict and Mead, an individual acquires his or her personality, the fairly stable patterns of thought, feeling, and action, through the process of enculturation. They believed that the cognitive component of personality consisting of thought patterns, memories, beliefs,

[4]Although Boas was influenced by the Herderian tradition, he did not assume that cultures were bounded and isolated from one another and indicated that culture changes derived from the interconnections among different societies (Bashkow, 2004; Denby, 2005; Lewis, 1999, 2001).

perceptions, and other intellectual capacities; the emotional component including emotions such as love, hate, envy, jealousy, sympathy, anger, and pride; and the behavioral component, the skills, aptitudes, competence, and other abilities, were all fundamentally shaped by the particular cultural environment of the individual. After studying processes such as child-rearing and enculturation, Benedict proposed that every culture is characterized by a dominant personality type. Culture, she argued, is essentially "personality writ large."

One classic example of the application of culture-and-personality theory is Benedict's analysis of the Plains and Pueblo Native American Indian societies. In an essay titled "Psychological Types in the Cultures of the Southwest" (1928) and in a classic book, *Patterns of Culture* (1934), Benedict classified Pueblo societies as having an Apollonian (named for the Greek god Apollo) culture. The Pueblo cultural ethos stressed gentleness, cooperation, harmony, tranquility, and peacefulness. According to Benedict, these values explain why members of Pueblo societies were "moderate." The Pueblo rarely indulged in violence, and they avoided the use of drugs and alcohol to transcend their senses. In contrast, Benedict characterized the Plains Indians societies as Dionysian (after the Greek god Dionysius). She described how the values and ethos of the Plains peoples were almost the direct opposite of those of the Pueblo.[5] The Plains Indians were involved in warfare and violence, and their ritual behavior included the use of drugs, alcohol, fasting, and physical self-torture and mutilation to induce religious ecstasy. Benedict extended her analysis to such groups as the Kwakiutl Native American peoples and the Dobu of Melanesia. She referred to the Kwakiutl as "megalomaniacs" and the Dobuans as "paranoid," fearing and hating one another. In each case, she claimed that the group's values and ethos had created a distinctive cultural personality. In Benedict's analysis, individual personalities were formed through enculturation, and the values, beliefs, and norms of different societies constituted variations in culture. In other words, Benedict believed that the culture of a particular society can be studied by studying the personality of its bearers. She thought that the patterning or configuration of a particular culture is simply reflected in an individual's personality.[6]

At the age of 23, Margaret Mead went to the islands of American Samoa to study adolescent development. In the United States and other Western societies, adolescence was usually marked by emotional conflict and rebellion against parental authority. Boas wanted Mead to investigate this aspect of life in Samoa to determine whether this pattern of adolescent development was universal or determined by their cultural environment. The central research question that Mead was to investigate was: To what extent are adolescent problems the product of physiological changes occurring at puberty or the result of cultural factors? Based on her ethnographic research in Samoa, Mead concluded that, in contrast to US society, adolescence in Samoa was not characterized by problems between the young and the old. She attributed the difference between the two societies to different sets of values, which produced different cultural personalities. In Mead's book, *Coming of Age in Samoa* (1928), she argued that Samoan society emphasized group harmony and cooperation. These values arose, according to Mead, from Samoan child-rearing practices. Samoan children were raised in family units that included many adults. Therefore, youngsters did not develop strong emotional ties to any one adult. Consequently, she argued, emotional bonds were relatively shallow.

As an aspect of these shallow emotional bonds, Mead argued that Samoan society was more permissive than US society. Children learned privately and often secretly about sexuality, and adolescents learned freely but had hidden,

[5]Benedict had read the work of German philosopher Friedrich Nietzsche, who used the terms Dionysian and Apollonian to describe different cultural ethos and styles of living in the world.

[6]Benedict's portrayals of culture as integrated coherent configurations that produced specific personality types were influenced by her readings of Gestalt psychology.

clandestine premarital sex. In addition, Mead contended that Samoan society shared a common set of values and standards. Therefore, Samoan children were not exposed to conflicting values and differing political and religious beliefs, as were US adolescents. For these reasons, Mead concluded, Samoan children experienced a much easier transition from adolescence into adulthood than did their counterparts in the United States. Like Benedict, Mead stressed that distinctive cultural values, beliefs, and norms formed an integrated system of behavior that resulted in specific types of personalities.[7] Individual cultures were the embodiment of the creative energies of the people who shared the same patterns of language and thought (or authentic *Geist)* in their everyday lives in particular times and places. The concept of culture maintained by Mead and some of the other Boasians[8] in North American cultural anthropology tended to produce a portrait of the multiplicity and plurality of geographically and historically conditioned discrete cultural wholes.[9]

[7]Margaret Mead's ideas became very influential in US society as she wrote monthly columns for Redbook magazine and was a regular guest on talk shows such as The Tonight Show with Johnny Carson. She also became well-known through the pediatrician Benjamin Spock who drew on her research on enculturation in his many editions of *Baby and Child Care* first published in 1946. Spock's book became the prominent guide book for many parents in American society for years. Mead's publications included over 1400 titles, including book reviews, articles in scientific journals, newspapers, popular magazines, as well as her ethnographies. After Margaret Mead's death, New Zealand anthropologist Derek Freeman published two controversial books, *Margaret Mead and Samoa: The Making and Unmaking of an Anthropological Myth* (1983) and *The Fateful Hoaxing of Margaret Mead: A Historical Analysis of Her Samoan Research* (1998), critiquing Mead's research in Samoa. Freeman argued that Mead had been duped and lied to by the Samoan girls that she interviewed and was wrong in many details about Samoan culture. Because of the immense popularity and reputation of Mead, the publication of these books created an international media event with headlines in major newspapers and magazines throughout the world. In 2009, Paul Shankman, an ethnographer who did ethnographic research in Samoa, assessed the Mead-Freeman controversy in his book *The Trashing of Margaret Mead: Anatomy of an Anthropological Controversy.* He asserted that differences in both Mead's and Freeman's personal histories resulted in misinterpretations and exaggerations about Samoan culture and society. In 1979, President Jimmy Carter awarded the Presidential Medal of Freedom to Mead, posthumously. Mead's daughter, well-known anthropologist Catherine Bateson, received the award, presented by Civil Rights leader and politician Andrew Young, on behalf of her mother.

[8]Another student of Boas, Edward Sapir, focused on the relationship between language and culture. Sapir was a prodigious fieldworker who studied and described many Native American languages and provided the basis for the comparative method in anthropological linguistics (1929). Like Benedict and Mead, Sapir thought that culture itself could be analogous to a personality and could be understood as systems much like grammatical and sounds (phonetics) of language. One of his students Benjamin Whorf, an insurance inspector by profession and a linguist and anthropologist by calling, conducted comparative research on a wide variety of languages. The research of Sapir and Whorf led their students to formulate a well-known hypothesis that was based on Herder and Humboldt's conceptions of language and culture (Whorf, 1956). It became known as the Sapir-Whorf hypothesis, which maintains that there is an intimate relationship between the properties or characteristics of a specific language and its associated culture and that these features of specific languages define experiences for the individual. It appears that Boas differed in his understanding of language from Whorf that the Sapir-Whorf hypothesis implied. He argued that thought determines language, rather than language vice-versa. For example, Boas believed that even if some primitive languages did not have sufficiently abstract concepts, all humans are able to carry on abstract philosophical conversations. He argued that both primitive and modern humans have similar cognitive capacities (Boas, 1911).

[9]At about the same time, as the Boasian paradigm of culture and society developed, varieties of "functionalism" were emerging in British anthropology. Bronislaw Malinowski (1944) and Arthur Radcliffe-Brown (1952) initiated their own versions of functionalism. Functionalist perspectives also produced portraits of societies as integrated organic coherent systems with interdependent social institutions based on values, kinship, and an awareness of common cultural identity. Malinowski was at one time a student of Wilhelm M. Wundt, the founder of German experimental psychology who was also deeply influenced by Herder.

Clifford Geertz and Symbolic Anthropology

Clifford Geertz was an anthropologist educated in the Department of Social Relations at Harvard under the guidance of sociologist Talcott Parsons. Parsons had earned his PhD in Germany and had translated some of the work of Max Weber, the

famed German sociologist. Geertz, inspired by Parsons and Weber, promoted an interpretive-based understanding of culture that had its intellectual roots in Herder.[10] Geertz and a number of other anthropologists at the University of Chicago initiated what became known as symbolic anthropology. In his 1973 volume, *The Interpretation of Culture*, Geertz advocated a method of ethnographic inquiry that he referred to as "thick description." Drawing on a famous statement of Weber, Geertz described the most important aspect of culture as the "webs of significance," that is, symbols that have meaning that humans have spun. Thick description focuses on the collection of data on social structure, the economy, ritual, myth, but especially symbols and cultural values. From these data, interpretations of symbolic meanings—webs of significance—are drawn. Geertz advanced the view that language and culture are publically shared by people within society. He emphasized the objectivity of a publically shared culture rather than its subjective aspect. Culture is not something stored within the mind, but rather it is publicly shared by individuals through their everyday language, symbols, and behavior.[11] As ethnographers use the methods of thick description, Geertz argued that they can observe, discern, and understand the interconnected patterns of meanings, motives, moods, intentions, and activities of people. Geertz acknowledged that anthropologists are interpreting other people's symbolic worlds when they write their ethnographic texts. The aim of the symbolic anthropologist is to make people's values, beliefs, and worldviews meaningful and intelligible to others. Vehemently rejecting any form of causal explanations, scientific models, or cross-cultural generalizations, Geertz proposed that "culture" ought to be studied and interpreted through thick description just as scholars would interpret a literary or historical text.[12] In his view, humans create their own "webs of significance" in incomparable ways and all human knowledge is "local knowledge" (Geertz, 1983). This approach to understanding local knowledge and particular cultures is somewhat parallel to the Herderian conceptions as proposed by Boas and some of his students. The Geertzian interpretive perspective had a widespread influence not only in anthropology but also in literature, art, law, politics, and many other fields.[13]

[10] As Herder had introduced his concepts of culture and language in Germany, he was instrumental in the development of a hermeneutic-interpretive method for use in critical Biblical studies. This hermeneutic method involved imagining what the original intentions of the authors who were writing the particular Biblical texts. Max Weber had been influenced by some of the developments within this hermeneutic tradition of scholarship. He proposed that social scientists rely upon *verstehen* (sympathetic imagination) in helping to comprehend human behavior (1949).

[11] The Geertzian conception of culture was influenced by Parsons and Weber and the approach was also consistent with the behaviorist psychologists led by J.B. Watson and B.F. Skinner who disdained any attempts to study the inner workings of the human mind. Geertz had been influenced by the philosopher Gilbert Ryle who argued that psychologists and social scientists should not be interested in understanding internal cognitive or perceptual mechanisms within the mind. Like the behaviorist psychologists, Ryle maintained that the most one could do is to understand what the circumstances are when individuals report something about their internal experience (1949).

[12] Geertz expressed skepticism about any claims regarding human nature or human universals. Like Margaret Mead or Ruth Benedict, he was constantly in search of ethnographic studies that demonstrated that particular societies were so culturally different in order to undermine any notion of human universals or aspects of a human nature. In his defense of cultural relativism, Geertz made the claim that anthropologists are the "merchants of astonishment" as they describe the exotic ways in which cultures differ (1984). For example, Geertz wrote a praiseworthy review of Chinese anthropologist Cai Hua's ethnographic study of the Na (Mosuo) of Southern China that suggested that they were matrilineal, matriarchal, and had no fathers or husbands (2001; Cai Hua, 2002). Cai Hua's book has been thoroughly criticized by both Chinese and Western anthropologists as a distortion of Na society. The Na are patrilineal, patriarchal, and they have fathers, marriages, and families (Harrell, 2002).

[13] One anthropologist influenced by the Geertzian perspective, Richard Shweder, developed a field known as "cultural psychology," which resonated with some psychological anthropologists. The cultural psychologists emphasize a Geertzian conception of culture in their exploration of psychological factors such as cognition, perception, emotions, morality, and behavior. See Shweder (1984) for how Geertzian concepts of culture represented a "romantic" rebellion against the Enlightenment and scientific views of human nature and human universals.

The Consequences of the Widespread Acceptance of Culture as Used by Anthropologists

This promotion of a Herderian conception of plural cultures by Boas, Benedict, Mead, and other students of Boas during the 1920s, 1930s, and 1940s needs to be understood within the historical context of international scientific and political developments in the early twentieth century. At that time, many social scientists and other intellectuals suggested that biology and race are the most influential determinants of human behavior. In the United States and Europe, there were many scientists and intellectuals who promoted eugenics policies that suggested that certain individuals with specific genetic or heredity traits should be sterilized. In Germany many social scientists, including anthropologists who were members of the Nazi Party, promoted the idea that because of biological characteristics, some races are superior to others in respect to behavior and thought. Cultural anthropologists in the United States trained by Boas vigorously challenged this view of biological or racial determinism through their research on enculturation. Boas' students adamantly maintained that culture was not the result of biological inheritance or race. Attributing genetic traits or biological instincts as determinants of human behavior was thoroughly rejected by these early twentieth-century anthropologists (Benedict & Weltfish, 1943; Degler, 1991; Konner, 2002). In their view, the human behavior of any group, regardless of their biological inheritance, was caused and determined by the process of enculturation.

Many of the early ethnographic studies by some of Boas' students were completed in small-scale non-Western societies on islands or Native American Indian reservations where cultural boundaries were assumed to be fixed. They believed that cultural boundaries were easy to delineate and that each distinct people had a distinctive culture. This formulation of culture produced essentialist or stereotypical portraits of different societies, viewed as isolated and bounded communities with only a small degree of internal differentiation, therefore appearing homogeneous and static. This became known as the "cookie-cutter approach" to culture. In the 1930s, 1940s, and 1950s, this understanding of culture as developed within anthropology gained broad acceptance and percolated into the public and academic spheres in politics, education, psychology, economics, history, and other arenas. For example, during World War II the term culture was used to refer to "Japanese culture," "German culture," "Chinese culture," "Russian culture," "American culture,[14]" etc. Cultures were discussed as if they were homogeneous, coherent, bounded, tightly woven, and unified entities that had an identity-determining role for individuals and groups in a uniform and static manner.[15]

[14]During World War II Ruth Benedict was hired by the Department of Defense to study the characteristics of Japanese culture which resulted in her book *The Chrysanthemum and the Sword* (1946). Other social scientists, such as the developmental psychologist Erik Erikson, a close colleague of both Margaret Mead and Ruth Benedict, wrote about Germany's culture during the Nazi period. Erikson also penned a book *Childhood and Society* (1963) that contained a discussion of the Yurok Indians of the Klamath River in northern California where he drew on Mead's discussions of child-rearing and culture.

[15]In reaction to the widespread diffusion of the anthropological concept of culture in the United States, the anthropologists Alfred Kroeber and Clyde Kluckhohn wrote a book describing the various definitions of culture used within anthropology and related fields (1952). Kluckhohn spent most of his career teaching at Harvard University but had studied at the University of Vienna where he was exposed to psychoanalytic theory. Kroeber had been a student of Boas at Columbia University and completed the first PhD degree in anthropology in the United States in 1901. In their 1952 book, they found 171 definitions of culture sorted into 13 different categories. They confirmed that there had been an easy assimilation of a loosely defined vague anthropological concept of culture in general use among psychologists, psychiatrists, economists, lawyers, and others to refer to "our culture" or "their culture" in a mechanical fashion (Fox & King, 2002; Kroeber & Kluckhohn, 1952). Though they appreciated the fact that the anthropological concept of culture had diffused widely into American usage, they expressed concern that this usage was too imprecise for explaining human behavior (1952, p. 5). The goal of their book was to promote a more systematic anthropological concept of culture that would emphasize the separation of genetic or biological inheritance from the social environment and demonstrate

The anthropological tradition represented by Mead and Benedict did stimulate more careful research regarding personality and culture. Much of the data provided by these early anthropologists was important in understanding the enculturation process. Despite these accomplishments, the culture-and-personality school has been criticized on many fronts. One major shortcoming cited is the practice of characterizing an entire society in terms of one dominant personality. Culture-and-personality theorists tended to suggest that all members of a given society share the same cultural knowledge. This assumption produced highly stereotyped presentations of various cultures and peoples.[16] In fact, culture and knowledge are distributed differently and unequally within society. Some people have knowledge of a culture's values, beliefs, and ideologies that others do not have. People do not all share the same culture; culture is variously distributed among different individuals.[17] Thus, defining an entire society as a single personality creates cultural stereotypes, rather than a realistic portrait of a people. This overly muscular conception of homogeneous cultures tended to dismiss any form of individuality or deviance.

Despite the ethnographic research on culture and personality inspired by the Boasian and Geertzian conceptions of culture, a divide developed between the disciplines of anthropology and psychology. Most anthropologists emphasized that culture was an external, "outside of the mind," phenomenon that had to be studied in order to comprehend human behavior.[18] Boas' students Benedict and Mead had argued that culture was "personality writ large," while Geertz argued that culture was located in a shared public life rather than within the mind.[19] Geertz

the integration and patterning of cultural values. Later, in 1958, Kroeber published a piece with sociologist Talcott Parsons entitled "The concept of culture and of social system" that defined culture as an autonomous variable consisting of patterned values and ideas. Talcott Parsons was the preeminent director of the Department of Social Relations at Harvard that trained Clifford Geertz and many other anthropologists that fostered this approach to culture in the 1970s.

[16]One psychological anthropologist, Anthony Wallace, differed from the mainstream culture and personality theorists. In his book *Culture and Personality* (1960), Wallace differentiated the "culture" of individuals versus the "culture" of whole societies.

[17]Boas was more cautious than some of his students regarding the relationship between culture and the individual. He was critical of the approach of Kroeber et al. who considered culture as a "superorganic" force or mystic entity that exists outside of the individual determining their behavior (Boas, 1928, pp. 245–46; Lewis, 2001, p. 386).

[18]Influenced by these semiotic and symbolic approaches, some mainstream political scientists and international relations specialists began to view "culture" as the major factor influencing the international arena. Two major books emphasizing the role of culture in international relations were published in 1996 by political scientists Benjamin Barber and Samuel Huntington. Barber's *Jihad vs. McWorld: Terrorism's Challenge to Democracy* (1996) argued that globalization represented by the spread of McWorld (McDonald's, Macintosh computers, and Mickey Mouse) through many societies has resulted in *jihad* the Arabic term for "Holy War" and defense of the Islamic faith by those who resist these global trends and, therefore, react in antagonistic ways, including supporting terrorism of the sort that led to 9/11.

Samuel Huntington wrote *The Clash of Civilizations and the Remaking of the World Order* (1996), which continues to resonate with many people in the West and other regions of the world. In this influential book Huntington argued that a unitary "Western civilization and culture" is at odds with "Islamic," "Hindu," and "Confucian civilizations and cultures." Huntington argued that these Islamic and Asian cultures do not have the institutions for developing civil democratic societies, individualism, free markets, secularism, or other elements that will enable them to coexist peacefully with Western societies. He envisioned these cultural and regional blocs along fault lines that fragmented the world order resulting in more conflict and instability throughout the world. Huntington's perspective has perpetuated a view that has been widely accepted within both the West and the Islamic world, especially after the tragedy of 9/11/2001 and the aftermath of the United States-led invasions of Afghanistan and Iraq. These views of Barber and Huntington have been criticized thoroughly by anthropologists who have debunked these crude and reified uses of the "culture" concept as applied to whole very complex "civilizations."

[19]During the 1950s a movement led by American anthropologist Leslie White known as "culturology," the study of culture, was emphasized in his book *The Science of Culture: A Study of Man and Civilization* (1949). White argued that culture was a superorganic phenomenon and was not reducible to psychology. Culture consisted of systems of technology, social systems, and ideologies that White discussed later in *The Concept of Cultural Systems: A Key to Understanding Tribes and Nations* (1975).

vigorously challenged any attempts of anthropologists to study psychological or cognitive aspects of the human mind. Most anthropologists marginalized Bastian's concept of the "psychic unity of mankind" in this understanding of culture (Shore, 1996). Culture was conceived of as an autonomous and potent external variable that had to be analyzed and separated from any psychological factor. Thus, for the most part during the 1950s, 1960s, and 1970s, the disciplines of anthropology and psychology drifted apart from one another.[20]

[20]There were some anthropologists during this period that remained interested in psychological explanations. Some of them such as Cora Du Bois, Abram Kardiner, and Melford Spiro were drawing on Freudian traditions (Boyer & Grolnick, 1990; Du Bois, 1960; Kardiner, 1939). Other psychologically oriented anthropologists were conducting experiments in their field studies. A number of anthropologists began ethnographic projects that have focused on mental disorders that are unique to specific cultural settings. These culture-bound syndromes include *latah* and *amok*. *Latah* was described as a mental disorder in areas of Southeast and East Asia. In Southeast Asia, *latah* appears as a type of hysteria or fear reaction that afflicts women. They become easily startled and compulsively imitate behaviors or shout repetitive phrases that they have heard (echolalia). Sometimes, this disorder is triggered when the woman hears the word *snake* or is tickled (Kenny, 1978). *Amok* is a culture-specific disorder that is described in Malaysia, Indonesia, and parts of the Philippines. It is a disorder of middle-aged males that follows a period of withdrawal marked by brooding over a perceived insult. During this period, in which the individual loses contact with reality, he may suffer from stress and sleep deprivation and consume large quantities of alcohol. Then, a wild outburst marked by rage occurs, with the individual attempting a violent series of murderous attacks. These aggressive, homicidal attacks will be followed by prolonged exhaustion and amnesia (Bourguignon, 1979). (The Malay term *amok* has entered the English language, referring to wild, aggressive behavior, as in someone running *amok*.) For an excellent overview of these culture-bound syndromes and psychological anthropology, see Charles Lindholm's *Culture and Identity: The History, Theory, and Practice of Psychological Anthropology* (2007).

The Cognitive Revolution: A New Merger Between Anthropology and Psychology

In the 1960s and 1970s a new understanding of human psychology reshaped the field of anthropology and the conception of culture in what is known as the cognitive revolution. In a broad survey of this development, cognitive psychologist Howard Gardner in *The Mind's New Science: A History of the Cognitive Revolution* (1985) explored the various innovators in this field. His survey included the work of the French anthropologist Claude Lévi-Strauss. Lévi-Strauss had done some brief ethnographic fieldwork in the Brazilian Amazon among various tribal populations during the 1930s. Later, during the 1940s he lived in New York where he became a colleague of Boas.[21] In his later works, Lévi-Strauss drew heavily on Boas' ethnographic research on myth and folklore. He also stated that Boas had contributed importantly to the unconscious aspect of culture, grammatical rules, and language, which anticipated later developments in linguistic theory (1963, p. 19; Gardner, 1985). While teaching at the New School for Social Research in New York, Lévi-Strauss was a colleague of Roman Jakobson, a Russian-American who was developing some of the new approaches in linguistics. Through his experience with American cultural anthropology and linguistic theory, Lévi-Strauss went on to initiate what became known as structuralism, or structural anthropology. The primary goal of structuralism is to investigate the thought processes of the human mind in a universal context; consequently, it is a field that overlaps with cognitive psychology. Lévi-Strauss brought a version of Bastians' "psychic unity of mankind" back to the forefront of anthropology. In contrast to the Geertzian perspective, structural anthropologists became devoted to a scientific enterprise to explore the psychological foundations of human nature and human universals.

[21]Famously Franz Boas died in the arms of Lévi-Strauss while they were eating lunch together in New York City in 1942.

Structuralists are interested in the unconscious and conscious patterns of human thinking. In one of his first major books, *The Savage Mind* (1966), Lévi-Strauss discussed how peoples living in small-scale societies use the same unconscious thinking and logical reasoning processes that people in large-scale, complex modern societies do. He proposed that there is a universal logical form in human thought and cognition around the world. Influenced by new developments in artificial intelligence (AI) and innovations in computer and mathematical research of the 1950s and 1960s, Lévi-Strauss argued that thinking is based on *binary oppositions*. In other words, as a computer code uses zeros and ones as binary digits, humans classify the natural and social world into polar types (binary oppositions) as a stage of reasoning. For example, foods are classified as raw versus cooked or hot versus cold. From these binary contrasts, coherent patterns of thought are developed. In addition, he suggests that the fundamental binary structural distinctions between "nature" and "culture" are found in all societies. He demonstrated how religious mythologies universally invoke symbols that have a dual aspect, representing nature and culture. In his many books Lévi-Strauss focused on such diverse phenomena as kinship, mythology, cuisine, and table manners to discover the hidden structural logic underlying these diverse cultural ideas and practices. Within all of these practices and beliefs, Lévi-Strauss maintains that there are important logical and deep structural distinctions between nature and culture. Even though the rules and norms that structure these ideas and practices may appear arbitrary, Lévi-Strauss believed that a "deep universal structure" underlies these cultural phenomena. Thus, this universal structure of the mind produces similar thinking and cognition throughout the world. In these efforts Lévi-Strauss was bridging the gap between psychology and anthropology. The aim of the structural anthropologist is not to account for why a culture takes a particular form but to understand and explain the inner principles of organization that underlie the external process.[22]

One of the major thinkers that shaped the cognitive revolution in both anthropology and psychology was the linguist Noam Chomsky. One of the earliest discussions in Western society of how humans learn their language came in the late fourth-century writings of the Catholic theologian Saint Augustine in his famous book *Confessions* (1995). Augustine believed that as we hear our parents speak words and point to objects, we associate the words with the objects. Later, the empiricist philosopher John Locke (1632–1704) maintained a similar belief and suggested that the human mind at birth is like a blank tablet, a *tabula rasa*, and that infants learn language through habit formation. This hypothesis was further developed by twentieth-century behavioral psychologists such as J. B. Watson and B. F. Skinner, who maintained that infants learn language through conditioned responses and feedback from their environment. This behaviorist approach to language became the dominant model of how language was acquired for many years. In the behaviorist view, an infant might babble a sound that resembles an acceptable word like *mama* or *daddy* and would then be rewarded for that response. Thus rewarded, the child would use the word *daddy* in certain contexts. According to Skinner, the human brain was a general purpose learning machine, and children learn their entire language through this type of social conditioning.

The Enlightenment French philosopher René Descartes (1596–1650) advocated a contrasting view of language learning. He argued that innate ideas or structures in the human mind provide the basis for learning language. Until the late 1950s, most linguists and anthropologists working on language assumed that Locke's model—and, by extension, Skinner's—was correct. Noam Chomsky became the most influential modern proponent of a view that is somewhat similar to Descartes. In 1957, Chomsky published his

[22] Predictably, Geertz wrote a critical piece about Lévi-Strauss' contributions aligning anthropology with psychology entitled *The Cerebral Savage: On the Work of Claude Lévi-Strauss* (1973). Lévi-Strauss died at the age of 100. For an obituary that delineated his definitive influence on the cognitive revolution and anthropology, see Bloch (2009).

revolutionary book, *Syntactic Structures,* which challenged the empiricist tradition in philosophy, psychology, and anthropology. Chomsky was interested in how people acquire *grammar*, the set of rules that determine how sentences are constructed to produce meaningful statements. Most people cannot actually state the rules of their grammar, but they do use the rules to form understandable sentences. For example, in English, young children can easily transform the active sentence "Bill loves Mary" into a passive sentence, "Mary is loved by Bill." This change requires much grammatical knowledge, but most English speakers carry out this operation without consciously thinking about it.

According to Chomsky, all children acquire these complex rules readily and do not seem to have difficulty producing meaningful statements, even when they have not been exposed to linguistic data that illustrate the rules in question. In other words, children use inferences regarding linguistic inputs and acquire these complex rules with minimal exposure to the language. Furthermore, children are able to both produce and understand novel sentences they have never heard before. All this would be impossible, Chomsky claims, if acquiring language depended on trial and error learning and reinforcement, as the behaviorist psychologists led by Skinner had thought (1959). In other words, Chomsky suggests that humans are born with a brain *prewired* to enable us to acquire language easily; Chomsky often refers to this prewiring as a *universal grammar*. This universal grammar is genetically determined within each individual and is further shaped by experience. Universal grammar serves as a template, or model, against which a child matches and sorts out the patterns of morphemes and phonemes and the subtle distinctions that are needed to communicate in any language. In Chomsky's view, the universal grammar of the human mind enables the child to acquire language and produce sentences never heard before. In addition, Chomsky and others who study language acquisition propose a *critical period*, beginning with infancy and lasting through about the age of five and the onset of puberty, during which language acquisition must take place. If children are not exposed to language during that period, they may never be able to acquire it, or they may learn it only in a very rudimentary fashion. Chomsky believed that the human brain contains genetically programmed blueprints or *modules* for language learning, and he often refers to language acquisition as a part of children's "growth," not something they do but rather something that happens to them.[23]

[23] One source of evidence for Chomsky's model of innate universal grammar is research on specific types of languages known as *creole* and *pidgin* languages. Linguist Derek Bickerton has compared these two types of languages from different areas of the world. Pidgin and creole languages develop from cross-cultural contact between speakers of mutually unintelligible languages. A *pidgin* form of communication emerges when people of different languages develop and use a simple grammatical structure and words to communicate with one another. For example, in the New Guinea highlands, where many different languages were spoken, a pidgin language developed between the indigenous peoples and the Westerners. In some cases, the children of the pidgin speakers begin to speak a *creole* language. The vocabulary of the *creole* language is similar to that of the pidgin, but the grammar is much more complex. There are more than a hundred known creole languages. Among them are the creole languages developed between African slaves and Europeans, leading to languages such as Haitian and Jamaican Creole. Hawaiian Creole emerged after contact between English-speaking Westerners and native Hawaiians. What is remarkable is that all these creole languages share similar grammatical patterns, despite the lack of contact among these diverse peoples. Bickerton suggests that the development of creole languages may parallel the evolution of early human languages. Because of an innate universal grammatical component of the human mind, languages emerged in uniform ways. Bickerton's thesis suggests that humans do have some sort of universal linguistic acquisition device, as hypothesized by Chomsky (Bickerton, 1985, 1999, 2008).

An interesting study of deaf children in Nicaragua conducted by linguistic anthropologist Ann Senghas and her colleagues also supports the view that language has some innate characteristics, as Chomsky has indicated. This study demonstrates how language can develop from a gesture system to a full-fledged language with grammar, symbols, and meanings (Senghas, Kita, & Özyürek, 2004). Nicaragua's deaf schools were established in 1977 and had many deaf children who interacted with one another. These children came from various backgrounds and regions of the country and had developed different means of communication with their parents. The school that was established focused on teaching the children to read lips and speak in Spanish. Senghas and her colleagues studied three generations of deaf schoolchildren

Most of Chomsky's writing is very technical and is based on the formal analysis of languages. However, his views about language and the mind/brain formed much of the basis for the cognitive revolution. Although there are critics of Chomsky's view of innate aspects of language development, most linguists have accepted his basic perspective.[24] His ideas were promoted and discussed in a less technical manner by cognitive psychologist and linguist Steven Pinker in *The Language Instinct: How the Mind Creates Language* (1994). Pinker directed the cognitive studies laboratory at MIT for a number of years where he conducted research on how children learned language. He continues his research on language and cognition at Harvard University.

Additionally, Chomsky's notions about the language acquisition device as a genetically based "module" within the brain led many cognitive scientists in both psychology and anthropology to consider the possibility that there were other modules for numeracy, music, and other functions of the brain. The field of evolutionary psychology emerged as a result of this modular view of the brain. At the University of California, Santa Barbara, John Tooby, an anthropologist, and his wife Leda Cosmides, a cognitive psychologist, were pioneers in this new field. They, along with Pinker and other evolutionary psychologists, concluded that the long process of evolution beginning in the Paleolithic (Old Stone Age, approximately 2.5 million to 10,000 years ago) had produced the modern human brain that consisted of modules or innate features or domain-specific regions that influenced cognition, emotions, and behaviors. These modules, each with its own specific mechanisms of operation and development, are hypothesized to be present in the modern human brain (Barrett, 2015).[25]

Aside from the language-learning module, anthropologists and psychologists, in a book entitled *The Adapted Mind* (1992), edited by Jerome Barkow, Leda Cosmides, and John Tooby, have hypothesized that modules in the brain enable humans to understand intuitively the workings of nature, including motion, force, and how plants and animals function. The authors refer to cognitive psychological research that demonstrates how infants innately distinguish objects that move around (such as balls) from living organisms (such as people and animals) that are self-propelled. These psychologists and anthropologists theorize that innate, specialized modules in the human brain help develop an intuitive understanding of biology and physics. Just as children learn their language without learning the formal grammatical rules, humans can perceive, organize, and understand basic biological and physical principles without learning formal scientific views. Children at very early ages have

in Managua, Nicaragua, and found that they were actually constructing linguistic rules from various gestures that they were using with one another over the years. These gestures were different from any other communicative gestures found in other sign languages. This linguistic study provides more confirmation of Chomsky's views on language acquisition. The study of deaf Nicaraguan children indicates that there is a biologically based language acquisition device that enables young children to learn and create extremely complex fundamental grammatical and linguistic systems with symbolic meanings understood by all of them.

[24]For criticism of Chomsky's perspective on language, see Geoffrey Sampson *Educating Eve: The "Language Instinct" Debate*, London and New York: Cassell, 1997. Another critic of Chomsky's approach to language is Michael Tomasello who has developed his own model of language learning. Tomasello is a comparative psychologist who studies chimpanzee and humans and is the co-director of the Max Planck Institute for Evolutionary Anthropology in Leipzig, Germany. His model of language learning suggests that children acquire their language through usage and experience by reading the intentions of speakers in their social environment as to the meaning of words and phrases. Tomasello's book *Constructing a Language: A Usage-Based Theory of Language Acquisition*, Cambridge, Mass: Harvard University Press, 2005, is critical of Chomsky's innate model of language acquisition. Sampson and Tomasello's empiricist approach to language learning has not attracted the attention of most linguists or psychologists.

[25]Many evolutionary psychologists hold that some of the evolved predispositions that are inherited may not be as adaptive today as they were during the time of the Paleolithic. For example, humans during that period had to worry more about avoiding the danger of wild animals and other groups and about getting enough salt and sugar to eat for survival, but such evolved predispositions may not help, and even hinder, human adaptations to modern society.

intuitive notions, or "theories," about persons, animals, plants, and artifacts.[26] They have an intuitive understanding of the underlying properties and behavioral expectations of these phenomena from early stages of infancy. In addition, children at 2 years old or so have the ability to comprehend how other people have intentions. In other words, these young children have an intuitive "theory of mind" and can determine how other people have thoughts and intend to use them in communication or behavior. These innate predispositions have been confirmed by extensive research and experiments with prelinguistic children by cognitive psychologists such as Paul Bloom and Alison Gopnik (Bloom, 2000, 2004, 2013; Gopnik, 2009; Gopnik, Meltzoff, & Kuhl, 1999).

Cognitive Anthropology and Culture

The merger between anthropology and psychology resulted in the field known as cognitive anthropology. Cognitive anthropologists have been doing joint research with cognitive psychologists. Cognitive anthropology is the study of cognition and cultural meanings through specific methodologies such as experiments, computer modeling, and other techniques to elicit underlying unconscious factors that structure human thinking processes. Cognitive anthropology developed in conjunction with the cognitive revolution of the 1950s and 1960s and has drawn on the findings within the field of cognitive science, the study of the human mind based on computer modeling (D'Andrade, 1995; de Munck, 2000, Kronenfeld, Bennardo, de Munck, & Fischer, 2011). Cognitive anthropologists have developed experimental methods and various cognitive tasks to use among people they study in their fieldwork so as to better comprehend human psychological processes and their relationship to culture. Through cognitive anthropology, we have learned that the mind organizes and structures the natural and social world in distinctive ways. This results in a conception of culture markedly different from the models promoted by the Boasian and Geertzian perspectives.

For example, cognitive anthropologists have been doing research on how humans classify and perceive colors in the natural world. Color is a complex phenomenon for scientists and for anthropologists. To physicists, color is determined by wavelengths of light. To biologists, color involves the neural responses in the human eye and the brain and is related to the ability of humans to adapt and survive in nature. Color can also be symbolic and represent our feelings and emotions, and this symbolism varies from culture to culture. Early philosophers and scientists such as Aristotle, René Descartes, and Isaac Newton believed that there were seven basic colors. Later, anthropologists and linguists began to ask questions such as these: Do people classify and categorize colors in an arbitrary manner based on their language and culture? Or do people classify, categorize, and perceive colors in similar ways throughout the world? Cognitive anthropologists Brent Berlin and Paul Kay have studied the basic color terms of different societies since the 1960s. They began by analyzing the color-naming practices of informants from 98 globally distributed language groups and found that societies differ dramatically in the number of basic color terms they possess, from 2 in some New Guinea tribes to 11 in English in the United States. They showed, however, that despite this difference, all color terms used by diverse societies follow a systematic pattern (Berlin & Kay, 1969).

[26] Evolutionary psychologists further contend that the mind is modular, in that it uses numerous innate rules ("algorithms") to process different types of information. In the social realm, for example, they suggest there are mental modules that help the individual interpret and predict other people's behavior by detecting and understanding basic emotions such as happiness, sadness, anger, jealousy, and love. These specialized modules thus influence male-female relationships, mate choice, and cooperation or competition among individuals and very much more. However, evolutionary psychologists emphasize that these specialized modules are not inflexible adaptations to the past. In addition to their outputs being modified by the novel inputs of the present and more recent past, their outputs gain flexibility through the interaction of one module with others and by some modules having been specifically designed to produce variable outputs (Barrett, 2015).

A language with only two color terms will divide the color spectrum between white and black. If a language contains three terms, the spectrum will be black, red, and white. A language with four terms will have black, red, white, and then green, yellow, or blue. A language with six terms will have black, white, red, yellow, green, and blue. These become the focal colors that are universal (Kay, Regier, & Cook, 2005). The evidence from Berlin and Kay's studies suggests that color naming is not at all arbitrary. If color terms were selected randomly, there would be thousands of possible color systems. In fact, there are only 33 possible color-naming systems. Recently, Paul Kay and other colleagues reported that statistical tests from more than a hundred languages in both industrial and nonindustrial societies demonstrated that there are strong universal tendencies in color classification and naming (Kay et al., 2005). In other words, to some extent, color perception transcends culture and language. Because of this research, the vast majority of psychologists and anthropologists concur that the physiological basis of color vision is the same for all humans (and some primates) with normal color vision. Additionally, more recent studies indicate that prelinguistic infants and toddlers within different language groups distinguish the same color categories (Franklin, Williamson, & Davies, 2005).[27]

In a cognitive anthropological study, James Boster concluded that as with colors, people from different societies classify birds in similar ways. Boster (1987) found that the South American Jivaro Indian population classified species of native birds in a manner corresponding to the way scientists classify these birds. To discover whether this pattern of classification was random, Boster had university students with no scientific training and no knowledge of South American birds classify these birds. The students did so with the same criteria used by both the Jivaro Indians and the Western scientists. More recently, two cognitive anthropologists working in Honduras found that insects were classified by Honduran farmers in the same way that scientists do worldwide (Bentley & Rodrigúez, 2001). Other cognitive anthropologists have studied how people classify plants. This research tends to demonstrate that people classify, order, and name plants in a similar manner all over the world (Atran, 1990; Atran & Medin, 2008; Berlin, 1992; Brown, 1984; Kronenfeld et al., 2011). Despite variations in classifications found within groups and individuals within societies, cognitive anthropologists have demonstrated that plants and animals are categorized and classified with universally similar taxonomies. These taxonomies are ordered according to the distinctive morphological or physical features of the various plants and animals in nature. Despite variant cultures in different regions of the world, the human mind appears to organize the natural world in non-arbitrary ways.

These findings in cognitive anthropology and cognitive psychology suggest that the human mind organizes reality in terms of prototypes, distinctive classifications that help humans map and comprehend the world.[28] Prototypes are used by humans to manage the social and natural environments. If reality was inherently unorganized and could be perceived in any way, then color naming and animal and plant classification would be entirely arbitrary.[29] The results of this research support the notion that people the world over share certain cognitive abilities and that language and culture are as likely to reflect human

[27] Cognitive psychologist Eleanor Rosch participated in Berlin and Kay's project by doing research on color categorization and classification among the Dani tribal people of Papua New Guinea. She found that though the Dani had only two color terms for "light" and "dark," they still perceived and categorized objects by colors that were the same for all humans.

[28] Cognitive psychologist Eleanor Rosch did much of the basic pioneering research on the universality of prototypes (Rosch, 1975; Rosch & Rosch, 1978).

[29] Aside from prototypes, both cognitive anthropologists and cognitive psychologists emphasize *schemas*, or cultural models that influence cognition, decision-making, and behavior. The concept of schema was introduced into mainstream psychology by Jean Piaget who conducted pioneering research on cognitive development of children at different ages (1970). Culture is acquired by and modeled as schema within individual minds, which can motivate, shape, and transform these symbols and meanings (Bloch, 2012; Quinn & Holland, 1987).

cognition as they are to shape it. It suggests that evolution selected certain fundamental visual-processing and category-building abilities for humans everywhere (Atran & Medin, 2008; Bloch, 2012; D'Andrade, 1995). In addition, this research supports the view that the human brain does contain innate modules and domain-specific mechanisms to classify, categorize, and learn about reality.[30]

The cognitive revolution and its development in anthropology and psychology resulted in a more widespread acceptance of biology, genes, and evolution along with environmental or cultural factors when analyzing human cognition, emotions, and behavior. In contrast to the conception of culture used by Benedict or Geertz, cognitive anthropologists and psychologists began to use biocultural or interactionist models to study cognition, emotions, and behavior. Instead of just focusing on culture as an external or public aspect of various populations, cognitive anthropologists and psychologists turned their attention to the inner workings of the human mind. Instead of viewing culture as an autonomous variable or deus ex machina, or prime determinant and cause of behavior, thought, and emotions within populations, cognitive anthropologists draw on the research of the fields of cognitive psychology, evolutionary biology, neurology and the brain sciences, social psychology, and related fields to develop an interactionist, biocultural approach. These interactionist/biocultural approaches avoid the problems of stereotyping or essentializing cultures or civilizations as discrete, fixed, static, exotic, and bounded wholes. Cognitive anthropologists pay as much attention to the human similarities and universals as Boas, Benedict, Mead, and Geertz did to cultural differences. Although the specific content and practices of these universals may vary from society to society, the fact that these cultural universals exist underlies the essential reality that modern humans are of one biological family and one species just as Bastian's "physic unity of mankind" had suggested.[31]

A conception of culture resulting from the cognitive revolution is the "epidemiological" model suggested by Dan Sperber and his colleagues (Bloch, 2012; Fessler & Machery, 2012; Ross, 2004; Sperber, 1996; Sperber & Hirschfeld, 1999).[32] These anthropologists draw on the fields

[30] Another research area that suggests that the human brain does have innate modules or specific domains is the study of patients that have had damage in localized regions of the brain (Pinker, 2002). Science writer Carol Kaesuk Yoon summarizes many cases of people who are not able to classify animals, plants, or inanimate objects because of brain damage in specific areas in her book *Naming Nature: The Clash Between Instinct and science,* New York and London, W.W. Norton and Company, 2009.

[31] In an influential book entitled *Human Universals* (1991), anthropologist Donald E. Brown suggests that in their quest to describe cultural diversity, many anthropologists have overlooked basic similarities in human behavior and culture. This has led to stereotypes and distortions about people in other societies, who are viewed as "exotic," "inscrutable," and "alien." Brown describes many human universals. In one imaginative chapter, Brown creates a group of people he refers to as the "universal people," who have all the traits of any people in any society throughout the world. The universal people have language with a complex grammar to communicate and think abstractly; kinship terms and categories to distinguish relatives and age groupings; gender terms for male and female; facial expressions to show basic emotions; a concept of the self as subject and object; tools, shelter, and fire; patterns for childbirth and training; families and political groupings; conflict; etiquette; morality, religious beliefs, and worldviews; and dance, music, art, and other aesthetic standards. Brown's depiction of the universal people clearly suggests that these and many other aspects of human behavior result from certain problems that threaten the physical and social survival of all societies. For a society to survive, it must have mechanisms to care for children, adapt to the physical environment, produce and distribute goods and services, maintain order, and provide explanations of the natural and social environment. In addition, many universal behaviors result from fundamental biological characteristics common to all people. Steven Pinker cites Brown's research on universals in his books *The Language Instinct* (1994) and *The Blank Slate* (2002) as evidence to support a species-wide human nature.

[32] In the epidemiological approach to culture, Sperber discusses two different kinds of representations—public representations, which are embodied in texts, talk, monuments, and other material phenomena, and private or mental representations. These representations may be widely shared within a population, or they may be idiosyncratic. Likewise, Pascal Boyer indicates that because of innate constraints of the human mind, certain representations are more likely than others to become acquired and transmitted to become stable sets of representations that anthropologists view as "culture" (1994, p. 391).

of cognitive science and cognitive psychology to discuss how culture propagates like a contagious disease from one person to another. They suggest that religious beliefs, cooking recipes, folktales, and even scientific hypotheses are ideas or mental representations within the human mind that spread among people in a shared environment. Chains of communication propagate these beliefs within a population. Yet, human communication does not proceed by the direct transfer of mental representations from one brain to another. As Chomsky suggests for the acquisition of language, children and adults make inferences from other people's speech, gestures, and behaviors (Sperber & Wilson, 1995). As in the spread of a contagious disease, some representations take hold and are maintained in particular populations, while other beliefs or representations do not resonate with specific groups and become extinct. Also, some beliefs or representations spread and are retained more easily within a population because they are more easily acquired than other beliefs.

These cognitive anthropologists who draw on the epidemiological approach to culture do not neglect the hermeneutic approaches that focus on symbolic culture. However, they maintain that anthropologists must combine the hermeneutic approach and ethnographic fieldwork with the scientific developments in cognitive science and cognitive psychology to explore the inner workings of the human mind. This involves the exploration of innate predispositions that influence cognition as well as language, symbols, and cultural factors. However, those cognitive anthropologists who use epidemiological view of culture caution that the spread of culture is not exactly like the spread of contagious diseases. The children or adults who are the recipients of culture are not just passive automatons reproducing various beliefs.[33] As culture is transmitted and communicated to others, it is reassembled, transformed, and *recreated* through psychological processes within people (Bloch, 2005, 2012).[34] This view of culture avoids the very muscular and determinate conception of an external culture proposed by earlier anthropologists such as Benedict or Geertz that tended to marginalize internal psychological processes.

Biocultural Approaches to Emotions

Aside from the investigation of cognitive processes and thinking, many cognitive anthropologists conduct studies of emotions. A significant question asked by Boas' students Benedict and Mead was: To what degree does enculturation influence emotions? Obviously, different language groups have different terms for emotions, but do the feelings of anger, happiness, grief, and jealousy vary from society to society? Do some societies have unique emotions? Anthropologists have conducted research on the topic of emotions since the early research of Benedict and Mead. As discussed earlier in the chapter, Benedict and Mead argued that each culture is unique and that people in various societies have different personalities and, consequently, different types of emotions. These different emotions result from the unique kind of enculturation that has shaped the individual's personality. In their view, the

[33]The model of culture promoted by Parsons, his students, and Geertz suggested that children were passively absorbing and internalizing the beliefs, norms, and values through the process of enculturation. The question of individual agency is undermined in this approach to enculturation or socialization.

[34]The evolutionary biologist Richard Dawkins introduced the concept of "meme," which he argued was the cultural equivalent of the biological gene that replicate into successive generations (1976). Dawkins suggested that memes were cultural units of ideas, behaviors, or styles that were transmitted to individuals and become the basis of cultural evolution. This term "meme" led to the development of memetics as a field of study (Blackmore, 1999). In a volume edited by Robert Aunger *Darwinizing Culture: The Status of Memetics as a Science* (2000), a number of biologists, anthropologists, and other scholars analyzed the concept of the meme. Most of the anthropologists who wrote chapters in the volume such as Adam Kuper, Peter Richerson, Robert Boyd, Dan Sperber, and Maurice Bloch were critical of the concept of the meme as a cultural unit equivalent to the gene. Most agreed that since there are no definite criteria for memes as cultural units in the mind or elsewhere, it is difficult to develop a valid science of memetics for understanding psychological processes, cultural evolution, or cultural transmission.

enculturation process creates varying emotions among different societies. In other words, culture determines not only how people think and behave but also how they feel emotionally.

For example, Catherine Lutz in her book *Unnatural Emotions: Everyday Sentiments on a Micronesian Atoll and Their Challenge to Western Theory* (1988) suggested that many of the emotions exhibited by the Ifaluk people in the Pacific islands are not comparable to American or Western emotions. She noted that the Ifaluk emotion words *song* (justifiable anger) and *fago* (compassion/love/sadness) have no equivalent in English emotion terms and that anthropologists need to examine the linguistic and cultural context to interpret what emotions mean from culture to culture. Lutz describes emotions for the Ifaluk as public and more relational and intersubjective, rather than individual, as in the West; more external, rather than interior to the body, sometimes with physical effects; and marked social status, rather than inner conditions. Lutz claimed that emotional experience is not pre-cultural but preeminently cultural. She questioned the assumption that emotions are invariant across cultures, and her objective was to replace how one cultural discourse on emotion may be translated into another cultural discourse. This view that emotions were socially or culturally constructed in different ways in various societies became a mainstream perspective of many anthropologists in the 1980s.[35]

However, following developments in cognitive anthropology, many anthropologists emphasized an interactionist or biocultural approach in their studies of emotions (Hinton, 1999). A study conducted by Karl Heider (1991) focused on three different ethnolinguistic groups in Indonesia: the Minangkabau in West Sumatra (an island in Indonesia), the Minangkabau Indonesians, and the Javanese.[36] Heider systematically described the vocabulary of emotions that each of these groups used to classify their feelings of sadness, anger, happiness, fear, surprise, love, contempt, shame, and disgust, along with other feelings. Through intensive interviews and observations, Heider determined whether the vocabulary of emotions is directly related to specific emotional behaviors. Heider concluded that four of the emotions—sadness, anger, happiness, and surprise—tend to be what he classifies as basic cross-cultural emotions. In other words, these emotions appear to be universally understood and stable across cultures. Other emotions, however, such as love, fear, and disgust, appear to vary among these societies. For example, love among the Minangkabau and Minangkabau Indonesians is mixed with the feeling of pity and is close to sadness. Fear is also mixed with guilt, and feelings of disgust are difficult to translate across cultural boundaries.

Daniel Fessler also explored how both biology and culture contribute to the development of human emotions (1999). Fessler did ethnographic work among the Bengkulu, an ethnic group in

[35] A number of other anthropologists in the 1980s studied emotions as socially or culturally constructed as Lutz did. Michelle Rosaldo did ethnographic research with her husband among the Ilongots of the Philippines. In her monograph *Knowledge and Passion: Ilongot Notions of Self and Social Life* (1980) she describes how emotions are especially important when connected with the practice of headhunting rituals. Rosaldo describes how the emotions of the Ilongot are not comparable to Western concepts of emotion. Another anthropologist Lila Abu-Lughod did research among Bedouins in Egypt and discusses how their emotions are expressed in poetry but are not comparable to Western emotions (1986). Lutz and Abu-Lughod edited a book *Language and the Politics of Emotion* published by Cambridge University Press in 1990 that expresses how the language and culture deeply influences emotions.

[36] Karl Heider's studies of emotions in Indonesia followed the work of cognitive psychologist Paul Ekman. Ekman is best known for his theory of the basic emotions that people of all cultures are said to have and which they are able to recognize in others. The basic emotions he describes are happiness, anger, disgust, fear, sadness, and surprise. Unlike the social constructionist view of emotions as in Lutz, Ekman argues that the expression of emotion is not something that occurs in language but is instead physical to be read in the face. According to Ekman, for every basic emotion there is a corresponding unmistakable facial expression which no one is capable of concealing. In his article, An Argument for Basic Emotions (1992), Ekman states that basic human emotions are present in other primates, they have a distinctive physiology, they are distinctive universals, and they have a quick onset, a brief duration, and an automatic appraisal.

Sumatra, in Indonesia. He discusses the importance of two emotions, *malu* and *bangga*, exhibited in many situations by the Bengkulu. *Malu* appears to be quite similar to *shame* in English. Bengkulu who feel *malu* withdraw from social interaction, stoop, and avert their gaze. People who feel *malu* are described as those who have missed religious services, did not attend to the sick, did not send their children to school, drank alcohol, ate during times of fasting, or violated other norms. *Bangga* is the linguistic expression of the emotion that people feel when they do something well and have had success, such as doing well in baking cakes, winning an election, hosting a large feast, being skilled in oratory, or feeling good about their physical appearance or house and furnishings. *Bangga* seems to be most similar to the emotion term *pride* in English. Fessler notes that *malu* and *bangga* appear to be exact opposites of one another, and both emotions provide individuals with an assessment of their relationship to the rest of the group. He suggests that these two emotions are universal, and that they have evolved in connection with attempts to coordinate one's mind and behavior for cooperation and competition within groups of people. Fessler emphasizes that though these emotions may be displayed and elaborated in different ways in various cultures, they reflect a universal, panhuman experience.[37]

Race, Ethnicity, Culture: Problematic Assumptions

Humans have been classifying populations into different races, primarily on the basis of skin color since at least the time of the Egyptians and Greeks, if not earlier (Brown, 2012; Lieberman & Scupin, 2012). Anthropologists have been attempting to classify and measure physical characteristics of differing populations for more than two centuries. One eighteenth-century approach placed all peoples in one of four racial categories: Europeans (white), American Indians (red), Asiatics (yellow), and Africans (black). These early classifications of humans by skin color resulted in stereotypes by Europeans and many others regarding different human populations. Modern classifications, which are based on more scientific knowledge of genetics, evolution, and geography, have concluded that any system of racial classification is too rigid and inflexible to deal with the actual dynamics of population movement, genetic change, intermarriage, and other conditions affecting the physical characteristics of a population (Lieberman & Scupin, 2012; MacEachern, 2012). Attempts to employ racial classifications for humans based upon "scientific criteria" have foundered because they were too rigid to account for the considerable variation within different so-called races. Clearly, bounded, racially distinct populations are not found in the real world.

[37] Anthropologist Richard Shweder emphasizes that ethnographic research on emotions has demonstrated the existence of both universals and culturally specific aspects of emotional functioning among people in different societies. He uses a piano keyboard as an analogy to discuss emotional development in children. Children have something like a universal emotional keyboard, with each key being a separate emotion: disgust, interest, distress, anger, fear, contempt, shame, shyness, guilt, and so forth. A key is struck whenever a situation such as loss, frustration, or novelty develops. All children recognize and can discriminate among basic emotions by a young age. However, as adults, the tunes that are played on the keyboard vary with experience. Some keys are not struck at all, whereas others are played frequently. Shweder concludes, "It is ludicrous to imagine that the emotional functioning of people in different cultures is basically the same. It is just as ludicrous to imagine that each culture's emotional life is unique" (1991, p. 252). In another original research project on emotions, cognitive anthropologist Scott Atran has teamed with neuroscientist Gregory C. Berns to employ functional magnetic resonance imaging (fMRI) to explore a number of issues related to religion and violence (Berns & Atran, 2012). With the use of fMRI this research team has been investigating brain activation and how sacred values trigger emotional responses consistent with sentiments that coincide with absolute morality and outrage (Berns & Atran, 2012; Berns & Atran, 2012). Specifically, when individuals are confronted with statements that are contrary to their sacred values, the amygdala, the region of the brain associated with physiological arousal, produces heightened affective emotional responses resulting in experiences of moral outrage and potential violence (Berns & Atran, 2012). Although this project in neuroanthropology is in its infancy, with future improvements in fMRI technology and more refined techniques, it may be possible to explore precise linkages between neurology, culture, emotions, and human behavior.

Despite the modern scientific findings regarding "race," humans in both the past and the present have used various racial classifications to categorize people and usually develop stereotypes about the behavior and mental abilities of different "racial categories." In other words, though the scientific meaning of a distinctive "race" or separate "races" is questionable, people in different societies maintain "folk categories" of "race" based on skin color, hair color and texture, nose shape, and other physical characteristics that become embedded within the culture. These folk categories of race are perpetuated and become cultural models for how racial identities are understood by outsiders and sometimes by the people themselves. Today many people identify with the concept of being a member of one or another "racial group," regardless of what science may say about the nature of race. The shared experiences of race create powerful social bonds. In many societies, including the United States, these invented folk categories are extremely powerful and are used by government agencies and medical practitioners to classify people according to arbitrary racial classifications. These folk categories of race have become culturally meaningful and potent classifications and the basis for social interaction within many societies throughout the world (Scupin, 2012).

In contrast to classifications of race based on physical characteristics such as skin color, ethnicity is based on shared cultural heritage such as language, nationality, religion, dress, diet, music, or other symbolic aspects of one's ancestral descent. However, as emphasized by twentieth-century anthropologists since Franz Boas, one's language or culture is not inherited through biological transmission or genetics. Boas and his students, as noted earlier, had stressed that an individual acquires his or her language and culture through enculturation. All contemporary anthropologists concur with this Boasian contribution. Despite early classifications of the European "race" or the English, German, French, or Polish "races," these differences among Europeans were not based on physical characteristics, but rather on linguistic and cultural variation. Likewise, there is no African "race." Rather, the African continent has hundreds of different ethnic groups that reside in locales that vary from region to region. The descendants of African slaves residing in the United States have a very different ethnicity than descendants of African slaves who live in the Caribbean. In Asia, the differences among the Chinese, Japanese, Koreans, Thais, Indonesians, Vietnamese, Cambodians, and Laotians are not based on racial differences but on ethnic differences. Though there may be some minor genetic differences among these populations, they are slight and do not result in distinctive "races." These ethnic groups have different languages, histories, and cultural traditions that create variation among them.

Although anthropologists have contributed to a much more refined conception of culture and ethnicity since the time of Boas, some applied psychologists tend to distort, simplify, or transform "culture difference," "race," or "ethnicity" into politicized notions that obscure precise analysis of various populations and individuals. These applied psychologists may associate culture and cultural differences with homogeneous "racial" or "ethnicity" group differences. This simplification results in marginalizing the vast cultural differentiation within any of these groups and populations. Categorizing people into social (racial or ethnic) groups and then attributing holistic "cultures" to them is a major methodological problem (Naylor, 1998). Many of the socially constructed "races" or ethnic groups can be represented within pluralistic societies such as the United States, and many "cultures" can be represented within any of these populations. Instead of recognizing these differentiated ethnic groups that represent a specific time and place, some applied psychologists draw on imprecise categories such as a generic "African American culture," "Hispanic" or "Latino culture," or "Asian American culture" (Frisby, 2005, 2013). In respect to individuals within these populations, two or more persons can be culturally similar and culturally different simultaneously. Also, applied psychologists often commit the "ecological fallacy" that assumes that each individual processes his or her "culture" in the same way (Dreher & MacNaughton, 2002). This ecological

fallacy ignores the fact that the behavior of individuals can be influenced by human universals that have nothing to do with "race" or ethnicity. Another related fallacy is based on what is known as the "fax model of enculturation (or socialization)," as if individuals are passively receiving their culture in a monolithic manner without agency (Quinn & Holland, 1987). As cognitive anthropologists and cognitive psychologists have demonstrated, the individual brain/mind is actively involved in the acquisition of culture, and it does not produce monolithic groups or populations of "races," or ethnic collectivities.

One of the reasons that applied psychologists and others tend to stereotype racial or ethnic collectivities has been illuminated by recent cognitive anthropological and cognitive psychological research. This research suggests that humans "essentialize" in regard to their perception and thinking about their own and different "racial" or ethnic groups (Brown, 2012; Gelman, 2003; Hirschfeld, 1996; Hirschfeld & Gelman, 1994). Essentialism is the cognitive tendency to treat members of certain categories like "races" or "ethnicities" as if they have an underlying nature that governs the observable characteristics of their membership in that category.[38] An ethnic or racial group is essentialized when either members of the group or outsiders assume that their members share some internal property or essence that is supposedly inherited and that creates the behaviors typical of that group. As these groups are essentialized, individuals make inferences about how the people in those groups think and behave. Another way of understanding how "races" and "ethnicities" become essentialized by people within different communities is through how one's own culture becomes *naturalized*. For example, to some people, a particular ethnicity feels "biological" or "innate" or "natural." To be an Italian American, a Native American, an African American, an Igbo from Nigeria, a Fijian, or Irish may feel emotionally rooted within the self of an individual.[39]

The widespread and universal essentialist conceptions of "racial" or "ethnic" groupings resemble the early Herderian conception of cultures as coherent, discrete, homogeneous, and unitary wholes. However, as mentioned earlier in this chapter, and in contrast to the configurational approach to culture of Ruth Benedict or other early ethnographers, cultural knowledge is not distributed equally by all members within "racial" and "ethnic" groupings. Cultural knowledge is shared differently by males and females, rich and poor, and young and old. Some individuals in these groups have a great deal of knowledge regarding agriculture, medical practices, or religious beliefs, while others have less. In a complex industrialized society such as the United States, culture consists of a tremendous amount of information and knowledge regarding technology and other aspects of society. Different people learn different aspects of this culture, such as repairing cars or television sets, understanding nuclear physics or federal tax regulations, or composing music. Hence, to some extent, culture varies from person to person, region to region,

[38] In *The Essential Child: Origins of Essentialism in Everyday Thought*, cognitive psychologist Susan Gelman offers a wide variety of data based on extensive psychological experimentation that explain why such essentialist thinking is so pervasive in a child's understanding of the natural and social world (2003). In an extensive psychological study of both French and US children, cognitive anthropologist Lawrence Hirschfeld demonstrated how children easily essentialize different "races" of people (1996). Both Gelman and Hirschfeld hypothesize that there may be a specific domain or module in the human brain that predisposes individuals to essentialize race and ethnicity (1994).

[39] One early model of ethnicity promoted in the 1960s is known as the "primordialist" model developed by Clifford Geertz (1963). Geertz suggested that ethnic attachments based on assumed ancestry, kinship, and other social ties and religious traditions are deeply rooted within the individual through the enculturation process. He maintains that ethnic affiliation persists because it is fundamental to a person's identity. In this view, as people are enculturated into a particular ethnic group, they form deep subjective "feelings of belonging" to a particular ethnic group. One of the criticisms of this primordialist approach is that like culture, ethnicity can be changed and transformed. For example, many European immigrants who came to the United States in the early twentieth century assimilated and learned the English language and became "white Americans." Thus, ethnicity is more fluid and to some extent people can choose their own ethnic identity (Barth, 1969).

class to class, age to age grouping, and gender to gender. In addition, in this global age individuals come in contact with a variety of different cultures as a result of international travel, reading, migration, and other activities including social media and Internet social networks as Facebook, Twitter, and YouTube. Anthropologists who conduct research on ethnic groups within multicultural and multiethnic societies find diverse assemblages of shared and unshared culture and practices. There may be some overlap in shared practices and culture among these different "racial" or ethnic groups, but there are various degrees of commitment to particular aspects of a "common" culture. And, in many cases, the so-called common culture may be contested. Individuals are not just automatons responding to cues within their own "racial" or ethnic and cultural backgrounds.

Culture and Applied Psychology

Since the cognitive revolution anthropologists have discovered that culture can be both diverse and universal. The challenge for anthropology is to understand the basis of both this diversity and this universality. To paraphrase the late anthropologist Clyde Kluckhohn: "Every human is like all other humans, some other humans, and no other human" (Kluckhohn & Murray, 1953). The interactionist or biocultural approach will undoubtedly continue to produce better understandings of human cognition, emotions, and behavior. This biocultural approach has helped merge anthropology and psychology into a dynamic interdisciplinary and cross-cultural field that can assist practitioners. For example, Arthur Kleinman, a pioneering cross-cultural psychiatrist, has encouraged a biocultural and psychocultural focus in counseling patients from different cultural backgrounds. He did extensive research on mental illness in China and directed the World Mental Health Report and co-chaired the American Psychiatric Association's Taskforce on Culture and the DSM-IV. Kleinman's biocultural research investigates how biologically based universal diseases such as depression have to be considered in varied cultural contexts. He describes how the Chinese report the symptoms of depression different from Americans (Kleinman, 2004). As is well-known, depression is a complex group of symptoms including negative cognitions, psychomotor retardation, sleep disturbance, fatigue, and loss of energy. However, as Kleinman indicates when the Chinese report their symptoms of depression, they tend to focus on the physiological and bodily factors, rather than any psychological or mental disturbance. This difference in how symptoms are diagnosed and reported may be due to how the Chinese culture has been influenced by their traditional religious beliefs from Daoism and the concepts of *yin/yang*, which claims a complementary and interpenetrating equilibrium between these two forces or energies of the universe. Traditionally, the Chinese were socialized to maintain a dynamic balance between these *yin/yang* forces. This *yin/yang* phenomenon involves beliefs about the inextricable linkage between body and mind. Kleinman concluded that this cultural and religious tradition may very well influence why the Chinese emphasize the external causes of their depression attributing their mental illness to somatic disorders or a loss of equilibrium.[40]

Applied psychologists in counseling fields or in social work settings may improve their work with patients by integrating the more recent biocultural perspective fostered by the cognitive revolution. The recent merger between cognitive anthropology and cognitive psychology can assist in providing evidence that will enable more effective counseling and treatment of patients, especially those with varied cultural backgrounds. By understanding that a culture cannot be conceived as some coherent, integrated whole shared by all members within a "racial" or ethnic group or community, but rather is distributed within a population with many differences based on age, gender, education, and socioeconomic

[40]The non-profit Foundation for Psychocultural Research at UCLA is also devoted to the merger of psychology, neuroscience, and culture. It is sponsored by a number of cross-cultural psychologists and anthropologists who do research on universal mental illnesses and treatments in different cultural environments.

background, the applied psychologist can improve their diagnosis and counseling of individual patients. Additionally, by recognizing the evidence that most humans tend to essentialize or stereotype their own "racial" or "ethnic" groupings as well as others, applied psychologists can better comprehend the psychological processes of their patients in relationship to their social environments. Generally, a more sophisticated appreciation of how the concept of culture can be used and misused by many within the public sphere in the United States can enhance the practice of applied psychology and related social work settings. An interdisciplinary approach that draws on the fields of cognitive cross-cultural psychology and anthropology is one of the primary means of establishing evidence-based practices in applied psychology and related fields.

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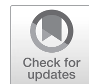

12 Evolutionary Perspectives on the Psychology of Intergroup Relations: Innate Predispositions and Cultural Malleability

Justin H. Park and David Francis Hunt

Introduction

Deep in the tropical rain forests of Africa, small groups of individuals live in distinct territories, which are often adjacent to each other. These groups are characterized by high degrees of social organization, with stable hierarchies, long-term friendships, and sex-typical behaviors. Furthermore, the residents are not fond of members of neighboring groups. The adult males sometimes conduct border patrols, and if they happen to encounter males from a neighboring group, tensions arise, with the two sides displaying loud vocal threats until one side backs down. Occasionally, an encounter can be more hazardous. When one group outnumbers the other group, the larger group may attack the smaller one, resulting in injury and sometimes death. Solitary individuals caught wandering the border areas are particularly vulnerable to lethal attacks. Over time, one group can be killed off by a neighboring group, and the victors may take over the victims' territory, thus acquiring more land and resources. Although this sort of intergroup violence may seem uncomfortably familiar, this is not a description of human groups—it is about chimpanzees (Mitani, Watts, & Amsler, 2010; Wilson & Wrangham, 2003; Wilson et al., 2014).

When we observe chimpanzees (*Pan troglodytes*) exhibiting behaviors that seem to have human parallels, an alluring inference is that the analogous human behaviors must have been biologically inherited and thus "hardwired." After all, chimpanzees are our closest living relatives, so the resemblance is unlikely to be mere coincidence, making it difficult to assert that the human behaviors are entirely "cultural." The idea that intergroup hostility is something that humans inherited from apelike ancestors could leave us with the pessimistic view that humans are doomed to perpetual intergroup conflict, with mild prejudice and discrimination at the best of times and warfare and genocide at the worst of times. However, this view is too simplistic, for several reasons.

First, bonobos (*Pan paniscus*), a species equally closely related to humans (chimpanzees and bonobos diverged a few million years after their lineage diverged from the human lineage), are distinctly less aggressive (Stanford, 1998). Therefore, acknowledging that humans possess biologically inherited tendencies does not demand the conclusion that humans must be innately aggressive (to the degree that chimpanzees appear to be). Second, research has shown that evolved behavioral tendencies—in

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humans and nonhuman animals alike—are far from "hardwired" in the sense of being fixed and inflexible; rather, they are strategically deployed, meaning that they are sensitive to contingencies and thus predictably flexible. Because every behavior is associated with costs and benefits and because these costs and benefits vary across contexts, animals have evolved to be sensitive to context and be more likely to execute behaviors when the net benefits are likely to be greater (Bertram, 1980; Lima & Dill, 1990; Schaller, Park, & Kenrick, 2007). This means that certain contextual variables (e.g., specific and general threats) may exacerbate belligerent tendencies but others may dampen them. Moreover, human behavior may be especially flexible because of our greater awareness of the costs, benefits, and consequences of our actions. Finally, it has become clear in recent years that the commonly drawn distinction between *biological* (evolved, innate) on the one hand and *cultural* (learned, flexible) on the other is scientifically untenable. As a case in point, two populations of chimpanzees were found to forage for ants in different ways (Whiten, 2000). One group used long sticks to gather large numbers of ants at a time, which were swept off with the free hand and eaten. The other group used short sticks and gathered fewer ants at a time, which were guided directly into the mouth. Despite being far less efficient, the latter practice was transmitted via social learning and maintained across generations—an example of a cultural tradition. These foraging behaviors cannot be neatly categorized as biological or cultural, as the biologically inherited psychology of chimpanzees both potentiates and constrains the cultural practices that are acquired and transmitted. Recently, many instances of cultural traditions in chimpanzees have been identified (e.g., Whiten et al., 1999), and it has become clear that culture—once assumed to be unique to humans—exists in many animal species (e.g., van de Waal, Borgeaud, & Whiten, 2013). An important implication is that human culture, though more complex than that of any other species, is a product of evolution and can only be understood within the broader biological framework (Heine, 2011).

We opened with a discussion of chimpanzees to provide a broad evolutionary perspective, a perspective that most students of human behavior tend to overlook, even when discussing intergroup conflict (e.g., Tropp, 2012). "Standard" psychology tends to focus on the proximate causes of human behavior—what makes people do what they do in the here and now. While this sort of approach can yield new knowledge, the knowledge can be disparate and disconnected. Adopting an evolutionary perspective encourages us to take a step back, to see deeper connections between seemingly separate processes, and to consider causal factors operating across longer stretches of time (i.e., selection pressures leading to the propagation of various adaptive physical traits and behavioral tendencies). As we illustrate below, the meta-theoretical framework provided by evolutionary psychology enables researchers to go beyond standard psychology, by drawing attention to several fundamental questions: Why does a behavioral tendency exist in humans? What might be its function? Are there parallels in other species? Within the last two decades, theoretical developments and empirical investigations guided by an evolutionary perspective have enriched our understanding of human social psychology, including group dynamics and intergroup relations (Van Vugt & Schaller, 2008). There has also been sophisticated integration of evolutionary and cultural perspectives (Richerson & Boyd, 2005), in line with the view that culture cannot be understood without evolution (by the same token, human behavior cannot be understood stripped of cultural context). Humans clearly possess a complex evolved psychology; at the same time, humans are inherently cultural animals, with the advent of the capacity for culture likely predating the emergence of *Homo sapiens*.

In the remainder of this chapter, we provide a review of the psychology of intergroup relations that is informed by these broad ideas. The review is not intended to be comprehensive but illustrative (for other similar reviews, see Cottrell & Park, 2013; Schaller & Neuberg, 2012; Schaller, Park, & Faulkner, 2003; Van Vugt & Park, 2010). We begin by discussing key theories and

hypotheses within evolutionary psychology relevant to intergroup relations. We then review empirical evidence pertaining to those theories and hypotheses. Although much of this evidence comes from laboratory studies conducted among peaceable populations with little experience of intergroup conflict, various lines of research have produced a rich body of knowledge regarding the fundamental psychological processes underlying intergroup psychology. As we elaborate below, although humans appear to harbor tendencies toward intergroup hostility, these tendencies appear to be flexible. So, we discuss how broader environmental and cultural factors may account for short- and long-term variations in intergroup conflict, which is relevant for interventions that may facilitate more positive intergroup relations. We close with a discussion of broader implications and future directions.

The Evolved Psychology of Intergroup Relations

Observations of chimpanzees and bonobos offer one kind of evidence regarding the origins of human intergroup psychology. These living apes, however, are not ancestral to humans and may possess humanlike tendencies (both malicious and benevolent) that evolved independently for different reasons. Therefore, an examination of how ancestral humans lived (before the advent of agriculture) and how extant hunter–gatherers live may yield more useful information regarding the "typical" human pattern. In fact, the archaeological and anthropological evidence indicates that intergroup violence is ancient within the human lineage. Intergroup conflict was ubiquitous enough to have shaped the evolution of human social behavior (Bowles, 2009). Although many people today believe that modern life has brought forth more intergroup violence (as it is difficult to overlook the major wars of the twentieth century and the ever-present threat of weapons of mass destruction), interstate warfare (and violence more generally) is actually on the decline around the world (Pinker, 2011). For a long time leading up to the twentieth century, war was simply part of life in many societies. It was considered necessary and inevitable, perhaps even serving a useful purpose, as illustrated by the metaphors "the sweeping broom, the bracing wind, the pruning shears, the cleansing storm, the purifying fire" (Pinker, 2011, pp. 243–244). Throughout history, as much as 20–30% of men may have died from intergroup violence, and this is also true of hunter–gatherers observed in more recent times (Keeley, 1996; Pinker, 2011). Like chimpanzees, contemporary hunter–gatherers have been observed to be territorial and tribal (Eibl-Eibesfeldt, 1974). Because of this evolutionary context, a complex psychology of intergroup relations appears to have evolved, involving a sense of social identity, intragroup cooperation, and intergroup competition (Alexander, 1987; McDonald, Navarrete, & Van Vugt, 2012; Park & Van Leeuwen, 2015). The result is a general tendency to favor *ingroup* members (people who belong to your own group) and a general wariness of *outgroup* members (people who do not belong to your own group). We elaborate on these points below.

Perceptions of Groups

Humans are social animals. We spend a lot of time in the company of others, and much of this time is spent talking about other people (Dunbar, 2004). When alone, we spend a lot of time thinking about other people—brain imaging studies suggest that, as a default, our minds process *social* information in particular (Iacoboni et al., 2004). Of course, the social world is not nebulous but textured. Some people are our kin; others are strangers. Some are friendly; others are threatening. Some are ingroup members; others are outgroup members. Different kinds of social interactions are associated with different types and degrees of benefits and costs (in terms of survival and reproduction). For instance, compared with interactions involving strangers, altruism between kin tends to be more beneficial, but sex between kin tends to be more costly (Park & Ackerman, 2011). Accordingly, many aspects of human social cognition exhibit functional

specialization, with distinct mechanisms for optimally managing the diverse kinds of social interactions (Bugental, 2000; Kurzban & Leary, 2001; Schaller et al., 2007). A crucial part of human social psychology is that, in addition to individual-based thoughts and feelings (e.g., liking one person more than another based on familiarity, attractiveness, reciprocal exchange, etc.), there exist group-based thoughts and feelings (e.g., favoring one person over another, based solely on group membership, even if this conflicts with the individual-based preferences). Group-based psychological processes are likely to have emerged due to the evolutionary benefits of within-group cooperation, benefits which are further bolstered by outgroup exploitation, resulting in the evolution of between-group competition (Kurzban & Leary, 2001). Over time, humans best able to cooperate with ingroup members and outcompete rival groups would have been most reproductively successful, resulting in a species-wide tendency to be tribal. The result is a psychology of coalitional exploitation—specifically, "membership in a potentially cooperative group should activate a psychology of conflict and exploitation of out-group members" (Kurzban & Leary, 2001, p. 195). This has been referred to as the *tribal instinct hypothesis* (Van Vugt & Park, 2010), and there is no shortage of evidence, both from the laboratory and the field, for humans' propensity to favor ingroup members over outgroup members (Brewer & Campbell, 1976; LeVine & Campbell, 1972; Sherif, Harvey, White, Hood & Sherif, 1961; Tajfel, 1982).

People appear to belong to a wide variety of "groups," for example, genders, age groups, races, occupations, and nationalities. Does membership in all those groups activate tribal instincts? The short answer is no. This is because not all social *categories* (e.g., male/female, old/young, lawyer/architect) are psychologically experienced as *groups* in the tribal sense (Park, 2012). So, which categories are experienced as tribal groups? The specific social categories that are significant in the tribal sense will, of course, depend on where and when you live. Accordingly, humans appear to possess a tribal "template" into which various kinds of social categories can be inserted, depending on the environmental context. As Kurzban, Tooby, and Cosmides (2001) argued, human tribal psychology should be sensitive to "(i) patterns of coordinated action, cooperation, and competition, and (ii) cues that predict—either purposefully or incidentally—each individual's political allegiances" (p. 15387). Examples of the former would be sports teams and opposing militaries. As for cues, examples might include religious affiliation and speech patterns (e.g., languages, accents). This may explain the historically ubiquitous antipathy between different ethnic and religious groups. Of course, social categories that do not fulfill the tribal criteria (e.g., male/female, old/young, lawyer/architect) may give rise to prejudice and discrimination as well, but this is likely to be for reasons qualitatively distinct from tribal conflict—men and women, the old and the young, and lawyers and architects do not go to war against each other or try to exterminate the other group. Human prejudices come in many different forms, each with a distinct psychology (Cottrell & Park, 2013).

What about racism? Does tribal psychology explain race-based prejudices that we observe in contemporary mixed-race societies? The answer seems to be yes, but the picture is more nuanced than it may first appear. Kurzban et al. (2001) argued that characteristics associated with race may serve as cues to coalitional alliance in societies without complete integration (e.g., the USA) and that this may contribute to race-based perceptions and prejudices. However, they further argued that race is merely a proxy coalition cue, as humans are unlikely to have evolved dedicated psychological responses to racial groups per se (given that humans rarely interacted with those of other "races" before the advent of transportation)—therefore, other, more diagnostic coalition cues may eliminate race-based perceptions. In several studies, they found that providing people with more diagnostic cues to coalition (e.g., sports team membership) undercut the perception of race as a cue, indicating that race-based perceptions are not mandatory but just one of the many possible outcomes of a flexible tribal psychology. Subsequent research has shown that

very young children may be attentive to speech patterns as coalition cues. In one set of studies, 6-month-old infants, 10-month-old infants, and 5-year-old children were found to prefer interaction partners who spoke in their native language or accent (Kinzler, Dupoux, & Spelke, 2007). Critically, 5-year-old White American children showed a preference for Black children speaking in their native accent over White children speaking in a foreign accent, a reversal of their typical preferences when presented with only images (Kinzler, Shutts, DeJesus, & Spelke, 2009). Taken together, these findings indicate that race-based perceptions may result from the tendency to perceive race as a coalition cues but that this tendency is not immutable, being overridden by other coalition cues such as team membership and accent. Given that a key function of tribal psychology is to track coalitions in the local social environment using the best available cues, this flexibility makes adaptive sense (for additional evidence, see Pietraszewski, Cosmides, & Tooby, 2014). (It should be noted that tribal psychology is not the only contributor to race-based prejudice. For instance, psychological processes underlying pathogen avoidance may contribute to prejudice for different reasons; Faulkner, Schaller, Park, & Duncan, 2004; Schaller & Neuberg, 2012).

Stereotypes (traits believed to be associated with specific social categories) also provide a window into the underlying psychology. In addition to serving cognitive "energy-saving" functions (Macrae, Milne, & Bodenhausen, 1994), stereotypes may also motivate adaptive behaviors, with different kinds of stereotypes potentially driving different kinds of behaviors (Schaller et al., 2003). Commonly held stereotypes tend to be either positive or negative, with ingroups typically being ascribed positive stereotypes (e.g., hardworking, trustworthy, intelligent) and outgroups typically being ascribed negative stereotypes (e.g., lazy, devious, superstitious). Among the negative stereotypes, some connote threat (e.g., untrustworthy), whereas others do not (e.g., lazy). In tribal intergroup contexts, ascribing threat-connoting stereotypes to outgroups may be functional, as such beliefs can promote potentially life-saving fear and avoidance. Consistent with this expectation, various lines of research have found that outgroups that can be categorized as coalitions (e.g., races, ethnic groups) do often inspire threat-relevant perceptions, including ascriptions of threat-connoting stereotypes (Cottrell & Neuberg, 2005; Maner et al., 2005; Schaller & Neuberg, 2012; Schaller et al., 2003).

Evolved Flexibility

As noted above, evolved psychological tendencies are expected to be predictably flexible, in ways consistent with optimizing their purported functions across contexts. The previous section covered one example of flexibility—the way in which coalitions are perceived is not hardwired but responsive to available information. There are additional ways in which human tribal psychology can be flexible. As the discussion regarding race perception makes clear, individuals' coalitional alliances are not always unequivocal given the available cues. How do people make ingroup/outgroup categorizations for ambiguous targets? How, for instance, are mixed-race individuals categorized? The answer to this question is informed by *error management theory* (EMT; Haselton & Nettle, 2006). When judgments must be made under uncertainty, a signal-detection problem exists, and different kinds of judgment errors can result: a false positive (inferring that something is the case when it is not) and a false negative (failing to infer that something is the case when it is). When one must detect potentially dangerous outgroup members, a false positive would constitute seeing an ingroup member is an outgroup member, and a false negative would constitute seeing an outgroup member is an ingroup member. According to EMT, the evolutionary costs of these two types of errors are rarely identical—in the current example, a false negative (failing to detect an outgroup member) is arguably costlier than a false positive (erroneously categorizing an ingroup member as an outgroup member). Consequently, perceivers may be biased toward minimizing the costlier false

negatives, which necessarily results in more frequent false positives. This bias toward committing false positives is argued to be common across hazard-detection systems and is also evident in human-engineered systems such as the smoke detector—which is designed to commit more false positives (sounding the alarm in the absence of fire) in order to avoid the highly costly false negatives (failing to sound the alarm in the presence of fire; Nesse, 2005). Importantly, the false-positive bias in biological systems may become stronger or weaker depending on the context (i.e., it is functionally flexible), as discussed next.

The logic of functional flexibility applies to broader individual differences and effects of contextual cues—people with chronically or temporarily heightened perceptions of threats in their environment may be more likely to execute intergroup vigilance responses (see Park & Van Leeuwen, 2014). For instance, the perception of ambiguous targets (as mentioned above) has been found to be influenced by threat cues: one study found that White individuals were more likely to categorize racially ambiguous targets as Black when perceptions of threat were heightened (e.g., when the target moved toward the perceiver or when the perceiver felt fearful; Miller, Maner, & Becker, 2010). Threat-relevant stereotypes and negative attitudes also seem to be responsive to threat cues. A series of studies showed that ambient darkness (an environmental threat cue) increased people's tendencies to ascribe threat-relevant stereotypes to specific outgroups (Schaller et al., 2003; Schaller, Park, & Mueller, 2003). In addition to stereotyping, another potentially functional response is to (mis)perceive aggressive intentions (as inferring nonexistent aggressive intent is less costly than failing to perceive existent aggressive intent). Maner et al. (2005) termed this tendency *functional projection*, and they proposed that people may tend to perceive anger in the faces of outgroup members (especially males), even if those people are holding neutral expressions. And this is expected to be functionally flexible as well. Maner et al. found that experimentally heightened self-protective motives increased the tendency among White American participants to perceive anger in the faces of Black men and Arab men (but not in the faces of White men or women). Other environmental cues, such as the perception that the ingroup is outnumbered by an outgroup, may also heighten intergroup vigilance (Schaller & Abeysinghe, 2006). More generally, people who perceive more threats in their environment may adopt more socially conservative attitudes (which are associated with a stronger emphasis on ingroup cohesiveness and a wariness of outgroups) as a defense mechanism (Van Leeuwen & Park, 2009).

Another sort of functional flexibility manifests as sex differences—in terms of both sex of perceiver and sex of target. Being vigilant and engaging in hostilities are costly, so such tendencies should be deployed when the net benefits are likely to be greater. Because males have historically been the primary players in intergroup hostilities (a characteristic that humans share with chimpanzees), males have had a greater need for intergroup vigilance, and outgroup males have been particular threats. This appears to have produced several outcomes. First, relative to women, men exhibit greater intergroup vigilance—they perceive greater threat in intergroup contexts and exhibit stronger intergroup prejudice (Schweitzer, Perkoulidis, Krome, Ludlow, & Ryan, 2005; Watts, 1996). Second, men show a stronger tendency to display ingroup loyalty under conditions of intergroup competition (McDonald et al., 2012; Van Vugt & Park, 2010). For instance, when playing an economic game, the prospect of intergroup competition makes men, but not women, give more money to their group (Van Vugt, De Cremer, & Janssen, 2007). Recent research indicates that the sex difference in intergroup bias emerges early in life: in an economic game tailored for children, 3–6-year-old boys (but not girls) evinced signs of intergroup bias (Benozio & Diesendruck, 2015). Finally, people appear to be especially wary of male outgroup members, a tendency which has been demonstrated in a number of studies (Navarrete, McDonald, Molina, & Sidanius, 2010; Navarrete et al., 2009).

It is noteworthy that in contemporary environments, people may—because of the mass

media—harbor exaggerated perceptions of the levels of threats (e.g., infectious diseases, dangerous outgroups) in their environment. Rationally speaking, people may fear the wrong things (Glassner, 1999). This leads us to the issue of how culture may influence people's intergroup psychology.

The Influence of Culture

The decline of intergroup violence in recent years (and, yes, there really has been a sustained decline; see Pinker, 2011) suggests that humans are not doomed to perpetual intergroup conflict. Blatant forms of prejudice and discrimination are also on the decline in many parts of the world, which has forced social scientists to devise increasingly subtle measures of prejudice (Fazio & Olson, 2003). Clearly, major changes have occurred, owing to reciprocal influences between tangible events, cultural norms, and individual psychologies. Pinker's (2011) tour de force provides an excellent review of the various historical forces that have led to the decline of violence over several centuries, and we will not attempt to summarize his book here. But we can highlight certain cultural psychological factors pertaining to intergroup vigilance that are relevant today and dovetail with the discussion above.

Historical and Cultural Variation

In a modern democracy, the probability of an average citizen dying from intergroup violence (e.g., interstate war) is close to zero. People living in developed countries today take peace and security as a given, and this is reflected in everyday sensibilities and politics. As Pinker (2011) remarked, "a politician in a democracy today who suggested conquering another country would be met not with counterarguments but with puzzlement, embarrassment, or laughter" (p. 260). As societies became more complex and more interdependent, people increasingly recognized the costs of intergroup conflict and the benefits of peace. This is not to suggest that humans somehow managed to rise above their lower instincts. The desire to engage in reciprocal, mutually beneficial relationships is as much a part of human nature as is the desire to exploit others for selfish ends (Ridley, 1996; Trivers, 1971). A key part of societal progress has been the inclusion of more people into our sphere of consideration—the expansion of the "moral circle" (Singer, 1981). Humans are also endowed with the capacities to plan and to anticipate the consequences of their actions. Over time, cultural shifts and growing awareness appear to have led to a growing aversion to intergroup exploitation and violence. By engineering societies that make it possible to live in relative peace, and by actively promoting norms that help to maintain that peace, humans appear to have achieved something that chimpanzees never could on their own. Of course, this progress has occurred in fits and starts, and there remains substantial variability around the world in levels of xenophobia and willingness to engage in intergroup violence.

Some of the factors that account for cultural variation today are closely linked to the functional psychology of threat perception discussed above. Just as individuals under greater (perceived) threat exhibit greater intergroup vigilance tendencies (changes in perceptions, emotions, and behaviors), groups of people under greater threat may develop norms and practices that are conducive to intergroup vigilance. Indeed, recent research has shown that many quantifiable aspects of cultures can be accounted for by variations in ecological factors that impinge on physiological and psychological processes. For instance, it has been argued that cultures vary in the extent to which they are "tight" versus "loose" (Gelfand et al., 2011). Tight cultures are those with strong norms and a low tolerance of deviant behavior (e.g., South Korea); loose cultures are those with weak norms and a high tolerance of deviant behavior (e.g., the Netherlands). Gelfand et al. (2011) further argued that this variation is linked to threats: "Ecological and human-made threats increase the need for strong norms and punishment of deviant behavior in the service of social coordination for survival" (p. 1101). The threats include resource deprivation, extreme

weather, threats from neighboring countries, higher infant mortality, and higher pathogen prevalence. A large-scale study involving 33 countries showed evidence for this link (see also Harrington & Gelfand, 2014). Why is this relevant for intergroup relations? Cultural tightness is a broad construct encompassing better-known variables such as collectivism and conservatism, which are associated with greater wariness of outgroups (Fincher, Thornhill, Murray, & Schaller, 2008; Thornhill & Fincher, 2007). Thus, groups of people who have faced more threats in recent history may harbor cultural norms that tend to promote intergroup wariness (i.e., ingroup loyalty, distrust of outgroups). It follows that the recent decline in intergroup conflict may be due in part to the greater security that humans (at least in some parts of the world) now enjoy. This has important implications for devising interventions and for predicting intergroup relations in the future.

Efficacy of Direct Interventions

The discussion above points to several possible ways of reducing intergroup hostility, for example, reshaping race perceptions, minimizing perceptions of threats, and actually managing threats in the environment. Here, we briefly review prejudice-reduction strategies that have been deliberately designed by social scientists, and we analyze them from the evolutionary perspective outlined above.

Probably the best-known intervention strategy (or set of strategies) is that based on Allport's (1954) *contact hypothesis*, which states that intergroup contact may reduce intergroup conflict and prejudice, as long as the groups (a) have equal status, (b) are in the pursuit of common goals, (c) have opportunities to get to know each other, and (d) have the support of authorities (no legal barriers to contact). Obviously, these conditions are crucial. Without all the factors pointing in the right direction, greater frequency of contact may actually exacerbate antipathy. Indeed, there is evidence that negative contact increases prejudice more than positive contact decreases prejudice (Barlow et al., 2012). More specifically, it has been shown that intergroup situations that are lacking in one or more of those four conditions face more challenges (Brewer & Kramer, 1985; Cohen & Lotan, 1995). There is also more direct evidence for the positive effects of implementing one or more of those conditions (e.g., Aronson & Bridgeman, 1979; Islam & Hewstone, 1993; Sherif et al., 1961). Pettigrew and Tropp (2006) conducted a meta-analysis of tests of the contact hypothesis, analyzing 713 independent samples from 515 studies. The analysis showed that contact was generally successful in reducing prejudice. What psychological processes underlie the positive effects of contact? In a meta-analysis of mediators of contact, Pettigrew and Tropp (2008) found that contact reduces prejudice by enhancing knowledge about the outgroup, reducing anxiety about intergroup contact, and increasing empathy and perspective taking (with anxiety and empathy having stronger effects than knowledge). At the same time, the contact hypothesis does have limitations and issues with generalizability. In particular, it remains unclear whether intergroup attitudes that have been changed in one setting precipitate a more global shift in ideological beliefs that underlie prejudices (Dixon, Durrheim, & Tredoux, 2005; Jackman & Crane, 1986).

An evolutionary perspective on the contact hypothesis shows why contact works and, perhaps more importantly, why those conditions that Allport (1954) outlined are crucial. If all of the conditions were met and sustained over time, there would be little to distinguish the groups at a psychological level (in terms of coalitional alliances), and much of the prejudice would disappear regardless of contact. Essentially, the critical aspect appears to be seeing other people as members of your coalitional group—without the initial categorization, there can be no prejudice, stereotyping, and discrimination. At its extreme, this would be the "melting pot" model of integration, in which different groups are expected to become more homogeneous. More practically, the research on race-based perceptions described above suggests that relatively minor interventions may induce people to see other members of society as coalitional ingroup members.

The reality is that different groups will continue to exist, and categorization will continue to occur, which means that we may need to focus on a different integration strategy that recognizes diversity—the "salad bowl" model. In this model, interventions may need to focus on trying to meet as many of Allport's conditions as possible and on direct education (for a review of interventions aimed toward shifting people's social categorizations, see Dovidio & Gaertner, 1999).

Broader Implications and Future Directions

For millions of years, the lives of humans (and prehuman ancestors) were filled with threats to survival—unpredictable resources, infectious diseases, and hostile outgroups. We are living specimens of the myriads of physical and psychological characteristics that evolved to manage those problems. Every single one of our ancestors possessed the traits necessary to survive and reproduce, and we have all inherited the basic set of those traits. Unfortunately, adaptations for survival do not necessarily contribute to happiness and social harmony. In this chapter, we have argued that some of the psychological tendencies that evolved to deal with threats (particularly threats posed by outgroups) may contribute to intergroup prejudice today. But there are reasons to be optimistic, as these tendencies are demonstrably flexible and responsive to changes in the environment, both natural and human made. To a substantial extent, the development of technology (e.g., tools, control of fire, agriculture) has been about trying to minimize or mollify the effects of those threats, and the relative comfort that at least some of us now enjoy means that many of those psychological processes designed to manage threats can remain largely dormant. In more recent decades, humans have become more conscious of the subjectivity of "groups," the natural tendency to be ethnocentric, and the consequences of intergroup conflict, resulting in profound changes in how people think about intergroup relations (Pinker, 2011). Especially notable is the expansion of the moral circle: Many things that were unthinkable (and illegal) in the past—universal suffrage, interracial marriage, same-sex marriage—are now the new normal in many parts of the world.

Of course, prejudice, discrimination, and stereotyping are far from being eradicated. Eliminating stereotyping may be particularly challenging, as it is a manifestation of a basic cognitive capacity (categorizing and inferring additional attributes) which pervades our mental lives. We would be faced with a much more incomprehensible world if we could not carve things up into categories and understand them in terms of those categories (imagine life in the absence of conceptual categories such as *fruits*, *animals*, *cars*, and *children*, where every entity we encounter must be understood as an individual). "Stereotyping" is therefore an immensely useful ability, and there is nothing inherently wrong with it. However, social categories capture attribute differences only *on average*, so stereotypes of social categories will rarely apply to every member (e.g., men are taller than women on average, but many women are taller than many men). Also, humans are aware (implicitly or explicitly) of being perceived in terms of categories, and this appears to have negative effects. Being the target of stereotyping—even when it happens very subtly—has been shown to be highly damaging (see research on *stereotype threat*; Steele, 1997). Thus, people now attempt to reduce stereotyping on moral grounds.

There remain many unanswered questions and future research directions with respect to how we might further reduce intergroup prejudice. We close with a few suggestions for interventions and research directions. Essentially, we should attempt to better understand how psychological group boundaries can be further broken down or reshaped and how overperceptions of threat can be further reduced in contemporary environments.

A major change that has occurred recently is the emergence of the Internet and the various forms of social media that have become entrenched in many people's lives. Many people today are acquainted with people from all over the world and possess historically unprecedented

levels of awareness regarding other cultures. At least to some extent, this may have the effect of eroding parochialism and fear-based prejudices. Of course, people may tend to connect with those who share similar attitudes, so these technologies may also facilitate connections between people who share parochial views and prejudicial attitudes (e.g., hate groups can now attract prospective members who previously may have been unreachable). The result may be greater polarization of attitudes (cf. Moscovici & Zavalloni, 1969). Thus, it remains to be seen how people's existing attitudes interact with specific forms of Internet use to influence changes in attitudes and cultural norms over time. To investigate more general effects of Internet use, research could address whether variation in the use of social media accounts for variation in prejudice, across individuals and countries. Also, just as television (particularly educational television) can have positive influences on intergroup attitudes (e.g., Gorn, Goldberg, & Kanungo, 1976), more focused social media may prove effective in exerting positive effects.

Even within multicultural countries (e.g., USA, UK), there is substantial regional variation in the extent to which individuals are exposed to people from other cultural groups. Perhaps more can be done to ensure that children growing up in less diverse communities receive focused education regarding other cultures, in conjunction with real opportunities for interactions with cultural outgroup members. Even in the absence of physical interactions, schools could easily facilitate Internet-based exchanges with students from other parts of the world. More generally, it would help for people to receive more balanced exposures to other cultures and peoples (as opposed to the "exotic" and threatening depictions of other cultures and peoples that dominate the media). That may lead to more realistic perceptions of threats (i.e., far lower than typical perceptions of threat that people hold today), which may foster more positive intergroup attitudes. Ultimately, promoting positive intergroup relations is a moral issue, and there are clear limits to what science can tell us. For instance, scientific knowledge cannot dictate whether societies should attempt to implement a "melting pot" versus a "salad bowl" approach—science can only illuminate the different benefits, costs, and challenges associated with these different approaches.

Humans seem to have inherited a tribal psychology, but humans have inherited many other psychological tendencies that make peaceful living possible. Although the future remains uncertain, we think this uncertainty is encouraging, compared to the near certainty of intergroup conflict that characterized life during most of human history.

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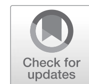

The Treatment of Race, Racial Differences, and Racism in Applied Psychology

13

Craig L. Frisby

Introduction

What are some initial impressions gleaned from strolling through an affluent neighborhood of custom designed homes? For starters, one immediately notices differences in the driveways leading up to each house. Some driveways are made of plain concrete, while others are made of stamped concrete sporting unique colors and geometric designs. Some houses have front porches (some covered, others uncovered), while others do not. Some main entrance doors have inlaid glass, while others do not – the sum total of which contributes to a first impression of being inviting, secretive, imposing, intimidating, elegant, bold, or charming. Another feature of note is the material that forms each house's exterior. The exteriors of some houses are composed entirely of brick, while other exteriors are brick in addition to stone, siding, or stucco. Even among homes made entirely of stucco, these are of different colors and textures. When the focus shifts to home interiors, it would take an entire chapter to describe differences in the choices homeowners make when choosing a home for its kitchen design, floor layout, number of bedrooms, and wallpaper/wall paint designs.

Yet what happens when this same neighborhood is viewed from an airplane 6 miles above the ground? Here, the observer notices *patterns* that are not noticed from the perspective of being on the ground. For example, one may find that all of the homes in a series of adjacent subdivisions are all arranged neatly and sequentially in an open-ended curved oval shape, while homes that comprise nearby subdivisions are aligned in straight rows. Perhaps a river snakes through numerous subdivisions, and one notices a green carpet of mature trees that appear all along the riverbed – but appear only in neat, rectangular plats within particular subdivisions.

Scholarly writing on cultural competence in applied psychology must come to grips with two fundamental truths that are analogous to the two ways neighborhoods can be viewed as described from these opening paragraphs. Just as neighborhoods can be viewed from the ground or from the air, applied psychologists appreciate individual differences (ground-level view) as well as subpopulation patterns (airborne view) in their work. These dual perspectives both compliment as well as create healthy tensions between each other. Nevertheless, honest scholarship must address both truths.

This chapter is about patterns, namely, patterns that are observed from human differences that can be organized by racial groupings. Debates over the validity of race as a sociobiological construct, the nature and scientific validity of racial differences, and the nature of racism are

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implicit subtexts that percolate silently behind discussions of multicultural issues in applied psychology – regardless of whether or not these are addressed openly. This chapter begins by discussing race, racial differences, and racism as basic concepts and then discusses how these concepts are handled in the social sciences, generally, and cultural competence advocacy, specifically.

Basic Concepts About Race

The serious study of "race" as a scientific construct originates out of various subbranches within biology, anthropology, and genetics (Cavalli-Sforza, Menozzi, & Piazza, 1994; Hartigan, 2013; Mayr, 2002). "Race" is a noun that refers to a category of persons within humankind that reflects an interbreeding group sharing distinctive physical, behavioral, and genetic traits that distinguish them from other such distinctive groups (although such distinctions are not rigid but can involve a continuous blending of characteristics). Qualitatively, outwardly observable physical characteristics used to categorize human subgroups involve physical trait clusters associated with skin, hair, and eye color, hair texture, facial features, bone structure, and body type.

In a strict scientific sense, the concept of race is not to be viewed as synonymous with the terms "ethnicity" or "culture" – although these terms are often (incorrectly) used interchangeably in scholarly writing (e.g., see Cornell & Hartmann, 2007). An ethnic group is a group of people whose members identify psychologically with one another on the basis of one or more commonalities in race, language, culture, country of origin, geographical residence, migration history, religion, folk traditions, and/or sociopolitical characteristics (Frisby, 2013, p. 553). "Culture" is a much more difficult and complex term to define precisely, as literally hundreds of definitions have been advanced in the social and behavioral science literature (Borowsky, Barth, Shweder, Rodseth, & Stolzenberg, 2001; Sapir & Irvine, 2002). As an example, defining culture as "shared patterns of meaning and behavior" (Danielson, 2014) means absolutely nothing in the absence of more detailed explanations for each term in this definition (and their associated nuances and qualifications). Like ethnicity, cultural groups may or may not be defined according to racial characteristics; however, culture itself is not synonymous with race. The bottom line is that there can be many cultural and ethnic groups represented within any given racial group, as well as many racial groups represented within any given cultural or ethnic group.

Using the quantitative language of population genetics, races are breeding subpopulations that differ from other breeding subpopulations in the frequencies of one or more genes (Garn, 1971). While genetic variation among humankind itself exists along a smooth continuum (and not discrete categories), breeding subpopulations (races) differ according to the degree of genetic distances between them. Since the degree of genetic distances between two or more groups varies and is multidimensional, then scholars will disagree on the number of distinct "races" that exists (Hamilton, 2008). A small sampling of this variation is given in Table 13.1.

Using hierarchical cluster analysis as an analogy, race is a term that can be applied to any number of superordinate and nested groups (called "major races," "geographic races," "continental races," "subraces," "local races," or "microraces"; see review by Hamilton, 2008). Sometimes the term is used to describe persons who share a common history, nationality, or geographic location – although as stated previously, race should not be confused as being synonymous with "ethnicity" or "culture" (although this confusion often appears in social science literature). According to Hamilton (2008), different races formed over time as a result of geographic isolation, culturally erected or geographical barriers to gene flow, genetic drift (see definition in Miele, 2002, pp. 115–16), natural/social/sexual selection, adaptation, and genetic mutation.

There has been considerable debate among scholars concerning the moral foundations and scientific viability of creating taxonomies of racial categories within human populations (e.g., Hamilton, 2008; Knight-Ridder, 2001; Koenig,

Table 13.1 Sample racial classification systems across a variety of scientific disciplines (for an overview, see Hamilton 2008)

Number of groups	Groups	Sources
3	Caucasoid (European ancestry), Negroid (sub-Saharan African ancestry), Mongoloid (East Asian Ancestry)	Rushton (1995)
5	*Homo albus* (white skin color), *Homo badius* (yellow skin color), *Homo niger* (black skin color), *Homo cupreus* (copper skin color), *Homo fuscus* (brown skin color)	Gmelin (1788)
	Africans (sub-Saharan Africa), Caucasians (Europe, Middle East, Indian subcontinent), East Asians (China, Japan, Philippines, Siberia), Pacific Islanders, Native Americans	Risch, Burchard, Ziv, and Tang (2002)
9	Amerindian (American Indians), Polynesian (subregion of Oceania[a], which includes Hawaiian and Samoan Islands), Micronesian (subregion of Oceania, which includes Guam), Melanesian-Papuan (subregion of Oceania, which includes Fiji and Papua New Guinea), Australian Aborigines, Asiatics, Indian (from India), European, African	Garn (1971)
	Sub-Saharan Africans, Non-European Caucasoids, European Caucasoids, Northeast Asians (excluding Arctic populations), Arctic Northeast Asians, Amerindians, mainland and insular Southeast Asians, Pacific Islanders, New Guineans, and Australians	Cavalli-Sforza et al. (1994)

[a]Oceana is a region that circumscribes the islands of the tropical Pacific Ocean and geopolitically includes Australia and its surrounding islands

Lee, & Richardson, 2008; Morning, 2006; Rushton, 1998a; Sussman, 2014; Wade, 2014). For clarity in this discussion, two broad groups called *race acknowledgers* (abbreviated hereafter as RA) and *race deniers* (abbreviated hereafter as RD) are described below.

Race Deniers (RD)

Those who do not agree with the validity of a biological reality that warrants the term "race" can be called *race deniers* (e.g., see Brace, 2000). According to Wade (2014), "A long-standing orthodoxy among social scientists holds that human races are a social construct and have no biological basis" (p. 1). In the 1990s, the formal denunciation of race as a valid method of categorization in the social sciences was codified by the American Association of Physical Anthropologists (AAPA, 1996) and the American Anthropological Association (AAA, 1998). This opinion finds support from a major encyclopedic text on race in the United States, which calls race "a wholly fabricated scientific category" that reflects "a grouping that is socially and politically constructed" (Gallagher & Lippard, 2014, p. xxxiv). RD views can be succinctly summarized in the sentiment that "there is only one race – the human race" (Angier, 2000). Although social scientists representing a wide variety of subdisciplines may all agree with this sentiment, support for this sentiment relies on a number of different arguments, described below:

1. There is little consensus on the exact number of races that exists currently (Cavalli-Sforza, 1995), which is used to support the view that racial divisions are ultimately meaningless.
2. Human biological variation falls along a continuum, and do not reflect biologically distinct and mutually exclusive categories. Said differently, there are no clear and sharp genetic lines that signify where one race ends and another begins (Cavalli-Sforza, 1995; Relethford, 2009).
3. There is no such thing as a "pure" race (i.e., genetically homogeneous populations; Cavalli-Sforza, 1995), and it is a gross over-

simplification to divide all of the world's people into three major races (Caucasoid, Negroid, and Mongoloids). There are numerous subdivisions within each of these three broad groups that reflect a high degree of genetic complexity, trait gradients, and ethnic subdivisions (Hamilton, 2008).

4. With the possible exception of skin color, the differences between individuals in hereditary features within racial groups can be much greater than differences between racial groups (Cavalli-Sforza, 1995; Tattersal & DeSalle, 2011). At a genetic level of analysis, individuals selected from different population groups (identified as different "races") can be genetically more similar than individuals selected from the same population (Witherspoon et al., 2007). With respect to skin color, Caucasians and East Asians are closer to each other than either is to Black Africans; however the distribution of blood groupings shows that Caucasians and Black Africans are closer to each other than either is to East Asians (Brace, 2000).
5. The acknowledgment of race is socially dangerous because it has the potential to promote racism. Therefore, it is much more socially responsible to emphasize variation in humankind as characterized by clines (gradual variation that cuts across groupings based on outward physical features, such as what is found in blood analysis).

Race Acknowledgers (RA)

In a nutshell, RA believe in the biological validity of racial groupings – and also see their view as the traditional view among anthropologists (Gill, 2000). Although RA value data derived from population genetics, they would also argue that there exist numerous questions about human variation that cannot be properly answered solely by population genetics (Hamilton, 2008). Many anthropologists who are RA specialize in physical (sometimes called morphological) anthropology, which explains how data from studying the physical features of the human body (both structural and anatomical) aids in understanding similarities and differences between human races, as well as the history of how human races formed over time (Baker, 2012).

RA often accuse RD of making reckless interpretations of biological and genetic data in order to erect "straw men" to knock down in conformity to popular sociopolitical ideologies – as well as for the purpose of distancing themselves from accusations of racism (Hamilton, 2008; Miele, 2002; Sarich & Miele, 2004). RA often promote the following reasons for defending the validity of race:

1. The "person on the street" can easily categorize individuals as belonging to major racial groups with reasonable accuracy (Hamilton, 2008).
2. "Old time" anthropological methods of classifying races and modern methods of population genetics produce consistently similar groupings (Miele, 2002). Contemporary forensic anthropologists are able to attain a high degree of accuracy in identifying the racial group of individuals from bone analysis (alone or in combination with other methods; Gill, 2000).
3. The concept of race is useful only to the extent that it acknowledges genetic differentiation in the human species and phenotypic similarities within groups (Baker, 2012; Hamilton, 2008). Outwardly observable physical traits that aid in differentiating between racial groups (e.g., skin and hair color, hair texture, eye color) are determined by numerous genes working in conjunction (i.e., they are polygenic in origin). Since a large portion of the genes in an individual's entire set of genetic information (i.e., the human genome) is involved in the structural and functional aspects of the brain (the primary organ of behavior), it would come as little surprise that inbreeding population subgroups would also differ to some degree on average physical, mental, and behavioral abilities and characteristics (Hamilton, 2008; Miele, 2002; Rushton, 1995).

4. Scientific constructs are useful only to the degree that they have explanatory power. The three broad racial groups (Caucasoid, Negroid, and Mongoloid) display a high degree of predictive and construct validity in their ability to organize and illuminate patterns in disparate data sets on human traits (Baker, 2012; Levin, 2005; Rushton, 1995).
5. While racial group membership is not the "cause" of certain diseases, it is highly correlated as a risk factor (along with other characteristics) for certain diseases within individuals (Bulatao & Anderson, 2004; Frank, 2006; Porterfield, 2015; Risch et al., 2002).

Basic Concepts About Racial Differences

All differences within human populations are most salient at the level of individual differences (see Frisby Individual Differences chapter, this text). That is to say, every human being is "different" from every other human being to some degree, and these differences are multidimensional. At the same time, however, *patterns* become evident when different subgroups consistently display different group characteristics (as well as display differences in outcomes) compared to other subgroups.

Obviously, any discussion of racial differences assumes implicitly the biological reality of racial groups. Physical and anatomical differences between racial groups will not be addressed in this chapter, as such information is provided in considerable detail elsewhere (e.g., see Baker, 2012). In order to promote clarity in understanding the concept of "racial differences" in psychological research, a distinction must be made between how this concept is used when referring to differences between individuals and how the concept is used when referring to differences between groups. Scientific and conceptual issues and problems related to how racial differences among individuals are discussed in applied psychology training will be addressed later in the chapter. This section addresses issues related to the comparison of groups.

When the mode of comparison involves continuous variables, group outcomes are arrayed in continuous distributions. Here, groups display central tendencies (e.g., mean, median, mode) and degrees of dispersion (e.g., standard deviation, variance, range) that contribute to different degrees of distribution normality or skewness (Wang, Frisby, & Waigandt, 2014). When the mode of comparison involves categorical variables, groups display discrete frequencies of outcomes across different levels within a category. In this instance, the concept of racial difference can be simply defined as a statistically significant difference between two or more racial groups in outcome variables measured as group frequencies. Depending upon how this comparison is done, a distinction must be made between racial group differences in the *weak sense* versus racial group differences in the *strong sense* (explained below).

Racial Group Differences (Weak Sense Versus Strong Sense)

Racial groups can be selected out of convenience (easy availability), compared on one or more outcome variables, and statistically significant differences can be discovered. A researcher may quite naturally interpret this as an example of statistically significant "racial differences." However, key variables that may be moderately correlated with the outcome variable may not have been controlled in the statistical analysis. Once these variables are controlled, a statistically significant difference between groups may or may not be found.

To illustrate, a researcher may test hypotheses about gender differences in annual salary within a company in two phases. In phase I, the researcher subdivides a sample of employees in a company by gender and discovers that females earn on average of 70 cents for every dollar that men earn. The easy conclusion is that one has discovered a statistically significant "gender difference" in earned yearly salary within this company. Here, the gender difference is "real"; however the question remains whether or not differences would

exist if other key relevant variables are controlled. In phase II of the study, the researcher statistically controls for preexisting differences in the number of years each employee has worked for the company, preemployment academic credentials, the number of weeks taken off due to illness or maternity leave, and differences in the job titles/responsibilities within the company. As a result of these controls, the group comparison may not achieve statistical significance. However, even after these secondary variables are carefully controlled (either by sample selection or by statistical procedures), a statistically significant group difference may still be found. If this were the case, then the researcher has a stronger case for pinpointing the cause of the difference that is directly linked to gender (e.g., gender discrimination). Thus, a statistically significant difference discovered in phase I would be an example of a "gender difference in the weak sense," while the statistically significant difference discovered in phase II would be an example of a "gender difference in the strong sense" (see "*Identifying Cultural Effects in Psychological Treatments Using Aptitute-Treatment Interactions*" Chap. 19, this book, for a fuller discussion of this issue).

The following material summarizes briefly the differences in global and American settlement patterns and select psychological variables between broad racial groups.

Racial Differences in Global and American Settlement Patterns

Broad racial groupings are not distributed randomly within all countries, nor are they distributed randomly within each state in America. Caucasoid peoples are concentrated in the European continent; however white European peoples and their descendants (including Caucasian Hispanics) can be found living outside of the European continent in significant numbers within 22 global regions: the United States, Brazil, Argentina, Canada, Australia, Mexico, Colombia, Venezuela, Chile, Cuba, South Africa, Costa Rica, New Zealand, Uruguay, Puerto Rico, Guatemala, Dominican Republic, Bolivia, Peru, Ecuador, Paraguay, and Nicaragua (see https://en.wikipedia.org/wiki/European_diaspora). The top 11 American states with the largest percentage of whites (not of Hispanic ethnicity) as of 2014 (in descending order) are Vermont, Maine, New Hampshire, West Virginia, Montana, Iowa, North Dakota, Wyoming, South Dakota, Idaho, and Wisconsin (Kaiser Family Foundation, 2016).

Negroid peoples are concentrated in the sub-Saharan African continent; however African peoples and their descendants can be found living outside of the African continent in significant numbers within 18 global regions: Brazil, the United States, Haiti, Colombia, France, Jamaica, Venezuela, the United Kingdom, Dominican Republic, Cuba, Italy, Puerto Rico, Peru, Germany, Canada, Spain, Ecuador, and Trinidad/Tobago (Davies, 2008; see also https://en.wikipedia.org/wiki/African_diaspora). The top ten American states with the largest percentage of African American residents as of 2014 (in descending order) are the District of Columbia, Mississippi, Louisiana, Georgia, Maryland, South Carolina, Alabama, Delaware, North Carolina, and Virginia (Black Demographics, 2014).

Recent statistics related to the East Asian world diaspora cannot be summarized succinctly within the scope of this chapter, as world diaspora data is often disaggregated by specific Asian ethnic groups or their source countries. Readers may consult the following references for a sampling of such information (see Academy for Cultural Diplomacy, 2016; Adachi, 2006; Ember, Ember, & Skoggard, 2005). According to the most recent 2010 US Census figures (Hoeffel, Rastogi, Kim, & Shahid, 2012), Chinese Americans are the largest East Asian group living in America (approximately 4 million) followed by Korean Americans (approximately 1.7 million) and Japanese Americans (approximately 1.3 million). The largest percentage of Chinese (36.2 percent), Japanese (32.8%), and Korean (29.6%) American groups all live in California, followed by New York (15.4%), Hawaii (5%), Texas (4.6%), and New Jersey (3.7%; of total Chinese Americans); Hawaii (23.9%), Washington

(5.2%), New York (4%), and Texas (2.9%; of total Japanese Americans); and New York (9%), New Jersey (5.9%), Texas (5%), and Virginia (4.8%; of total Korean Americans).

Group Differences and Cultural Capital

There are numerous factors that converge to influence and shape observed patterns worldwide across human populations and subpopulations in abilities, behaviors, values, attitudes, and accomplishments. Attempts to understand these patterns – using the broad lens of race alone – would not do justice to the complexity of the subgroup differences observed within broad racial groupings that regularly occur historically within countries across all continents throughout the world. Average group differences occur across combinations of racial, ethnic, geographical, and cultural subdivisions.

Thomas Sowell, in his magisterial trilogy *Race and Culture* (Sowell, 1994), *Migrations and Cultures* (Sowell, 1996), and *Conquests and Cultures* (Sowell, 1998), traveled extensively throughout the world to study how these patterns unfolded historically and are manifested in contemporary life. As a result of many years of scholarship on these issues, Sowell (1998) writes:

> The tendency to explain intergroup differences in a given society by the way that particular society treats these groups ignores the fact that differences between groups themselves have been the rule, not the exception, in countries around the world and down through history. These groups differ in specific skills – whether in optics, winemaking, engineering, medicine, or numerous other fields – and in attitudes toward work, toward education, toward violence, and toward life. Thus people living in the same immediate surroundings, and facing the same current economic and other options, react very differently as a result of their very different cultures, which evolved in different settings in centuries past. (p. 335)

According to Sowell, intergroup differences are by no means unique to racial or ethnic differences, as he states:

> All sorts of other groupings of human beings – by religion, nationality, or geographical settings, for example – show similarly sharp distinctions in everything from income to alcoholism and from fertility rates to crime rates. (Sowell, 1998, p. 332)

Sowell locates the reason for subgroup distinctions in what he calls *cultural/human capital* that can have more influence on groups' overall economic development than material wealth or natural resources.

However, "cultural/human capital" can be a double-edged sword. He also discusses extensively the concept of *negative human capital* (Sowell, 1998, p. 339), defined as attitudes, cultural traditions, specific features of group pride, and ethnic identity – which can prevent or impede the performance of economically advantageous behaviors of which groups are fully capable, but for culturally specific reasons do not manifest.

Basic Concepts About Racism

A few books have been written that purport to trace the historical development of the concept of "racism" in both its definition and in its practice within the Western sociological tradition (e.g., D'Sousa, 1995; Eliav-Feldon, 2009; Fredrickson, 2002). Scientists writing in the eighteenth and nineteenth centuries observed little to no boundaries or filters that would modulate the language they used to describe racial differences and the presumed superiority/inferiority among racial groups. Thus, what was considered to be objective "scientific facts" – when read in light of their times – immediately strike most contemporary readers as nakedly offensive to modern ears (see examples cited in Cuvier, 1832, quoted in Hamilton, 2008, p. 20; D'Sousa, 1995, pp. 28–29; Plous, 2003; Rushton, 1995, Chapter 5; Valencia & Suzuki, 2001, p. 4).

The suffix "ism," when attached to a root word, denotes a practice, philosophy, ideology, doctrine, condition, or action related to the root word to which it is attached. Thus, any attempt to understand the meaning of "racism" must begin with the concept of race. After reviewing a variety of definitions of racism, D'Sousa (1995) concludes that these definitions share common features, one of which includes belief "in the

existence of biologically distinguishable groups or races" (p. 28). This component of the definition for racism (and by extension, a "racist") is rejected in this chapter, on the grounds that this does not connote a racist any more than a belief that bullets fired from a gun can harm human flesh describes a murderer. Said differently, a belief in the validity of races may be a necessary precursor to racism, but the presence of a belief in the validity of racial categories *is not sufficient* for promoting racism.

The following definition for racism is not new, but represents a distillation of core elements that stays close to its roots in the study of races within physical anthropology. *Racism* is thus more narrowly understood and defined as a belief or ideology that (a) race is a fundamental *determinant* of human traits and capacities, (b) all members of each racial group possess characteristics or abilities *that are specific to that race*, and (c) racial differences produce an *inherent superiority or inferiority* in worth of a particular racial group relative to another. Racism may or may not be manifested in racially discriminatory actions among members within a society, whereby certain racially identifiable groups are denied rights or benefits, while others receive preferential treatment on the basis of racial group membership (Frisby, 2013, p. 572).

Implicit in this definition are the following ideas: First, racism is not characterized as descriptive of only a certain subset of persons (e.g., "only whites can be racist") but reflects the quality of ideas *that are independent of the characteristics of persons who hold such ideas*. Second, racism, as defined here, is a generalized belief that is "blind" to specific causal pathways for understanding human traits and capacities. Individual differences in temperament and personality traits, as well as idiosyncratic differences in situation-specific contexts in which individuals operate, are ignored in favor of explanations that boil down to one cause – *racial group membership*. Third, racism ideology is rooted in what Morning (2011, pp. 12–13) calls *essentialism*, which suggests that all members of a given racial group share one or more psychological qualities that are inherent, innate, and fixed. Here, simple knowledge that a person belongs to a particular racial group leads to the implicit assumption that particular traits are necessary, natural, and immutable. According to Morning, essentialist beliefs cannot only be rooted in biology but can also be thought of as rooted in the *soul* of a person. In sum, particular individuals are viewed as possessing certain traits because *it is within his/her racial nature* to be that way. Fourth, this definition does not ascribe any moral value judgments to these beliefs or to persons who hold these beliefs, as this definition fundamentally describes errors in thinking and cognitions. Finally, no assumptions are made about correlated feelings, which are often incorporated into popular definitions of what does or does not constitute racism. When the definition of racism is limited to cognitive errors, then, many beliefs that are popularly accused of racism do not fit this definition. Conversely, many beliefs that would not be popularly accused of racism do in fact fit this definition.

The Treatment of Race in the Social Sciences

Race in American Society

The United States Census Bureau is charged by the US Constitution to collect nationwide data on American citizens at regular intervals, which includes, among many things, how Americans self-identify with respect to their racial group. Up to the time of this writing, US census forms ask respondents whether they are of Hispanic, Latino, or Spanish origin and state that "Hispanic origins are not races." Respondents can select from the categories Mexican, Mexican American, or Chicano; Puerto Rican; Cuban; or another origin (e.g., Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, or Spaniard). The US government defines Hispanic as an "ethnicity," as opposed to a race – despite the fact that some Latinos believe that Hispanicity is a race (Cohn, 2015).

Another census question asks "What is this person's race?" and includes a list of options with checkboxes and write-in spaces (e.g., white,

black, African American, or Negro; American Indian or Alaska Native; Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; Native Hawaiian; Guamanian or Chamorro; Samoan; other Pacific Islander such as Fijian or Tongan; some other race). According to Cohn (2015), the problem with using the word "race" is that many Americans say they do not know what it means, and do not appear to know how "race" differs from "origin." Focus group research finds that some people think the words mean the same thing, while others see race as meaning skin color, ancestry, or culture, while origin is the nation or place where they or their parents were born (Cohn, 2015). According to Compton, Bentley, Ennis, and Rastogi (2013), there is an emerging need to recognize the complexity of factors (i.e., family and social environment contexts, historical or sociopolitical constructs, personal experiences) individuals use to self-identify with a racial or ethnic category. According to Cohn (2015), these are the reasons why the US Census Bureau is currently experimenting with changes to future census forms that would ask respondents to self-identify using the more neutral term "categories" rather than "race" or "ethnicity."

Bulatao and Anderson (2004) opine that "race is a potent social reality and an important and enduring component of personal identity" (p. 9). The word "race" – or its many derivatives – occurs in many different contexts in general American society. Whenever national news stories are reported that detail violence that is perpetrated by whites against blacks or blacks against whites, national headlines often include the phrase "racial violence" (Feldscher, 2015; Flaherty, 2012). Businesses, educational institutions, and other large agencies that are supported in full or in part by the federal government are required to display prominently federal antidiscrimination statements which state that the organization will not discriminate on the basis of race, color, or national origin – among other group characteristics. On college campuses, urban communities, and public schools throughout the nation, organizations with names such as *Institute for Race and Justice*, *Racial Equity Institute*, *Institute for Racial Reconciliation*, *Race Institute for Educators*, *Institute for the Study of Race and Ethnicity*, *Institute of Race Relations*, and *Institute for the Study and Promotion of Race and Culture* are plentiful. The name of the largest Latino advocacy organization in the United States includes a Spanish word for "the race" (la raza) in its title (The National Council of La Raza).

Race in the Social Sciences

On the topic of how "race" is treated in the social sciences, Miele (2002) opines:

> That one four-letter word has bedeviled not just American history but also the social sciences from their beginning. In the minds of many, it is inextricably linked with a record of violence, slavery, prejudice, hatred, and all that we hope not to be… Discussion of race can end friendships, derail careers, or set off riots…. (pp. 109, 112)

Social scientists have different views on the scientific validity of race as a biological construct that has relevance to psychological research. Ultimately, these views originate from the "race denier" vs. "race acknowledger" frameworks.

Race Denier Viewpoints As discussed earlier, race deniers from the anthropological tradition use scientific arguments as grounds to reject the concept of valid racial classifications. In contrast, it is the fear of, and loathing for, racism that lies at the root of race denial for scholars who are aligned with social science fields outside of anthropology (e.g., psychology). In writing for *Psychology Today*, Fuentes (2012) opines:

> …if you look across the USA you can see that there are patterns of racial difference, such as income inequalities, health disparities, differences in academic achievement and representation in professional sports. If one thinks that these patterns of racial differences have a biological basis, if we see them as "natural", (then) racial inequality becomes just part of the human experience (remember a book called *The Bell Curve?*). This fallacy influences people to see racism and inequality not as the products of economic, social, and political histories but more as a natural state of

> affairs…Solutions to racial inequalities and the problems of race relations in the USA are not going to emerge as long as a large percentage of the public holds on to the myth of biological races.

Helms, Jernigan, and Mascher (2005) provided a detailed critique of the use of race in psychological research. Helms et al. fundamentally argue that the concept of "race" is little more than a social construct that has little to no scientific or theoretical consensus as to its meaning and that there is no scientific merit in "using race as an explanatory construct in psychological theory, research, and, by implication, practice" (p. 27). To support this view, Helms et al. (2005) cite an article by Yee (1983) citing a resolution passed by the Council of Representatives of the American Psychological Association that opposes using the concept of race to explain human behavior (with further elaboration by the American Psychological Association, 2003).

In order to replace bad practices with better practices, Helms et al. (2005) argue that racial categories (e.g., black, white) be replaced with ethnicity, ethnic identity, and other individual difference variables as independent variables in psychological theory and research. Although social scientists (including psychologists) offer methodological objections to the use of race in research, Helms et al. (2005) argue that curtailing the wrong use of race will permit "the discipline of psychology to function as an objective science" (p. 27). Others hope that the rejection of the race construct will diminish or eradicate racial stereotypes, racism, and general "harm" in society (Barndt, 2007; Helms et al., 2005).

Although Helms et al. (2005) do not provide specific examples as to the exact forms such harm would take, other writers who are sympathetic to their viewpoint argue that belief in the validity of race provided the historical foundation for the eugenics movement, hostility to immigration, and scientific views supporting the inferiority of certain racial groups (Sussman, 2014). Barndt (2007) opines that race is a societal concept that was fundamentally designed and ultimately used for evil purposes. With this as a starting point, he defines "race" as:

> …an arbitrary (specious, false) socio/biological construct created by Europeans during the time of world wide colonial expansion and adapted in the political and social structures of the United States, to assign human worth and social status, using themselves as the model of humanity, for the purpose of legitimizing White power and White skin privilege. (p. 72)

Race Acknowledger Viewpoints Representing an opposing philosophical viewpoint, Levin (2005) argues from an empirical and logical perspective that broad racial categories are "real" and that acknowledging this reality has important implications for multiracial societies. A first step, according to Levin, is for social scientists to acknowledge that group differences exist, as opposed to denying them. He argues that social science efforts to explain broad group differences are in itself a tacit admission that group differences do exist.

The next step, according to Levin, is to acknowledge that these average differences matter in important ways in society. As examples, he argues that practically all "front-page" issues within American society (e.g., crime, education, presidential politics, employment) are influenced in varying degrees by an unspoken subtext of race and racial differences.

Further complicating matter is the existence of scholars who deny the biological validity of racial groups while at the same time acknowledging that average group differences exist in categories commonly referred to as races. This seeming contradiction is "resolved" in the reasons that are given for these differences – which usually are attributed to "cultural differences," "misperceptions," "stereotypes," "discrimination," or "adaptations to racism."

Levin (2005) argues that these attributions, though popular, lead to destructive attempts to address social problems with "solutions" that instead exacerbate these problems - e.g., automatically laying responsibility for the failures of minority groups at the feet of whites; stoking resentment and fatalism among minority groups that sap drive and ambition; erecting

impossible standards for businesses to meet in defending against racial discrimination; lowering admission standards for colleges and universities for meeting diversity goals; enacting divisive affirmative action guidelines in colleges and universities that lead to disproportionate failure among minority groups; banning psychometrically sound employment tests because they reveal average group differences in scores; or striking down reasonable criminal justice sentencing standards due to their disproportionate impact on racial groups (Levin, 2005).

Some scholars attempt – sometimes awkwardly – to forge a third viewpoint that borrows some elements from both the "there is no such thing as race" and "race is real and important" viewpoints. These scholars will argue that race is a "social construction," yet at the same time feel that the concept is so deeply embedded in human thinking that it can be freely used in applied psychology. These commentators will boldly claim that "race matters" (e.g., see Jones, 2013), yet the meaning behind this phrase is often not the same as the meaning behind Levin's (2005) use of this phrase. As an example of this viewpoint, Sanchez and Davis (2010) write:

> For the most part, scholars now define race as a social construction, based on a biological derivative, with social hierarchies that can have psychological meaning comprised of emotions, thoughts, and attitudes about one's identification or lack thereof with their racial group…The terms race, ethnicity, and culture are often used interchangeably in the multicultural literature…Race can take on ethnic meaning when, and if, members of that biological group have evolved specific ways of living…[R]acial groups also [display] cultural patterns that might transgress race, particularly those needed to function in larger society. (p. 268)

Jones and Bryant-Davis (2013) write:

> Race is intricately woven into the culture, the institutions and the psyche of America. Its presence has been overt, intentional, self-aggrandizing and instrumental at times, or covert, subtle, unconscious at other times. However, it is there, waiting for a drop of animus or fear to ignite its destructive potential.

The Treatment of Racial Differences in the Social Sciences

In the mid-1990s, Rushton (1995) conducted a massive review of the international research literature on racial differences on more than 60 psychosocial variables (including brain size, intelligence, reproductive behavior, sex hormones, twinning rates, speed of physical maturation, personality, family stability, law-abidingness, and social organization). He discovered a clear and distinct pattern in the results. Persons of East Asian ancestry (Mongoloids) and persons of sub-Saharan African ancestry (Negroids) were positioned at opposite ends of the spectrum, with persons of European ancestry (Caucasoids) falling in the middle. A summary of these findings is adapted from Rushton (1995) in Table 13.2. More current data on racial and ethnic group differences in select American social indicators are described next.

Select American Social Indicators (Racial and Ethnic Groups)

Marriage and Family Indicators Each year beginning in 1980 and leading to 2014, data have been collected on the rate of births annually for every 1000 unmarried women (between the ages of 15 and 44). Between 1980 and 2014, approximately 61–90 per thousand births to unmarried women occurred annually for blacks; between 1990 and 2014, approximately 24–34 per thousand births to unmarried women occurred annually for non-Hispanic whites; and between 2000 and 2014, approximately 20–23 per thousand births to unmarried women occurred annually for Asian or Pacific Islanders (Hamilton, Martin, Osterman, Curtin, & Matthews, 2015). In 2013, 72% of all births to black women, 66% to American Indian or Alaskan native women, and 53% to Hispanic women occurred outside of marriage – compared with 29% for white women

Table 13.2 Patterns of average group differences in developmental, psychological, and social traits between Negroid (blacks, African ancestry), Caucasoid (whites, European ancestry), and Mongoloid (Orientals, East Asian ancestry) racial groups

	Racial groupings		
	Mongoloid	Caucasoid	Negroid
Cognitive			
IQ test scores	Higher	Intermediate	Lower
Decision times	Faster	Intermediate	Slower
Physical maturation			
Skeletal	Later	Intermediate	Earlier
Motor	Later	Intermediate	Earlier
Dental	Later	Intermediate	Earlier
Social/developmental			
Age at first sexual intercourse	Later	Intermediate	Earlier
Age at first pregnancy	Higher	Intermediate	Lower
Law-abidingness	Higher	Intermediate	Lower
Marital stability	Higher	Intermediate	Lower
Personality			
Activity level	Lower	Intermediate	Higher
Administrative capacity	Higher	Higher	Lower
Aggressiveness	Lower	Intermediate	Higher
Cautiousness	Higher	Intermediate	Lower
Dominance	Lower	Intermediate	Higher
Impulsivity	Lower	Intermediate	Higher
Mental health	Higher	Intermediate	Lower
Self-concept	Lower	Intermediate	Higher
Sociability	Lower	Intermediate	Higher

Adapted from Rushton (1995)

and 17% for Asian or Pacific Islander women. However, the difference between black and white women in the percentage of births that are not within wedlock has been shrinking since 1980, while the difference between white and Hispanic women has been widening (Child Trends DataBank, 2015).

For all racial groups studied between years 2006 and 2010, the probability of a first marriage remaining intact (without disruption) goes down every 5 years between the 5th and 20th years of marriage. For each 5-year period that marriages remain intact, Asians have the highest probabilities of intact marriages, followed by whites and then followed by blacks who show the lowest probabilities of intact marriages (Copen, Daniels, Vespa, & Mosher, 2012).

Education Indicators From 1972 to 2013, the percentage of American high school dropouts among persons aged 16–24 years has been lowest for whites (approximately 4–13%), higher for blacks (approximately 7–27%), and highest for Hispanics (approximately 11–35%). Within each of the years for which national data were collected, the white < black < Hispanic pattern has held constant (National Center for Educational Statistics, 2014a).

According to the National Center for Education Statistics (2015), the percentage of American public high school freshmen who graduate (for year 2013–2014) with a regular diploma within 4 years after starting 9th grade is 89% (Asian/Pacific Islanders), 87% (whites), 76% (Hispanics), 73% (blacks), and 70% (American Indian/Alaska Natives).

The percentage of full-time bachelor's degree-seeking students who graduate from a 4-year postsecondary institution (aggregated across 1996–2007 beginning cohorts) is highest for

Asians (approximately 45–46% in 2005–2007 starting cohorts), followed by whites (approximately 36–43% for 1996–2007 cohorts), Hispanics (approximately 22–29% in 1996–2007 cohorts), Pacific Islanders (approximately 22–25% in 2005–2007 cohorts), American Indians/Alaska Natives (approximately 18–23% in 1996–2007 cohorts), and blacks (approximately 19–21% in 1996–2007 cohorts; National Center for Education Statistics, 2014b).

American Crime Statistics Most recent state and national crime statistics show that racial differences in American crime rates (e.g., homicides, forcible rapes, robberies, assaults, kidnappings, car thefts, arson, drug offenses) are stark and significant, with blacks having the highest crime rates and Asians having the lowest crime rates (Rubenstein, 2016). As of 2013, a black perpetrator was 6 times more likely (than someone who was not black) to commit murder and 12 times more likely to murder someone of another race than to be murdered by someone of another race. In New York City alone, a black person was 31 times more likely than a white person to be arrested for murder and 98 times more likely than a white person to be arrested in 2014 for the crime of shooting another person. Evidence also suggests that police arrest violent criminals at rates that closely mirror the actual rates at which different ethnic/racial groups commit violent crimes and that police bias fails to adequately explain racially disproportionate arrest and incarceration rates (Flaherty, 2012; MacDonald, 2003, 2016; Rubenstein, 2016; Wagner & Rabuy, 2016).

Patterns of Racial/Ethnic Excellence In numerous countries throughout the world, Jews are significantly overrepresented in exceptional achievement at universities (within fields such as mathematics, philosophy, economics, physics, and engineering), among world-class chess masters and champions, among business leaders, among Nobel prize winners in science and literature, and generally among those with high IQ scores (Lynn, 2011).

East African runners own virtually all longer-distance running records (Entine, 2000). Men and women of West African descent dominate and are overrepresented (in proportion to their numbers in the US population) in the professional sports of sprinting, football, and basketball (Johnson, 2014; Lapchick, 2015a, 2015b).

In a large meta-analysis of cognitive ability data from nine global regions throughout the world, East Asians display the highest average intelligence compared to other global racial and ethnic groups (Lynn, 2006). The Chinese as a group have usually averaged considerably higher incomes than the surrounding populations of the countries in which they live worldwide (Sowell, 1996). Asian Americans – and particularly Chinese Americans – tend to have higher average IQs than other groups, even when a variety of racial/ethnic groups are all adopted by white families (Rushton, 1995). Even when IQ is controlled, more Chinese Americans tend to enter high-status occupations compared to comparable samples of whites (Nisbett, 2009).

The Complexity of Interpreting Racial/Ethnic Group Differences in Health Outcomes

Recent data on racial group differences in select health outcomes are shown in Table 13.3. Reasons for these differences, however, are deceptively complex. In their National Research Council Report on American racial and ethnic differences in health in later life (Bulatao & Anderson, 2004), the report's panel asks the following basic questions: Does poor health start earlier, last longer, and appear more common for some American racial and ethnic groups than for others? If this is indeed the case, then what are the causes of and interventions that can be implemented for these differences? (p. 7). Due to the complexity of factors that influence answers to these questions, the report is organized into numerous sections that describe different categories of influence: genetic influences, socioeconomic factors, behavioral risk factors, social and

Table 13.3 Select summaries of current racial/ethnic group disparities in health and health-related outcomes

Dependent variables	Content (citations)
Alcohol use (heavy)	Between 2010 and 2014, approximately 6.6% of Americans aged 21 or older reported heavy alcohol use in the month prior to being surveyed. Whites reported the highest rates (7.4%), and Asians reported the lowest rates (2.1%). Heavy alcohol use is defined as drinking five or more (alcoholic) drinks on the same occasion on each of 5 or more days in the past 30 days (Substance Abuse and Mental Health Services Administration, 2015)
Cigarette use	The percentage (for all groups combined) of the past month cigarette use among adolescents decreased each year from 8.4% in 2010 to 4.9% in 2014. White adolescents aged 12–17 had a higher percentage of cigarette use compared to black, Asian, or Hispanic adolescents during all years (Substance Abuse and Mental Health Services Administration, 2015)
Heart disease	Non-Hispanic African American adults are at least 50% more likely than non-Hispanic whites to die prematurely (before age 75) from heart disease or stroke (Morbidity and Mortality Weekly Report, 2013)
Hepatitis	In 2013, Asian Americans were 1.2 times more likely to contract hepatitis A and 3 times more likely to develop chronic hepatitis B (compared to whites). Asian Americans have the highest incidence of hepatitis A among all racial/ethnic groups. Asian American women are 1.3 times more likely to die from viral hepatitis and 8 times more likely to die from hepatitis C, as compared to non-Hispanic whites (Office of Minority Health, 2016)
HIV infection diagnosis	In 2013, although Hispanics/Latinos comprise approximately 17% of the total US population, they accounted for 23% of new diagnoses for HIV infection; in 2014, although African Americans comprise 12% of the US population, 44% of estimated new HIV diagnoses in the United States were among African Americans; although Asian Americans comprise approximately 5% of the US population, they accounted for 2% of new HIV diagnoses; the rate for American Indians and Alaska natives was roughly similar to their proportional representation in the US population (1%); native Hawaiians and other Pacific islanders make up 0.2% of the US population and were less than 1 percent of new diagnoses of HIV (Centers for Disease Control and Prevention, 2015)
Death	For year 2014, the percentage of American Indian males and females, for all ages combined, who died due to unintentional injuries from accidents was more than twice the percentage for whites, blacks, and Asians/Pacific islanders (Centers for Disease Control and Prevention/National Center for Health Statistics, 2014)
Drug use (illicit)	In 2014, the percentage of Americans aged 12 or older reporting illicit drug dependence or abuse was highest for blacks (4.1%) than for whites, Asians, or Hispanics. Overall rates were highest for young adults aged 18–15 (Substance Abuse and Mental Health Services Administration, 2015)
Major depressive episode	In 2014, 11.4% of American adolescents aged 12–17 had at least one major depressive episode in the year prior to being surveyed, with the percentage being higher for white and Hispanic adolescents than for black adolescents (Substance Abuse and Mental Health Services Administration, 2015)
Thoughts of suicide	In 2014, 3.9% of American adults aged 18 or older had serious thoughts of suicide in the year prior to being surveyed, with the percentage of whites (4.2%) being higher than for blacks, Asians, or Hispanics (Substance Abuse and Mental Health Services Administration, 2015)

personal resources, prejudice and discrimination, stress, biopsychosocial interactions, and health-care factors. Each of these categories is discussed briefly below (for citations to supporting studies, see Bulatao & Anderson, 2004):

Genetic Influences The field of population genetics documents differences among population groups in frequencies of alleles within populations. An allele is one of a pair of genes that appears at a particular location on a particular chromosome and controls the same characteristic (e.g., blood type or color blindness). Some alleles are dominant, meaning that it produces the same phenotype (outward observable expression) whether its paired allele is identical or different. Other alleles are recessive, in that it produces the phenotype only when its paired allele is identical.

For individuals generally, genetic predispositions underlie the mechanisms involved in health and disease. The gene pools of different racial/ethnic groups may contain different frequencies of alleles at some site on the chromosome that is pertinent to health status or disease processes. However, the question of whether these predispositions vary significantly by racial/ethnic groups is considerably complicated by multiple and complex factors. Genetic influences (as well as environmental influences) are mediated through mechanisms involved in human anatomy, biochemistry, physiology, immunology, and endocrinology. Some racial/ethnic groups display significantly greater vulnerabilities and predispositions to certain medical conditions or diseases as well as sensitivity to certain therapeutic drugs. Nevertheless, variability within groups is considerably large as well.

Socioeconomic Factors Socioeconomic status (SES) differs considerably as a function of race and ethnicity. SES is typically determined by one or more of the following indicators: educational attainment, yearly income, and occupation. There is a considerable body of evidence that has established that persons of low SES are typically more likely to suffer from disease and impaired cognitive and/or physical functioning, and to experience higher mortality rates (Bulatao & Anderson, 2004). SES influences health beginning in the prenatal environment. Parents' SES can affect childhood conditions such as exposure to harmful toxins and infectious agents.

Further complicating matters is the reciprocal relationship between health status, yearly income, and accumulated wealth. For example, more affluent persons are able to afford a higher quality of health care, are less exposed to health-threatening conditions, and have more financial resources that serve as a buffer against threats to one's health. Poor, racially and ethnically segregated communities have greater sustained exposure to substandard housing, overcrowding, elevated noise levels, crime, and exposure to noxious pollutants and allergens. In turn, poor health can negatively influence earning potential. When SES is controlled, health differences between certain racial/ethnic groups can be eliminated, although this relationship does not hold for some specific diseases.

Behavioral Risk Factors Risk factors that can jeopardize an individual's health can involve behaviors that are freely chosen. Such behaviors include, but are not limited to, smoking, illicit drug usage, overeating, unsafe sex, avoidance of daily exercise, seeking health care, and compliance with doctor/caregiver instructions. Some behaviors have a higher frequency of occurring due to "supporting influences" in the environment (e.g., peer pressure, high presence of liquor stores in the neighborhood). Other behaviors have a higher frequency of occurring due to "environmental barriers" (e.g., elderly persons who need medical care but who stay indoors from fear of an unsafe/violent neighborhood). There are significant differences between racial/ethnic groups in these behaviors, with some groups exhibiting more healthy behaviors and other groups exhibiting less healthy behaviors – although patterns in group rankings can also differ significantly as a function of the specific behavior. Nevertheless,

some racial/ethnic groups display larger absolute numbers of overall behavioral risk factors compared to other groups.

Group differences in overall SES does play a role in group differences in behavioral risk factors. Controlling for factors such as educational attainment and yearly income can reduce the gap between groups in behavioral risk factors for some outcomes but not others. Interestingly, acculturation of immigrants to American norms can influence behavioral risk factors. The more acculturated a person is (of any race), the more prone that person is to certain deleterious health behaviors. In addition, health-related risk behaviors can be higher in racial/ethnic groups with larger proportions of immigrants compared to other groups.

Social and Personal Resources Personal and psychological factors on which individuals can draw can reduce the risk of experiencing certain negative health outcomes. These factors include, but are not limited to, social resources, social integration (e.g., emotional support from others), social engagement (e.g., social activities with others, religious involvement), and self-efficacy beliefs (e.g., belief that one has the ability to control outcomes).

Having close and supportive relationships in one's life has been shown to be associated with lower blood pressure, lower levels of serum cholesterol, and lower levels of stress hormones. Religious beliefs, as one form of social engagement, are an important source of hope and comfort. Religious groups provide "systems of meaning" to help vulnerable individuals cope with stress, disability, fear of death, and the loss of loved ones and significant others. Older adults with stronger self-efficacy beliefs are more likely to exercise regularly than those with lower self-efficacy beliefs.

The contribution of social and personal resources to racial and ethnic group differences in health outcomes has received less systematic study compared to other factors. Nevertheless, some studies have found moderating effects, where the influence of these factors on health outcomes is significant for some groups but not for others.

Prejudice and Discrimination Some studies suggest that racism, prejudice, and discrimination are possible reasons for higher levels or morbidity and mortality in some racial/ethnic groups compared to others. Definitions for these terms are numerous and complex (see later sections of this chapter); however these terms share in common negative attitudes or treatment of persons as a function of their racial/ethnic group membership.

Discrimination can be generally defined as unequal treatment that is based on group membership. If this unequal treatment is negative, then discrimination can negatively affect a group's living conditions; life chances in education, employment, and housing; and differences in access to quality health care.

There exist individual differences in the ability of persons to cope with hostile living conditions due to prejudice. This affects (to varying degrees) how persons internalize negative stereotypes, the use of drugs and alcohol to dull emotional pain, blood pressure levels, and general mental health functioning.

It is not known, however, if the effects of prejudice, discrimination, and racism perform in the same manner for all groups or are "counterbalanced" by other factors such as "selectivity effects" (in the case of immigrants), stronger personal/social resources, or high SES status.

Stress Factors Stress can be generally defined as "environmental demands that tax or exceed the adaptive capacity of an organism, resulting in biological and psychological changes that may be detrimental and place the organism at risk for disease or disability" (Bulatao & Anderson, 2004, p. 82). Studies are designed to generally test the hypothesis that greater exposure to stress over one's life course increases their susceptibility

to morbidity and mortality – and that members of racial/ethnic minority groups are at greater risk for such stress.

Life stressors can take many forms, which include, but are not limited to, pressures associated with economic difficulties, physical deprivation, occupational strain, death of a spouse or loved one, increased family responsibilities (birth or a child, divorce, remarriage, care of sick, or disabled family members), or neighborhood instability. Depression, anxiety, anger, and hostility can be triggered by stressful life experiences.

Some racial/ethnic groups report higher levels of stress compared to other groups, with significant differences observed between ethnic subgroups within broad racial groups. Higher numbers within certain groups react to the same stressful events with higher levels of stress compared to how members of other groups react to these same stressful events.

Biopsychosocial Interactions The effects of the six factors briefly discussed thus far are typically studied independently and often within the boundaries of separate disciplines. However, there is much research to suggest that these factors exert *interaction effects* among themselves and with biological systems. "Biopsychosocial" is the name given to the study of psychosocial and biological interactions. For example, psychosocial and behavioral factors have been shown to affect cardiovascular, neuroendocrine, central nervous, and immune systems (e.g., heart rate, blood pressure) in response to acute psychological or behavioral stress (called *physiological reactivity*). Individuals who are at risk for hypertension (which is higher in some racial groups compared to others) may also exhibit cardiovascular hyperreactivity to stress.

Allostatic load is defined as the overtaxing of several physiological systems ("wear and tear") in response to stress or other psychosocial or behavioral factors, which may lead to dysregulation and/or disease (Bulatao & Anderson, 2004, p. 88). Allostatic load scores have been found to be higher among persons with lower educational attainment and higher levels of hostility than average, which suggest linkages to racial and ethnic group differences.

Psychoneuroimmunology is defined as the examination of the interactions among psychological, behavioral, and social factors with immunological and neuroendocrine outcomes. As an example, it is well established that chronic stress can lead to impairments in immune system functioning in both younger and older adults, which again suggests linkages to racial and ethnic group differences.

Health Care Racial and ethnic minority groups may face significant challenges in having access to the same quality of medical care in the United States. These challenges can result in differences related to the ability to pay medical fees (e.g., group differences in levels of health insurance coverage), differences in provider behavior and treatment (e.g., group differences in the likelihood of receiving commonly performed hospital procedures), differences related to patient behavior (e.g., differences in fidelity to treatment plans), and geographical variability (e.g., differences in quality care within the same hospital, between hospitals in a single geographic location, or across different health systems).

The Treatment of Racism in the Social Sciences

The Depiction of "Racism" in General Society

Literally hundreds of definitions for the word "racism" have been advanced within scientific writing and popular writing and in contemporary civic life. It is no exaggeration to opine that the meaning of racism has been stretched to convey

Table 13.4 A Variety of Implicit/Explicit Definitions for 'Racism'

According to contemporary commentaries in general society and in the social sciences (including applied psychology), you may be accused of "racism" or "being a racist" if:

- You are a human being (Ojiaku, 2016; Payne, 2014)
- You are white (DiAngelo, 2012; Sue, 2003)
- Your political interests align with conservative or patriotic principles, policies, or values (Kinder & Sears, 1981; Sears, 1988; Sears & Henry, 2003)
- You agree with a highly disliked person (on an issue that has little or nothing to do with race) who has been judged to be "racist" (Sanchez & Pitzl, 2014)
- You notice social problems that involve racial/ethnic groups and desire to discuss them openly (Bonilla-Silva, 2010; Stein, 2012)
- You prejudge someone on the basis of their observed physical features (CliffsNotes, 2016; Velasquez-Manoff, 2016; Williams, 2009)
- You hold views that are different from the mainstream media on multiculturalism, affirmative action, crime, and educational underachievement (Helms, 2008; Horowitz, 2016; Stein, 2012; Taylor, 2004)
- You criticize or disapprove of the negative behavior of individuals from racial/ethnic minority groups (Flaherty, 2012; Horowitz, 2016; Johnson, 2012)
- You fail to combat racism (Burk, 2015; Ridley, 1995, p. 22; Townsend, 2003)
- You believe that artistic/scientific contributions from Western societies and cultures are superior than contributions from non-Western societies and cultures (Helms, 2008; Prager, 2016)
- You believe that race is a biologically useful concept for classification of human subgroups (D'Sousa, 1995, p. 28; Southern Poverty Law Center, n.d.)
- You attempt to treat persons in a "color-blind" manner (Sanchez & Davis, 2010; Trepagnier, 2010; Williams, 2011; Wise, 2010)
- You conduct research on racial differences (Rushton, 1998b; Southern Poverty Law Center, n.d.)
- You believe that no average differences between racial groups exist beyond superficial differences in skin color (Williams, 2011)
- You believe that average differences between racial groups exist beyond superficial differences in skin color (Gasper, 2008; Gelman, 2014; Southern Poverty Law Center, n.d.)
- You believe in a genetic basis for variation in human traits (Gelman, 2014; Levin, 2005; Steadman, 2014)
- You believe in a biological or genetic basis for why certain groups excel on average in certain areas (Gil-White, 2004; Woo, 2012)
- You believe that racially/ethnically diverse societies promote greater problems than racially/ethnically homogeneous societies (Jonas, 2007; Taylor, 2004, 2011)
- You believe that all subgroups must be held to the same standards (e.g., in employment, education, civic behavior; Sperry, 2016; Thrasher, 2010; Toplansky, 2012; Quinlan, 2015)
- You believe that all subgroups should not be held to the same standards (e.g., in employment, education, civic behavior; Independent Radical, 2014; Namazie, 2001; Sleeper, 1997)

whatever a speaker subjectively wants the word to mean. As a result, the terms "racism" and "racist" have literally lost all meaning – making the rational communication of ideas literally impossible. The wide variety of definitions for "racism" and "racist" – used in both general society and in the social sciences – are depicted in Table 13.4.

The terms "racism" and "racist" function as epithets meant to evaluate an idea or person as bad, sinister, despicable, evil, or vile (e.g., see Barndt, 2007). Levin (2005) states:

> [C]alling someone or something "racist" automatically condemns him or it. In fact, the fierce emotions accompanying "racism" suggest that its core meaning is "grossly improper race consciousness." Yet at the same time "racism" is freely used of an enormous range of beliefs, attitudes and practices, many of which seem in no way grossly improper, or improper at all. That is why the word serves only to obscure…Precisely because things [called] racist are bad by definition, it is tempting to try to force condemnation of an attitude or practice by labeling it "racist", when in point of logic the attitude or practice in question must *first* be shown to be bad by some independent standard *before* it can be so labeled… [A]ll [we] can conclude when [we hear] "racist" employed today is that its referent [has] something to do with race that the speaker dislikes. "Racism" is not so much uttered as shouted; its conversational function is to shut conversation down. (p. 153)

Calling something or somebody "racist" becomes a tactical weapon intended to "shut conversation down." When an accuser calls people, ideas, or actions "racist," it is hoped that:

- The person will stop believing, saying, or writing things about race or racial group differences that causes others to feel embarrassed or uncomfortable.
- Society will be protected from ideas about race or racial group differences that the accuser believes has the potential to damage democracy, equality, and equal treatment under the law.
- The person will be intimidated into silence by ceasing arguments about race or racial group differences against which the accuser has no rebuttal.
- Audiences will be predisposed to reject a priori any merits of an argument about race or racial group differences.
- The accuser will be viewed as morally superior or more virtuous than his/her opponent.

There appear to be no limits as to how far the general media will go to use the words "racist" or "racism" to generate attention-grabbing headlines. As one among countless examples, one overzealous Louisiana lawmaker openly criticized a proposed state bill that would require schoolchildren to recite portions of the Declaration of Independence. Her justification was that it would be unfair to require schoolchildren to recite a document that was crafted at a period of time when African Americans were slaves. While this was arguably a provocative position to take, the online headline for the story read in part: "Louisiana rep causes outrage by implying Declaration of Independence is racist" (Chia, 2016). In another example, the head of a shirt company discovered that he could do a better job of custom-fitting tailored shirts if he collected information on the race/ethnicity of customers, due to reliable patterns he discovered between race/ethnicity and upper body measurements. An online story about the company led with the provocative title "Can a Dress Shirt Be Racist?" (Velasquez-Manoff, 2016).

The sloppiness with which the word racism is used should not be misconstrued to mean that the organized hatred of racial/ethnic minority groups (originating from organized white groups) is not "real" or has ceased to exist in contemporary American society. Although the existence of openly hostile groups (who proudly identify themselves as "racist") has by and large retreated to the outer fringes of society, such groups continue to operate "under the radar" of civic life. Swain (2002) carefully documented the rise of "white nationalist" groups who target white Americans who are aggrieved over multiculturalism, real or perceived racial double standards, race-based affirmative action policies, rising minority-on-white crime rates, and failure to combat illegal immigration (e.g., see Reeves, 2016). Such groups capitalize on such grievances by recruiting members through the Internet, "white power" books and music, spreading recruitment literature through foot canvassing efforts, and organizing high-profile marches and rallies.

National Surveys of American Racial Attitudes

There are two frameworks that social scientists follow in using survey methodology to understand changes in the general public's racial attitudes. One method is to survey the public closely following a national event in the public's consciousness that may influence racial attitudes (e.g., school desegregation, Martin Luther King assassination, O.J. Simpson murder trial, riots in Ferguson, Missouri). Another strategy is to use the same questions to periodically "take the pulse" of the public annually, in order to measure longitudinal changes in attitudes as a function of the passage of time.

As an illustration of this second framework, in 1972 the General Social Survey (GSS) asked questions of interest to the general public on American race (i.e., black/white) relations up to 2008 (as part of many other questions of interest to social scientists; Marsden, 2012). Bobo, Charles, Krysan, and Simmons (2012) arrived

at several broad conclusions about both black and white attitudes from the GSS (which have not changed in data collected since 2008; see Krysan, 2015):

White Attitudes First, longitudinal results demonstrated a dramatic change away from support for "Jim Crow" segregation, revulsion against interracial marriages, and belief in the biological inferiority of blacks toward broad support for equal treatment, integration, and increasing tolerance of interracial marriages. Second, although whites demonstrated general support for general principles of integration (in schools, neighborhoods, and public spaces), they still expressed social distance preferences (away from blacks) in certain circumstances. Third, white support for a strong and active government role in reducing racial inequality (e.g., affirmative action, racial preferences) was limited. Policies aimed at enhancing the human capital of blacks (e.g., "playing by the rules of the game") continued to be popular. Fourth, negative racial stereotypes remain widespread but have a "gradational" rather than "categorical (either/or)" character. Bobo et al. (2012) write: "The basis for such perceptions also appears to have shifted away from presumed biological or natural differences toward presumptions rooted in group culture" (p. 75). Fifth, white explanations for socioeconomic racial inequality have moved from "biology" to "culture." Sixth, most white Americans maintain a "significant" (p. 75) affective, social, and emotional distance from blacks. Seventh, most whites believe that blacks are not deserving of special treatment and should "just sink or swim in the modern free market" (p. 75).

Black Attitudes First, blacks are increasingly less likely to explain racial inequality in structural, discrimination-based terms. Second, blacks have shifted significantly toward more motivational and cultural explanations for racial inequality. Third, a significant reduction over time was observed in support for certain forms of government intervention to advance the status of blacks. Bobo et al. (2012) offer the following conclusions:

> The attitudinal record assembled in the GSS provides a remarkably rich and sociologically important lens on race in the United States. These data vividly document both significant progressive changes regarding race, as well as substantial enduring frictions and conflicts that continue to make race such a fraught terrain … This conceptually broad and analytically powerful record is a strong caution against glib generalities that try to reduce an enormously multifaceted social phenomenon to simplistic catch phrases like "racist America," "the end of racism," or most recently "postracial America."

Bobo et al.'s (2012) comments reflect subtle nuances, as well as appropriate caution, in advancing interpretations as to what these survey data implies. In contrast, other scholars continue to be committed to defining the presence or absence of racism in society according to a simplistic equation – that is, "racism in society" is eradicated only when there is a complete absence of statistically significant social and economic inequalities between groups (Barndt, 2007; Brown et al., 2013). Along these lines, Barndt (2007) writes: "If we measure results, it becomes quickly obvious that racism has not been overcome" (p. 46).

Racism as Studied in Social Science Scholarship

There exist four broad philosophies that are woven throughout the history of social science writing on the nature and origins of racism. Although these philosophies are described separately for didactic purposes, they can overlap to some unspecified degree. For purposes of this discussion, these competing philosophies are called the "unusual/damaged personality" view, the "ordinary human nature" view, the "alien entity" view, and the "kitchen sink" view of racism.

The Unusual/Damaged Personality View According to this view, persons who are labeled "racists" have deep-seated character or personality flaws. These flaws require them and their views to be shunned, isolated (so they cannot damage others), or at least rehabilitated so that they can discover the error of their thinking/ways and change to think/behave more like "normal" (nonracist) persons.

A well-known illustration of this viewpoint is early research on *The Authoritarian Personality* (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950), which represented an attempt by a group of researchers to explain the conditions that allowed Adolf Hitler's Nazi movement to gain a foothold in 1940s Germany, specifically, and in Europe, generally. In Adorno et al.'s view, Freudian psychodynamic theory posits that overly harsh and punitive parenting causes some children to internalize immense anger toward their parents. Instead of confronting their parents directly, such children grow up to identify with and idolize strict authority figures. According to their theory, highly authoritarian personalities display blind allegiance to conventional beliefs about right and wrong, are comfortable with being aggressive toward others who are different, and have a tendency to project their own feelings of inadequacy, fear, and rage onto a scapegoated group. A full explication of this theory, as well as subsequent criticisms of this theory, is beyond the scope of this chapter but can be accessed elsewhere (e.g., see Martin, 2001; Roth, 1994; Smith, 1997).

Thus, persons who draw attention to themselves by joining high-profile (and what many would consider to be extremist) organizations like the Aryan Nations, ISIS (Islamic State of Iraq and Syria), New Black Panthers, Ku Klux Klan, and the Westboro Baptist Church are considered to have disturbed personalities, in this view.

The Ordinary Human Nature View According to this view, "racism" is a name that is given to what is considered to be a wrong application of normal psychological and cognitive processes that are universal among all human beings. As one among many examples, human thinking (from infancy to adulthood) is characterized by both an unconscious and conscious ability to habitually sort the wide variety of disparate objects, events, and people into a smaller number of meaningful categories. This is called *social categorization*, a construct that has been studied in social psychology since the 1950s (for a review, see Gaertner, Dovidio, Guerra, Hehman, & Saguy, 2016). According to Gaertner et al.:

> Categorization enables decisions to be made quickly about incoming information because the instant an object is categorized, it is assigned the properties shared by other category members. Time-consuming consideration of each new experience is forfeited because it is usually wasteful and unnecessary. Categorization often occurs spontaneously on the basis of physical similarity, proximity, or shared fate…Social categorization not only produces greater reliance on heuristic, relative to more detailed and elaborative processing, but also it produces systematic social biases in evaluations of others. Attraction and prejudice are fundamentally related to social categorization and to the perception of intergroup boundaries that define who is included in one's own group (a "we") and who is excluded (a "they"). (p. 435)

Feelings/opinions collectively labeled "racism" are not qualitatively distinct constructs that are disconnected and mutually exclusive from universal human psychological processes of discrimination, prejudging, and in-group favoritism. When stripped of their negative connotations, to "discriminate" simply means to recognize or understand the difference between one thing and another (http://www.merriam-webster.com/dictionary/discrimination). To "prejudge" simply means to judge beforehand (http://www.dictionary.com/browse/prejudge). To display "in-group favoritism" simply means to display a pattern of favoring members of one's in-group over out-group members (https://en.wikipedia.org/wiki/In-group_favoritism). In normal human functioning, all people discriminate (e.g., in selecting a life's mate, in buying an expensive coat), all people prejudge (e.g., when selecting a political party to support, when anticipating how to respond appropriately to extreme weather conditions), and all people display in-group favoritism (e.g., related to their age, gender, or religious affiliation). A person judged to be guilty of "racism" describes an individual who applies these normal cognitive processes to negative evaluations of racial/ethnic/language/culture groups that are different from one's own group.

A hypothetical illustration may shed light on this process. Suppose a young boy gets bitten by a snake 5 out of the 7 days of the week that he plays in the backyard behind his house. It would be quite natural, then, for this boy to develop

negative stereotypes or prejudgments about snakes (as well as being wary of, or hostile toward, their presence). It would not make sense to accuse the boy of harboring symptoms of a disturbed personality, as his beliefs, feelings, and attitudes toward snakes simply reflect normal self-protecting cognitive processes. The only way for this boy to lesson his negative perceptions/feelings about snakes is for *snakes to reliably and consistently change their behavior* in their interactions with the boy. In the absence of consistent exposure to different behaviors from snakes, then the boy's stereotypes have a rational connection to accurate truth (see Jussim et al., 2016). D'Sousa (1995) has described this process as reflecting "rational discrimination" (p. 281).

This observation is consistent with the conclusion that stereotypes are often accurate (e.g., see Lee, Jussim, & McCauley, 1995) and that sustained contact with different racial/ethnic groups often *increases* the saliency of negative stereotypes. As an illustration, D'Sousa (1995) writes:

> It is obvious to most people that groups do differ. Therefore it is possible to make accurate generalizations. As the term suggests, generalizations hold true in general: they work best when, circumstances permitting, they take into account individual exceptions to the rule and overlapping traits between groups…[T]he liberal assumption that greater contact between groups can be expected to eliminate prejudices and stereotypes turns out to be illusory. It is possible to tell a young boy or girl who has never met Puerto Ricans that they have no recognizable group traits, but after that child has lived in New York for a few months, such an argument from a sensitivity counselor will come to sound comical. In fact, studies confirm that greater exposure often has the effect of reinforcing negative perceptions of distinguishing group traits: familiarity sometimes does breed contempt. (p. 275)

The Alien Entity View The innovative television series "Star Trek" aired for three seasons in the 1960s (1966–1969). The episodes were known for their dramatization of then-current social problems (e.g., war, population overcrowding, drug abuse, poverty, mental health treatment) in a futuristic science fiction context. One third season episode, entitled *Day of the Dove* (originally airing November 1, 1968), represented a thinly veiled allegory on the problem of racism.

In this episode (description accessed at https://en.wikipedia.org/wiki/Day_of_the_Dove), a landing party from the Starship Enterprise responds to a distress call from a planet, only to encounter hostile Klingon troops from their own starship who were also responding to a distress call. The Klingon officers and Enterprise crew eventually transport back to the Enterprise, but unbeknown to them, an alien entity consisting of pure energy follows them and also enters the Enterprise. It is later revealed that the distress calls to both groups was only a ruse, engineered by this alien entity. The entity is eventually revealed to be a force that "feeds" on group conflict by manipulating matter, influencing a person's thoughts, and causing individuals from both sides to imagine nonexistent offenses from members of the opposing group, feel hatred and resentment toward the opposing group, and engage in aggressive fights with members of the opposing group. Once this alien entity is discovered by the crew, they decide to fight it by cajoling one another to lay down their weapons, laugh at the entity, and display joviality and friendship with members of the opposing group. This, in turn, weakens the entity and causes it to leave the ship (in search for other groups that can be manipulated in order to feed its appetite).

This episode, though obviously fictional, largely reflects how social science often characterizes the construct of "racism" and how it should be addressed in cultural competence training. In this characterization, "racism" is fundamentally viewed as qualitatively distinct from, and thus foreign to, human nature (as illustrated in the phrase "no one is born with racism, it must be learned" – see Irving, 2014, p. xiii). Said differently, racism is a problem located "out there" in words, ideas, pictures, and objects that are external to human nature, rather than originating from human nature and residing "in here." Like the alien entity in the Star Trek episode, racism acts like a malevolent force that infects persons and negatively distorts their thinking, attitudes, and behaviors. Racism can manifest itself in overtly ugly ways. In contemporary times, however, it is often characterized as subtle, sublimated, implied, hidden, unconscious, or having the ability to manifest itself through cultural institutions and symbols. The

implications of this characterization are for applied psychology scholars to aggressively search within the nooks and crannies of contemporary social and civic life to identify all the ways in which racism can manifest itself and expose it to the sunlight. Practitioners can then be trained to recognize racism and exorcize it from on'e thinking and actions so that racial/ethnic minority clients will not be harmed. If a critical mass of current and future practitioners can be convinced (or required) to get on board with this mandate, then racism can ultimately be "understood," dismantled, "rooted out," banished, or "cured" (see Barndt, 2007; opening quote in Bobo et al., 2012, p. 38; Winter, 1977). While some psychologists may not go so far as to think that racism can be eradicated forever, they nevertheless believe that racism can be neutralized (or at least rendered ineffective) by the internalization of more "enlightened" knowledge, attitudes, and behaviors.

The Kitchen Sink View This category derives its name from the fact that ideas, objects, events, or persons (for whom no previous connection to racism is indicated) are suddently and arbitrarily associated with racism – simply as a result of trendy political movements or shifting social mores. Here, charges of racism have no connection to established theory or research, although a case could be made that such labels reflect a broader manifestation of intergroup conflict within societies (e.g., Horowitz, 2000). Stated succinctly, *"kitchen sink" racism is whatever anyone says that it is* at any given point in time. As examples, contemporary civic life is governed by unspoken and often incoherent rules for what words/phrases are or are not considered "racist" (Asante, 2003; Malesky, 2014; Sue, 2010). Names for sports' team mascots that have been around for decades are suddenly deemed "racist" and therefore unfit for public use (King, 2010). Symbols of southern history and culture (e.g., confederate flag, statues of confederacy generals), as well as revered historical figures from the past, suddenly become racist and therefore must be banished from civic recognition (Brumfield & Ellis, 2015; Cassini, 2015; D'Sousa, 1995, p. 286) when viewed through the prism of contemporary sensibilities.

At times, the rules for what is or is not considered racist are inconsistently applied or are applied using a double standard. Famous late-night "blue" comedians fill their comedy routines with "racial" humor which is regularly greeted with appreciative guffaws from multiracial audiences (e.g., see Bogosian, 1997; Hibberd, 2016), yet others could get fired (or worse) if similar content is openly displayed by the wrong person, in the wrong setting, or offends the wrong people (Bryant, 2016; Hanna, 2015; Mettler, 2016). A popular mantra among antiracism advocates is that "people of color cannot be racist" (Mzwakali, 2015; Sensoy & DiAngelo, 2012; Thorne & Wood, 2015; TrueBlueMajority, 2009). According to Helms (2008), "[f]or racism to disappear in the United States, White people must take responsibility for ending it" (p. v). Yet an opposing mantra - defended with equal ferocity - is that "everyone is racist" (Ojiaku, 2016; Payne, 2014).

Different Types of Racism in the Social Sciences

As there are different flavors of ice cream found in a local Baskin-Robbins store, so are there different kinds of racism that have been identified in the social science literature. The following list is by no means exhaustive, but simply testifies to the diversity of terms. Leavitt (2010) opines that *individual racism* "is no doubt the easiest form of racism to identify and comprehend" (p. 143). According to Leavitt (2010), a demeaning racial joke told at the expense of another, racial epithets publically written on walls/sidewalks, and poor restaurant service given to a customer which is based solely on their skin color, all reflect examples of this form of racism.

Dominative racism was first coined by Kovel (1970) and subsequently described by Gaertner and Dovidio (1986) as characteristic of a more "red-necked" individual who acts out his/her bigoted beliefs (p. 62; see also *old fashioned racism* in McConahay, 1986).

Baruth and Manning (2016) use the term *personally mediated racism* to refer to prejudice (defined as holding different assumptions about the abilities, motives, and intentions of others based on their race) and discrimination (defined as the display of different actions toward others based on their race). According to Baruth and Manning (2016), personally mediated racism takes many forms, which include (but are not limited to) a lack of respect, delivering poor or no service in public places, shopkeepers' increased vigilance of customers due to suspicion, avoidance of others, and surprise at displays of competence (by a person of a different race).

There is a category of alternative forms of racism presumed to be rampant and pervasive in modern society, even though one is hard pressed to find many explicitly and openly racist individuals (Bonilla-Silva, 2010). Trepagnier (2010) coins the term *silent racism*, which she defines as a characteristic that exists within the minds of all "well-meaning white people… whether they acknowledge it or not" (p. 2). In her view, silent racism manifests itself in two forms: stereotypical images (defined as misinformation about blacks prevalent in the culture) and paternalistic assumptions (defined as a sense of superiority found in some relationships between blacks and whites). She argues further that silent racism is "built into the fabric of (American) society," which also "maintains racial inequality" (p. 1).

Bonilla-Silva (2010) discusses the concept of *color-blind racism*, which he describes as an explanation for contemporary racial inequality that is elusive, because it is not characterized by explicit racial features. As one among many examples, residential segregation is used to be enforced by overt means (openly discriminatory restrictive covenants). In contrast, color-blind racism can be displayed covertly:

> …such as not showing all the available units, steering minorities and whites into certain neighborhoods, quoting higher rents or prices to minority applicants, or not advertising units at all. (p. 3)

In economic areas, color-blind racism can be displayed covertly through:

> …advertising job openings in mostly white networks and ethnic newspapers, and steering highly educated people of color into poorly remunerated jobs or jobs with limited opportunities for mobility…this new [color-blind] ideology has become a formidable political tool for the maintenance of the racial order…color-blind racism serves today as the ideological armor for a covert and institutionalized system in the post-Civil Rights era…it aids in the maintenance of white privilege without fanfare. (p. 3)

Gaertner and Dovidio (1986) coined the term *aversive racism* to describe a peculiar brand of conflicted attitudes and feelings within white Americans who possess strong egalitarian values. In their view, aversive racists:

> …sympathize with the victims of past injustice; support public policies that, in principle, promote racial equality and ameliorate the consequences of racism; identify more generally with a liberal political agenda; regard themselves as nonprejudiced and nondiscriminatory; but, almost unavoidably, possess negative feelings and beliefs about blacks. Because of the importance of the egalitarian value system to aversive racists' self-concept, these negative feelings and associated beliefs are typically excluded from awareness. (p. 62)

According to Gaertner and Dovidio (1986), when faced with an anxiety-evoking situation that threatens to expose their negative feelings about blacks, the aversive racist will "overcompensate" by amplifying "their positive behavior in ways that would reaffirm their egalitarian convictions and their apparently nonracist attitudes" (p. 62).

There is a particular brand of racism that is presumably present in the world of ideas within academia. *Scientific racism* is a term used to describe the use of scientific or pseudoscientific techniques to classify phenotypic characteristics of human beings into discrete races for the purposes of supporting or justifying the belief in racial superiority and/or inferiority. Whereas this term has a clear meaning when applied to clearly discredited historical practices of anthropometry (e.g., phrenol-

ogy, physiognomy, craniometry), the term has been widened to include any scientific acknowledgment or study of race and/or racial differences in contemporary times (Byrd & Hughey, 2015; Herbert, 1994; Newitz, 2014; Tucker, 2007).

The description of scientific racism overlaps considerably with its cousin term *academic racism* (Chu, 2013), defined as "academic theories and scholarly research and writing that perpetuate the notion of racial superiority" (p. 13). According to Chu (2013), academic racism is dominant within academia and is perpetuated through the higher education curriculum, the press, and the media. She argues that its danger lies in its "scientific and intellectual integrity," which automatically confers "legitimacy and authority" to such theories in the eyes of students, the popular media, and government decision-makers.

There is an entire category of labels that attempt to link racism with particular ideas that are not explicitly "racial" on the surface. *Symbolic racism* is a term coined by Sears and his colleagues (Kinder & Sears, 1981; Sears, 1988; Sears & Henry, 2003; Sears & Kinder, 1971) to partly explain why white Americans oppose government policies designed to aid black Americans. According to symbolic racism theory, most whites in contemporary times no longer subscribe to *old-fashioned racism* (e.g., belief in the biological inferiority of blacks and support for racial segregation and discrimination; see McConahay, 1986) but instead display their primitive racism more covertly through political support for "traditional" American values. In their view, symbolic racism represents a form of resistance based on feelings that many blacks violate "traditional" American values of the Protestant work ethic, individualism, self-reliance, and self-discipline. This, in turn, nurtures attitudes in opposition to government largess in welfare benefits, forced busing, racial quotas, and abortion services that benefit blacks (Kinder & Sears, 1981). Slightly revised versions of symbolic racism theory have appeared in the social psychology research literature under the term *modern racism* (McConahay, 1986).

Many of these forms of racism have been used in attempts to link racism with conservative political viewpoint reference. As a result of a backlash against the perception that politically conservative viewpoints are little more than a cover for racism, the term *liberal racism* (also nicknamed *friendly racism*, p. 5) was created to refer to views about race that are particularly characteristic of political liberals. Liberal racism refers to a patronizing set of attitudes and beliefs which embraces an "almost primordial" (p. 4) concretization of racial differences, holds lowered expectations for members of minority groups, and constrains them to adopt a rigid group identity despite wide individual differences within groups (Sleeper, 1997). Along these lines, Horowitz (2016) coined the term *progressive racism* that describes what he calls a "destructive" world view held by persons who are sympathetic to a progressive political philosophy. In his view, this philosophy seeks to replace the idea of equal treatment under the law with an ideology based on "group identities and group privileges based on race and gender" (p. x).

Reasonable racism is a term used as a reaction against the concept of rational discrimination (see earlier section on the *Ordinary Human Nature* origin of racism). Rational discrimination (D'Sousa, 1995) is a term that describes decisions that may negatively affect individuals but which are made on the basis of statistical facts about groups (see examples of mortgage lending and criminal justice in Chapter 7 of D'Sousa, 1995). Many feel that rational discrimination is merely a cover that justifies racial animus toward individuals and thus have renamed this term "reasonable racism" (Armour, 2000; Kane, 1997).

Not only can racism be directed at others who are different from oneself, but racism has also been characterized as being directed inwardly toward oneself. Baruth and Manning (2016) define *internalized racism* as:

> acceptance of negative messages by members of stigmatized groups about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them and not

> believing in themselves. It involves accepting limitations to one's full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-expression. (p. 20)

Some forms of racism are not viewed as localized within individuals but instead are viewed as abstractions that are characteristic of institutions and entire societies. Trepagnier (2010) coined the term *metaracism* to describe a form of racism that has been "displaced onto economic structures" and reflect "beliefs of entitlement regarding the economic position of whites vis-à-vis blacks" (p. 20). Jones (1981) introduced the term *cultural racism* that describes the condition where an entire society "considers some beliefs to be more important than others" (Clauss-Ehlers, 2006, p. 52). According to Helms (1993), cultural racism exists whenever societal beliefs and customs promote the assumption that the language and traditions of that culture are superior to those of other cultures or when there is widespread acceptance of stereotypes concerning different ethnic or racial groups. According to Clauss-Ehlers (2006), cultural racism can be expressed in how a society defines standards for beauty, or when it places a higher value on certain forms of art or music above others, or when it favors certain philosophical orientations (e.g., individualism) above others (e.g., collectivism).

Institutional racism is a term that was first coined by Carmichael and Hamilton (1967) but has been defined in more recent times as "different access to the goods, services, and opportunities of society [which] impedes social acceptance and economic progress" (Baruth & Manning, 2016, p. 19). Implicit within this definition is the idea that racism is covert, legal, and codified into institutions' policies and decision-making practices.

At the highest level of abstraction, *environmental racism* has been defined as "the enactment or enforcement of any policy, practice, or regulation that negatively affects the environment of low-income and/or racially homogeneous communities at a disparate rate than affluent communities" (U.S Legal.com, 2016; Zimring, 2016). Sometimes environmental racism does not even have to originate from human beings but can be attributed to the forces of nature (e.g., see Wright, 2005).

Stereotype Research

Stereotype research within social psychology is given special attention here, as it arguably represents the most focused and well-known attempt to carefully study important psychological processes related to racism, prejudice, and discrimination (Jussim, 2012; Lee et al., 1995; Nelson, 2016; Schneider, 2004).

Stereotypes have been defined in many different ways; however this chapter defines stereotypes most simply as people's beliefs about groups, which in turn may be positive, negative, accurate, or inaccurate (Lee et al., 1995, p. 6). This definition more closely harmonizes with the views of modern researchers whose "neutral" definitions of stereotypes include no a priori assumptions as to their accuracy/inaccuracy or rationality/irrationality (Jussim, 2012).

Lee et al. (1995) reviewed stereotyping research up to the mid-1990s. According to Lee et al. (1995):

> The preponderance of scholarly theory and research on stereotypes assumes that they are bad and inaccurate…The idea that stereotypes are inaccurate and unjustified pervades the social sciences, many educational and business communities, and the everyday discourse of pundits and politicians. It often influences the content of programs designed to promote diversity…[and is a] common theme in everyday cultural discourse…[The assumption that stereotypes are bad and inaccurate] is conceptually problematic and empirically unjustified…[there are] both theoretical and practical reasons why the scientific study of stereotype accuracy and inaccuracy is both timely and important. (pp. 3–4)

They identify an overemphasis on error and bias in stereotyping that works to suppress any hypotheses that seek to investigate – or research findings that would uncover – the *accuracy* of stereotypes about groups (e.g., see review in Jussim, 2012, Chapters 16 and 17). They opine

that the fear of being labeled as "sexist" or "racist" within scientific communities is largely responsible for this research bias (Jussim, 2012).

Lee et al. (1995) list 11 common criticisms of stereotypes that are most prominent in social perception research. According to these criticisms, stereotypes are "bad" and/or "wrong" because (pp. 6–14):

1. Stereotypes are factually incorrect.
2. Stereotypes are illogical in origin.
3. Stereotypes are based in prejudice.
4. Stereotypes are irrationally resistant to new information.
5. Stereotypes are exaggerations of real group differences.
6. Stereotypes are ethnocentric.
7. Stereotypes imply genetic origins of group differences.
8. Stereotypes imply out-group homogeneity.
9. Stereotypes lead people to ignore individual differences.
10. Stereotypes lead to biased perceptions of individuals.
11. Stereotypes create self-fulfilling prophecies.

Jussim (2012) cites an additional concern about stereotypes, which is the fear that stereotypes will be "used by bigots to promote their evil agenda" (p. 279).

A thorough empirical review of the research literature that addresses these criticisms is beyond the scope of this chapter (see also "*Cultural Competence as Stereotype Rationality*" Chap. 26, this book). Nevertheless, rebuttals to these criticisms can be briefly summarized as follows (Jussim, 2012; Lee et al., 1995):

1. *Hypotheses as to whether or not stereotypes are accurate are fundamentally empirical questions, not ideological or moral questions.*
2. *Criticisms of stereotypes often erect straw men to knock down*. As an example, no research evidence identifies a single individual who believes that stereotypes apply to all members of a given group.
3. *The research evidence that validates criticisms of stereotypes often show mixed results or are inconclusive.* Said differently, some criticisms of stereotypes are occasionally valid, but not in all circumstances. Thus, it is a misrepresentation to claim a general condition from only occasional instances.
4. *There is a virtual absence of serious research studies that clearly specify what beliefs about groups constitute a stereotype* vs. *what beliefs about groups do not constitute a stereotype.* Thus, literally anything that is said about a group is labeled as a stereotype – which is by definition (according to some) always "wrong."
5. *There is nothing "irrational" about harboring a stereotype that is divorced from personal experience.* To illustrate, one does not have to have been personally attacked by a shark to harbor the belief that sharks are dangerous.
6. *There have been few empirical studies linking the accuracy of a stereotype with attitudes toward stereotyped groups.*
7. *Many criticisms of stereotypes reflect popular narratives that have not been subjected to hypothesis testing.*
8. *Groups can be evaluated as similar or different using a variety of criteria that differ along a continuum of subjectivity/objectivity: personality trait words, quantitative scores on evaluation instruments, and percentage and/or frequency counts*. Hence, the validity of criticisms of stereotypes differs as a function of the criteria used for evaluating group differences.
9. *The possible genetic or biological origins of group differences are a legitimate area of scientific inquiry, along with environmental origins of group differences.*
10. *Some mental processes involved in stereotyping are natural and/or universal; hence judgments that these processes are "wrong" or "bad" reflect "stereotyping the stereotypes."*
11. *Related somewhat to the last point, moral evaluations of stereotypes are often a func-*

tion of context. That is, in some contexts, stereotypes are assumed to be "inherently evil." In other contexts, stereotypes are considered to be basic common sense.

12. *Some criticisms of stereotypes create logical inconsistencies (*i.e.*, it would be logically impossible for two or more criticisms to be true at the same time).*
13. *The fear that empirically sound research has the potential to be used for evil purposes can apply to almost any research.* Hence, fears as to what "might" happen, particularly with no documentation of such potentialities, are an argument for halting all research.
14. *Principled scientists do not have the luxury of holding on to demonstrably false beliefs in the face of accumulating countervailing data.* This is particularly true when a false belief leads to concrete harm (see example in Jussim, 2012, p. 281). Jussim (2012) states:

> Any science, if it wishes to be credible, cannot be in the business of denying reality, even if it is for some supposedly greater political purpose. If it does get into this business, it has shed its role as an objective explorer of the nature of reality and has, instead, become a propaganda tool serving a particular political agenda. (p. 280)

Jussim (2012) argues that if the civic and educational communities are serious about addressing the deleterious effects of social problems, the first step is to be willing to acknowledge group differences (e.g., in education, criminal justice, economic indicators, etc.), as well as acknowledge that some stereotypes related to these inequalities are justified (even if they appear disparaging).

The Treatment of Race in Cultural Competence Advocacy

It is much more difficult to discern clear distinctions between "race deniers" and "race acknowledgers" in cultural competency advocacy within the context of applied psychology. There are at least two reasons for this state of affairs. First, in some instances, both positions sometimes appear to be supported by the same author (e.g., see Helms, 2008; Helms et al., 2005). In other instances, applied psychologists' reasons for supporting the "race acknowledger" position differ from reasons put forth by physical anthropologists. That is, when some writers say "race is important" or "race still matters," they say this as a philosophical reaction against a "color-blind" approach to dealing with others (Beyer, 2009; Jones, 2013).

The word "race" and its derivatives ("racial") occur in many contexts in applied psychology. As examples, counseling psychologists write books, book chapters, and articles on the concept of "racial competence" in therapy, specifically, and in civic life, generally (e.g., see Sanchez & Davis, 2010; Sue, 2015; Sue & Torino, 2005). Racial identity is one of the most frequently researched constructs in applied psychology (Cokley, 2007; Ratts & Pedersen, 2014, Chapter 3; Wijeyesinghe & Jackson, 2012). Sue and Sue (2016) use the term "racial realities" to contrast the emotional reactions of white psychologists versus the emotional reactions of "psychologists of color" to the content of their text on cultural competence in counseling (p. xv). Terms such as "race salience" (Cross, 1991), "racial awakening" (Sue & Sue, 2016, p. 357), "racial/cultural awareness training" (Sanchez & Davis, 2010), and "racial socialization" (Lee & Ahn, 2013) frequently appear in cultural competency textbooks for counseling psychologists.

The Treatment of Racial Differences in Cultural Competence Advocacy

The perennial struggle in applied psychology boils down to attempts to integrate common sense observations and research on race and racial differences, while at the same time avoiding giving offense to multicultural sensibilities in academia and professional practice. How successful applied psychology is in doing this is an issue that is open to much debate and disagreement (e.g., see Frisby, 2013, Chapter 2; entire

series of articles on the multicultural counseling debate in *Journal of Mental Health Counseling*, Vol. 26, No. 1). One reason for these challenges can be attributed to the fact that *applied psychologists are trained to interact professionally with individuals, not groups.* Therefore, it becomes much more difficult to disentangle the sources of individual differences as these relate to human variation encountered in psychological services.

The Complexity of Individual Differences

Kluckhohn and Murray (1953) articulate a useful heuristic that succinctly captures the complexity of human differences in three timeless principles: (1) all human beings share some characteristics in common with all other human beings, (2) each individual is similar only to particular subsets of all other human beings, and (3) each individual is unique and unlike any other human being.

The tendency to eschew the first principle (human universals) stems in part from fear of what may be found when common standards are applied to all groups. Frisby (2013) writes:

> Multiculturalism avoids any emphasis on human universals, because these imply common standards along which groups can be compared and evaluated…In comparing different groups on the same standard, the fear is that one group may be unfavorably compared to other groups, which is politically embarrassing to multicultural advocacy efforts. (pp. 46–47)

This fear is caricatured by Ratts and Pedersen (2014), who write:

> Ahistoricism [is] a core tenet of science that all humans are the same regardless of race, gender, sexual orientation, social class, disability status, and religion…This belief often leads to the application of dominant cultural theories and concepts on cultures and groups that hold differing worldviews and perspectives, which in turn can lead to labeling marginalized communities as abnormal. (p. 6)

Most authors who write textbooks on culturally competent practice at least pay lip service to Kluckhohn and Murray's third principle (individual uniqueness). As an example, Ridley (1995) writes:

> Every client is unique – each one a mixture of characteristics and qualities unlike everyone else. Clients of similar backgrounds are even different from each other. Although they have much in common, their differences outweigh their similarities. When clients arrive for counseling, they bring their personal stories, and each has a different story to tell. Because everyone is unique, counselors should not attempt to counsel every client in exactly the same way. (p. 81)

However, this message is quickly lost in the context of advocacy for viewing individuals as little more than reflections of their ethnic/racial/language subgroups. Without exception, all major cultural competence textbooks in applied psychology focus almost exclusively on Kluckhohn and Murray's second principle (i.e., individuals are similar to their subgroups) to the near exclusion of universal and/or individual difference factors. That is, cultural competency textbooks typically devote separate chapters to African Americans, Hispanics, Asians, Native Americans, Jews, Arab Americans and Muslims, multiracial individuals, immigrants/refugees, LGBT individuals, women, the elderly, and the disabled (McAuliffe & Associates, 2008; Ponterotto et al., 2010; Ratts & Pedersen, 2014; Sue & Sue, 2016).

Frisby (2005) called this the "Group Identity Doctrine" in multiculturalism advocacy. The *Group Identity Doctrine* is the name given to the implicit belief within multiculturalism ideology that views individuals are little more than representatives of their (racial, ethnic, language, etc.) subgroups. According to this doctrine, in order to properly understand the individual, one must first understand the (racial, ethnic, language, etc.) subgroup to which he/she belongs. It then follows that an individual's behavior/thinking is to be interpreted as reflecting some characteristic of his/her group. As an example, consider the number of times the word "group(s)" appears in one writer's argument as to the importance of group identity in counseling and psychotherapy:

> Accepting the premise that race, ethnicity, and culture are powerful variables in influencing how people think, make decisions, behave, and define events, it is not far-fetched to conclude that such forces may also affect how different **groups** define a helping relationship…Given that schools of counseling and psychotherapy arise from Western European contexts, the worldview that they espouse as reality may not be shared by racial/ethnic minority **groups** in the United States…Each cultural/racial **group** may have its own distinct interpretation of reality…. (Sue & Sue, 2016, p. 53)

Some scholars attempt to go beyond this simplistic formulation by advancing theory-based models that allow for within-group differences in psychological functioning – as can be clearly seen in racial/ethnic identity research (e.g., Charmaraman & Grossman, 2010; Rivas-Drake et al., 2014; Sue & Sue, 2016, Chapter 11). However, even these within-group differences are tied to the practice of explaining thinking, attitudes, and behavior as ultimately a function of one's ethnic/racial group membership.

The problem is *not* that subgroup factors based upon race, ethnicity, or language play no role at all in an individual's life issues and problems. The issue is one of the *perspectives and balances*. Individuals are members of many subgroups simultaneously (e.g., based on age, gender, religious views, political views, geography of residence, etc.). The only way that researchers can tease out the influence of different subgroup factors on outcomes is to apply multivariate analysis techniques to large group samples (e.g., using factor analyses, multiple regression). Teasing out subgroup factors that may influence an individual's behaviors cannot be quantitatively determined, but instead relies on clinical experience, professional judgment, and at times blind speculation and guesswork. As some cultural competence advocates have stated, the unique manner in which subgroup factors work together to influence human functioning ultimately boils down to *individual differences*. Sue and Sue (2016) write:

> The African American population is becoming increasingly heterogeneous in terms of ethnic and racial identity, social class, educational level, and political orientation, so it is important to remember that the following are generalizations; their applicability needs to be assessed for each client. (p. 459)

Stereotypes Bad, Generalizations OK?

Some cultural competence advocates continue to use the term race (or its derivatives), particularly when describing issues and problems related to blacks (e.g., see Ridley, 1995). Nevertheless, "culture" has largely replace "race" in applied psychology as the preferred taxonomy for subdividing groups and explaining group behavior – a finding that is consistent with national survey data on whites' beliefs about the source of black problems (Bobo et al., 2012). Although an earlier discussion has shown that cultural competence advocates often use the word "race" or its derivatives in their writing, they almost exclusively discuss racial differences under the guise of the much softer phrase "cultural differences" (Watson, 2000). Multicultural counseling texts discuss culture as an overarching concept that subsumes race, as when Draguns (2016) writes:

> The term *culture* is…also frequently extended to the ethnically linguistically, and/or racially distinctive segments of the American society. (p. 34)

Pedersen, Lonner, Draguns, Trimble, and Scharrón-del Rio (2016) write:

> Culture may be defined narrowly as limited to ethnicity and nationality or defined broadly to include any and all potentially salient ethnographic, demographic, status, or affiliation variables…[t]he "culture-centered" perspective describes the function of making culture central rather than marginal or trivial to psychological analysis. (pp. 26–27)

This leads to a plethora of new concepts that include the root word "culture," as in "culture-infused counseling" (Pedersen et al., 2016, p. 32) or "inclusive cultural empathy" (Pedersen et al., 2016, p. 17; see also Frisby, 2013, pp. 40–41).

According to Jussim (2012):

> Cultural psychology has become something of a cottage industry of difference documenting … In many universities, there is widespread support for

> "multiculturalism." Why? Although different proponents have different rationales, themes typically emphasize understanding and respecting the beliefs, values, and practices of people from different groups and backgrounds than oneself…This constitutes a call for an increase in the accuracy of people's beliefs about (understanding of, insight into) those from other cultural backgrounds. (p. 288)

Typically, any references to racial differences are called "stereotypes" and are usually proceeded by the adjectives "ugly" (Byrd & Hughey,

Table 13.5 Special characteristics of racial/ethnic groups promoted in cultural competence counseling textbooks (Baruth & Manning, 2016; McAuliffe & Associates, 2008; Pedersen et al., 2016; Sue & Sue, 2016)

African Americans
• Place less urgency and importance on time and more value on involvement in a specific activity
• Functions in harmony with nature rather than be oriented to developing mastery over nature
• Spirituality, religion, and church attendance play an important role in coping with life stressors
• Most families headed by single mothers
• Flexibility in family roles and strong kinship bonds
• Youth communication style is animated, persuasive, confrontational, aggressive, and/or noncompliant
• Perceptions of racism and prejudice are significant concerns within communities
• Will find occupational achievement difficult due to continuing discrimination in society
Hispanics
• Family unity, respect, and tradition are important aspects of life
• Within the family, sex roles are clearly delineated. Men are expected to be strong, dominant, and providers for the family. Women are expected to be nurturing, modest, virtuous, submissive to males, and self-sacrificing
• Special authority is given to parents, older family members, and males in tradition oriented families
Asians/Pacific Islanders
• Worldview and personality characteristics emphasize humility, modesty, treating oneself strictly while treating others more leniently, conformity, and obedience
• Families have a "collectivist" group orientation (adherence to "correct values," family harmony, and adaptation to the needs of family members) as opposed to promoting individual needs and one's personal identity
• Traditional families are hierarchical and patriarchal in structure, with males and older family members occupying a higher status
• Parenting styles more authoritarian and directive
• Strong emotional displays, particularly in public, are considered signs of immaturity or lack of strength. Control of emotions is considered to be a sign of strength
• Expresses emotional difficulties through somatic complaints
• Considerable pressure for children to succeed academically and to have a successful career
Native Americans
• Tribal identification is of fundamental importance for a sense of belonging and security
• For most tribes, the extended family is the basic unit (i.e., children are partially raised by aunts, uncles, and/or grandparents)
• Greater focus on a present-time orientation, as opposed to a future-time orientation (i.e., life is to be lived in the "here and now")
• Belief that the spirit, mind, and body are all interconnected, where illness involves disharmony between these elements
• Substance abuse is a large problem, with many youth engaging in substance abuse at an early age
• Suicide rates have reached "epidemic proportions," with adolescence and young adulthood being the time of greatest risk
Arab Americans/Muslims
• In traditional families, men are considered to be heads of the family, and women are homemakers and rear the children
• Traditional Muslim women avoid physical contact (shaking hands or hugging) with nonrelated males
• Hospitality is considered to be an important aspect of interpersonal interactions
• Strong sense of community and identity that revolves around culture and God

2015) or "dangerous" (Steadman, 2014). Ratts and Pedersen (2014) write:

> The messages we learn about social group identity are often based on stereotypes and prejudice. When left unexamined, stereotypes and prejudice can lead to discrimination and oppression. (p. 47)

Yet, such objections literally vanish when recast as "cultural differences." The variety of cultural differences of which counselors are urged to be aware are given in Table 13.5.

Cultural competency advocacy has a difficult path to tread. On the one hand, their entire *raison d'être* is to convince consumers that racial/ethnic groups possess certain identifiable cultural traits about which practitioners need to be aware, which in turn should be integrated into service delivery. Pedersen et al. (2016) describe a "culture-centered" and "multicultural" perspective in counseling:

> History documents that injustices can be expected when a monocultural, dominant group is allowed to define the rules of living for everyone; shifting to a multicultural orientation curbs this tendency. (p. 2)

On the other hand, generalizations run the risk of turning into lazy stereotypes, which cultural competence texts consider to be "bad" (see Baruth & Manning, 2016, p. 335).

Jussim (2012) writes:

> …[I]n contrast to a social problems context, where believing in group differences constitutes lowdown dirty stereotyping, in a (multi-) cultural context, recognizing and being "sensitive" to group differences shows how benevolent and egalitarian we are. Embracing cultural psychology and multiculturalism, while rejecting stereotypes, may make sociopolitical and rhetorical sense, because it positions the embracer/rejecter as an unbigoted egalitarian who respects others. But, from a scientific standpoint of evaluating the validity of people's beliefs about groups, embracing cultural psychology and multiculturalism while rejecting stereotypes as inherently inaccurate is logically incoherent. (pp. 288–89)

Jussim (2012) offers an interpretation pointing to a deeper reason for this paradox:

> Laypeople and scholars…typically use the word "stereotype" as a damning indictment of *someone else's* beliefs about a group. *My beliefs are reasonable, rational, and appropriate; yours, at least when they differ from mine, are mere stereotypes.* This definition helps us understand why social scientists can perform research documenting cultural, ethnic, social class, or racial differences and, *at the same time*, rail against other people's inaccurate stereotypes. Indeed, one of the easiest and most effective ways for Person A to derogate and dismiss Person B's claims about a group is to say, "But that is just a stereotype." Person B, now implicitly accused of being an "ist" of some sort, is most likely to just shut up and go away, and even if he or she doesn't, has been discredited anyway. (p. 301)

Is Cultural Relativism the Answer?

Cultural relativism is a philosophical perspective that has two components. The first is an intentional or unintentional nonrecognition of the existence of universal human values that transcend specific racial, ethnic, or language subgroups (e.g., see Brown, 1991, 2000; Pinker, 1997, 2002). The second concerns the assumption that no set of values for living should be viewed as better or worse than any other set of values. Both of these components rest on the assumption that values are connected directly to a person's racial/ethnic group membership, and that individual differences in life values have a perfect correlation to individual differences in racial/ethnic group membership. Thus, when a white therapist promotes values that a nonwhite client does not share, this constitutes a prime example of "cultural insensitivity." As one among many examples, Sue and Sue (2016) write:

> A counselor's reaction to a client's family structure may be affected by a Eurocentric, nuclear-family orientation. Similarly, many assessment forms and evaluation processes are based on a middle-class EuroAmerican perspective of what constitutes a family. For family therapy to be successful, counselors must first identify their own set of beliefs and values regarding appropriate roles and communication patterns within a family and take care not to impose these beliefs on other families. (p. 462)

Occasionally, cultural competence advocates express irritation over the practice of attributing social problems to the culture of racial/ethnic groups. Many dismiss such writing as an overreliance on a "deficit model," which they explicitly reject. According to Ridley (1995), for example, "the deficit model is the most explicitly racist model of mental health" (p. 43). He goes on to opine that social scientists who criticize the culture of ethnic minorities are "prisoners of their own cultural conditioning" (p. 43).

Cultural competence textbooks counterbalance discussions of a subgroup's social problems with a narrative encouraging therapists in training to properly recognize the "strengths" of each subgroup. As an example, a long-standing problem in African American communities is the high percentage of out-of-wedlock births and large numbers of black families with no stable father figure in the home (Frisby, 2013). This leads to older siblings and sometimes grandparents who must provide family responsibilities that would normally be provided by fathers. Yet this alarming state of affairs is depicted by cultural relativists as a strength. Sue and Sue (2016) state:

> One of the strengths of the African American family is that men, women, and children are allowed to adopt multiple roles within the family. (p. 462)

Some try to "put a positive spin" on generalizations – by rewording them from something that is negative to something that is positive or merely "different, not deficient" (see Tucker & Herman, 2002; Wright, 2008). As an example, Gonzalez and Trimble (2016) object to the phrase "Indian time" as being "misconstrued" to mean that Native Americans are always late. Their preferred characterization is characterized as follows:

> The real meaning behind this orientation is that, in the Native worldview, things will happen when they are supposed to happen. This can have profound effects on behavior in many areas of life that conflict with Western or mainstream American values…Thus, Native people will live for the present moment, with less emphasis on, or indifference toward, planning for the future. This can translate into the idea that if there is a future, it will take care of itself. (p. 109)

Some frank discussions of observed racial differences are published by obscure companies, which allow them a greater freedom to discuss perceptions of racial/ethnic groups without fear of pressures to be "politically correct." As one example, one text includes a chapter that describes a white teacher's impressions of teaching students in a predominantly black high school (Jackson, 2014). Although he does acknowledge occasional exceptions, he describes most of his students as "noisy," obsessed with rap music (which he describes as "degenerate"), often overweight, extremely uninterested in school or academic achievement, prone to use grammatically deficient language, prone to blame racism almost exclusively as an excuse for the shortcomings of blacks, keenly self-aware of racial physical traits that can be ranked as superior/inferior, violent, and prone to promiscuity, impulsivity, and profanity (see also Ferguson, 2000).

Search for descriptions of black students in academic psychology, and one has to "read between the lines" several times in an attempt to comprehend how the descriptive words and phrases used relate to concrete educational and/or classroom behavior observed in the "real world." As examples, Allen and Boykin (1992) describe "Afro-cultural" behavioral styles as characterized by "verve, the special receptiveness to relatively high levels of sensate stimulation"; "affect, an emphasis on emotions and feelings"; "expressive individualism, the cultivation of a distinctive personality and a proclivity for spontaneity in behavior"; "orality, a preference for oral/aural modalities of communication"; and "social time perspective, an orientation in which time is treated as passing through a social space rather than a material one" (p. 589).

In providing an explanation as to why black students fail to achieve at academic levels commensurate with whites, the learning behaviors of black students are described as showing "a tendency to approximate space, number, and time, instead of aiming for complete accuracy" (Rimer, 1988), requiring "instructions that deal more with people than with symbols or abstractions," needing "more chances for expressive talking rather

than writing," requiring "more freedom to move around the classroom without being rebuked," and valuing "charismatic and stylistic use of language rather than fluency and vocabulary breadth" (Berger, 1988, Hale-Benson, 1986). Taylor (2004) sarcastically writes "That sort of thing used to be called bad conduct or poor self control" (p. 259).

The Treatment of Racism in Cultural Competence Advocacy

Like the social sciences in general, cultural competence advocacy in applied psychology characterizes racism using a wide variety of definitions. As one among many examples, Ridley (1995) defines racism as "any behavior or pattern of behavior that tends to systematically deny access to opportunities or privileges to members of one racial group while perpetuating access to opportunities and privileges to members of another racial group" (p. 28). Yet in the same breath, he opines: "Even social scientists and human relations experts seldom agree on a uniform definition (of racism). In fact, they often contradict each other" (p. 28).

Minority Group Status as Victimhood

In cultural competence advocacy, racial, ethnic, and minority group status is characterized as practically synonymous with victimhood and oppression. Ratts and Pedersen (2014) write:

> Helping professionals are better able to understand clients when they consider how environmental factors…shape and influence a client's identity and lived experiences. Clients do not exist in a vacuum; we cannot truly understand a client's racial and ethnic identity without also exploring how this aspect of identity is influenced by racial dynamics in society…An understanding of internal and external dimensions of identity is enhanced by further classifying these dimensions into oppressor, border, and oppressed groups. (p. 42)

Nonwhite groups are fundamentally depicted as historical, present, or potential victims of white racism. One of the first indicators of the presence of victim ideology is the adjectives used to describe groups. The title that precedes a series of five chapters in *Counseling the Culturally Diverse: Theory and Practice* (7th Ed.) (Sue & Sue, 2016) is "Counseling Marginalized Racial/Ethnic Group Populations." Pedersen et al. (2016) write:

> It is vital that mental health professionals learn and understand how indigenous people have experienced and continue to experience tremendous trauma and suffering as a consequence of European contact. There is a cumulative sense of trauma as a result of centuries of massacres, disease, forced relocations, forced removal of children, loss of land, broken treaties and other betrayals, unemployment, extreme poverty, and racism. (pp. 103–104)

Toldson, Anyanwu, and Maxwell (2016) write:

> Racism and oppression are forces that have shaped the experiences and development of Black people worldwide…The vestiges of racism and oppression survived centuries after propaganda campaigns ended and influence all human interactions, including counseling relationships. (p. 145)

Feagin and Sikes (1994) conducted interviews with middle-class "persons of color" to understand their experiences with everyday racism. They report the following comments from a successful black entrepreneur:

> What is it like to be a black person in white America today? One step from suicide! What I'm saying is – the psychological warfare games that we have to play everyday just to survive. We have to be one way in our communities and one way in the workplace or in the business sector. We can never be ourselves all around. I think that may be a given for all people, but us particularly; it's really a mental health problem. It's a wonder we haven't all gone out and killed somebody or killed ourselves. (p. vii)

One can legitimately raise questions as to whether these experiences are "real" versus being reflective of biased perceptions due to idiographic personality factors. Nevertheless, the point here is that this comment perfectly illustrates what applied psychology training programs see as an area of personal distress for which culturally sensitive counselors can provide healing services.

According to Ratts and Pedersen (2014), "oppressor groups" are whites, gender-conforming men and women, heterosexuals, the rich upper class, adults, the temporarily able-bodied, and Christians. "Oppressed groups" consist of people of color, cisgender women (persons whose self-perception matches their biological sex from birth), transgender, genderqueer, intersex persons, gay males and lesbians, poor and working-class individuals, youth, persons with mental and physical disabilities, and Jews, Muslims, Buddhists, and Mormons (pp. 42–43). Oppression, in turn, is characterized as leading to increased risk for all kinds of psychological and physical problems. According to Sanchez and Davis (2010):

> Knowing that one is a member of a stigmatized group has some predictable psychological, social, and behavioral consequences. Experiences with racial discrimination and harassment have been shown to cause stress, health-related problems, and psychological injury to persons of color… Specifically, racism-related stress places targets of racism at risk for depression and anxiety…as well as high blood pressure, hypertension, stroke, and cardiovascular disease. (p. 269)

Microaggressions: Racism Under the Microscope According to Sue and Sue (2016), the term *racial microaggressions* was originally coined by Chester Pierce in describing subtle "put-downs" that African Americans receive from nonblacks (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978). More recently, the term has been more broadly defined as "brief, everyday exchanges that send denigrating messages to a target group, such as people of color; religious minorities; women; people with disabilities; and gay, lesbian, bisexual, and transgendered individuals" (Sue & Sue, 2016, p. 183). Sue and Sue (2016) describe microaggressions as displayed "automatically and unconsciously" and being "subtle in nature", which in turn can be manifested in the verbal, nonverbal, visual, or behavioral realm (p. 183).

The microaggression movement has spawned an entirely new lexicon of related terms representing events that presumably oppress racial/ethnic and other "marginalized" groups in society. *Microassaults* are defined as "blatant verbal, nonverbal, or environmental attack(s) intended to convey discriminatory and biased sentiments" (Capodilupo, 2016, p. 188). *Microinsults* are "unintentional behaviors or verbal comments that convey rudeness or insensitivity or demean a person's racial heritage/identity, gender identity, religion, ability, or sexual orientation identity" (p. 188). *Microinvalidations* are defined as "verbal comments or behaviors that exclude, negate, or dismiss the psychological thoughts, feelings, or experiential reality of the target group" (p. 189). According to Sue and Sue (2016), the recently introduced term *hierarchical microaggressions* has been defined as "everyday slights found in higher education that communicate systemic valuing (or devaluing) of a person because of the institutional role held by that person" (Young, Anderson, & Stewart, 2015, p. 66).

Caregiver Responsibility for "Nonracist" Practice

For all practical purposes, the cultural competence movement in applied psychology is geared to white audiences. Although writers will mention briefly the need for scholarly writing on models where the therapist is a member of a nonwhite minority group (and clients are either white or nonwhite; see Ratts & Pedersen, 2014; Sue & Sue, 2016), the bulk of textbook materials that are currently available assume that caregivers will be white. With this premise as a starting point, the cultural competence movement ostensibly trains whites to better serve nonwhite clients through improving their knowledge, skills, attitudes, and behaviors – while at the same time avoiding harmful practices in the context of delivering direct or indirect services.

Nonwhites are depicted as potential victims of racist practices by psychological and mental health caregivers. According to Sanchez and Davis (2010):

> The professional dominance of White researchers and clinicians in psychology has also had significant implications for the perpetuation of racism and oppression and to the imposition of limited

> and dehumanizing racial categories on visibly racial (non-White) groups. (p. 269)

Declaring War on Racism Even a casual reading of cultural competency advocates leads readers to the conclusion that racism is an enemy that must be identified, attacked, and vanquished. Ridley (1995) opines that racism must be "confronted" (p. 38). According to Utsey, Gernat, and Hammar (2005), psychologists who fail to address issues of racism and discrimination as potential sources of distress for racial minority clients are exhibiting a form of "color blindness" that is unethical according to APA ethics codes.

In cultural competence within counseling texts, racism, stereotyping, and discrimination are terms that are blended together to form one evil, amorphous entity. Thus, to experience "racism in society" is depicted as reflecting anything from overhearing ethnic jokes or racial slurs to being the target of racial profiling in law enforcement, to being exposed to stereotypes in TV programs and movies, to perceived unfairness in how news stories are reported about racial/ethnic groups, to inappropriate comments directed at a person's ethnicity, to impolite questions asking about a person's racial/ethnic heritage, to opposition to illegal immigration, and to calling some groups "model minorities" (Sue & Sue, 2016).

"Racist" Counselor Behaviors According to Ridley (1995), "many well meaning counselors should discover that, despite their best intentions, they are unintentional racists" (p. xiv).

One form of racism, according to Ridley, is "color blindness" (i.e., treating clients similarly without regard to their race/ethnicity). He writes:

> The adverse consequence of color blindness is misdiagnosis. The counselor automatically labels deviations from White middle-class values as psychopathology. Counselors who do not understand the culture of their minority clients tend to look upon the clients' values and cultural idioms as inherently inferior to their own. For example, some minority clients come from cultures that value group affiliation and collectivism. Counselors stuck on rugged individualism may misinterpret the behavior of these clients as codependency. Color blindness is a major contributor to the disproportionate number of minorities assigned a pathological diagnosis. (p. 68)

He goes on to argue that "…no race has a monopoly on racism. Anyone is capable of behaving as a racist…all counselors – regardless of race – should be involved in combating their own racism and the racism of other professionals" (p. 27). According to Ridley (1995), "Without an effective system of monitoring, chances are that counselors will drift back into racist practices" (p. 26). Ridley argues that to change racism, begin by identifying specific behaviors as either racist or nonracist (p. 25). According to Ridley (1995), therapeutic relationship behaviors labeled as indicators of racism include, but are not limited to:

- Participating in any behaviors/practices that would lead to inequitable outcomes for racial/ethnic minority groups (p. 33)
- Misinterpreting the deference of an Asian client as passivity (p. 29)
- Assuming that minority professionals are the exclusive experts on treating minority clients (p. 38)
- Setting low or unrealistically high expectations on minority clients (p. 43)
- Failure to teach coping skills that enable minority clients to "negotiate the stressful demands of reality" (p. 47)
- Failure to teach minorities illness prevention or health promotion behaviors (p. 52)

Ridley (1995) argues that "covert racism" is more subtle, and the criterion making it racist is its consequences, and that one component of racism is "inequitable outcomes" (p. 33). As examples, he argues that nonwhite clients of mental health services are more likely to receive a clinical misdiagnosis; have a higher likelihood of being assigned to junior, para-, and nonprofessionals for treatment; are a more likely to receive treatments that cost less and/or are lesser preferred; be underrepresented in private treatment facilities and overrepresented in public treatment facilities; have higher rates or premature termination; be confined to longer stretches of inpatient

care; and are more likely to report more dissatisfaction and unfavorable impressions regarding treatment.

Sue, Gallardo, and Neville (2014) argue that a comprehensive understanding of clients' problems requires an understanding of how their racial/ethnic identities may relate to their trauma experiences that are related to racism and/or immigration experiences. They suggest that the following questions be included in any intake protocol (p. xxxvi):

- Have you ever been discriminated against? If so, what events stand out to you the most?
- Do you think about this (these) experience(s)?
- Have one or both of your parent(s) experienced a significant form of discrimination? If so, describe the experience(s).
- If you have children, has one or more of your children experienced a significant form of discrimination? If so, describe the experience(s).

Adopting a Social Justice Ideology According to Ratts, D'Andrea, and Arredondo (2004, as quoted from McAuliffe & Associates, 2008):

> Counselors must develop more proactive, value-laden, politically conscious, and advocacy-based counseling interventions … Counseling can, and should, be used as a political and liberatory mechanism for dismantling oppressive systems in society, beginning with the institutions in which we work. (p. 30)

One form of advocacy-based counseling is to adopt a "social justice" mind-set in counseling with "marginalized" groups. According to McAuliffe and Associates (2008):

> Given the fact that their clients will experience various levels of inequity and oppression based on group memberships, counselors are asked to do social justice work every day … By promoting social justice, the counseling field returns to its early twentieth-century roots as an effort to promote equity for underserved and oppressed groups…Each child who experiences school yard taunting, each woman who is sexually harassed by a person in power, each immigrant who is discriminated against in a job application, and each gay person who experiences anti-gay jokes will need counselors, as advocates, to stand up to the more powerful and the victimizers. (pp. 75, 80)

Some writers give very specific prescriptions for how therapists in training should implement social justice. The first proposed remedy is self-awareness. According to Helms (2008), white people:

> …must become aware of how racism hurts White people and consequently, how ending it serves White people's best interests. Moreover, this awareness not only must be accompanied by enhanced abilities to recognize the many faces of racism, but also by the discovery of options to replace it. (p. v)

According to Barndt (2007):

> I believe that we who are white need to come to new understandings about ourselves and about our racism, and we need to take responsibility for bringing racism to an end. (p. 6)

Irving (2014) gives voice to her "racial awakening" experienced a result of her newfound awareness of white privilege through personal introspection:

> …[I]f I, a middle-aged white woman raised in the suburbs, can wake up to my whiteness, any white person can. Waking up white has been an unexpected journey that's required me to dig back into childhood memories to recall when, how, and why I developed such distorted ideas about race, racism, and the dominant culture in which I soaked…Exploring one's relationship to that culture is where the waking-up process begins. (pp. xii, xiii)

Helms recommends a series of self-exploration exercises, one of which is named "Taking Personal Responsibility for Your White Privilege" (Helms, 2008, p. 76). Here, readers are encouraged to make a list of all the ways in which white privilege is present in your everyday life. For each example of privilege, readers are instructed to think about possible ways to take "personal responsibility" and counteract the privilege. Helms gives an illustration using the privilege example: "I live in a neighborhood where all of my neighbors are White" (p. 76). This is to be processed through the lens of how this illustrates racism, which is interpreted as follows:

> I think this is a case of housing discrimination. I don't think real estate agents show houses in this

> neighborhood to People of Color. I don't think my neighbors want them to. (p. 76)

Helms illustrates how readers can take personal responsibility with the following exhortation:

> I could move to a more racially diverse neighborhood. I could report real estate agents to the local housing authorities if I think that they are illegally steering People of Color away from my neighborhood. I could talk to my neighbors about how integrating the neighborhood would make it a more interesting place. (p. 76)

Concluding Thoughts

One challenge in digesting all of the material reviewed in this chapter is the same challenge experienced from writing it. That is, attempts to didactically distinguish between race, racial differences, and racism in the social sciences and applied psychology is analogous to trying to subdivide water in a full bathtub into three equal parts using a machete. To illustrate, discussions of racial differences assume implicitly a scientific and biological validity to the concept of race, about which social scientists vigorously disagree. If there is no such thing as race, then by extension, there are no such things as racial differences. If there are no such things as racial differences, then all of the research that has been conducted over the past century on racial differences is but an illusion (or, more accurately, a mass delusion). Racism has been defined by some as holding certain beliefs about racial differences, yet applied psychologists advocate the explicit consciousness of race (culture) and racial (cultural) differences in training in order to ostensibly combat racism. One would be hard pressed to blame readers for feeling uttlerly confused by this paradox.

Nevertheless, this chapter only addresses half of the story of understanding human differences in cultural competence advocacy. While this chapter focused on group patterns in understanding human differences, there is also a need to delve deeper into individual differences within observed patterns – or the "ground-level view" in the analogy that opened the chapter. The next chapter addresses the second half of this story, namely, the role of individual differences in person, setting, and content variables in applied psychology work.

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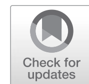

14 Important Individual Differences in Clinician/Client Interactions

Craig L. Frisby

At the time of this writing, track and field events are being televised from the 2016 Summer Olympics in Brazil. Nearly all of the male and female competitors for the short sprinting distances (i.e., 100 and 200 m) are of African descent – regardless of the racial/ethnic makeup of their countries of origin. Given that other Olympic events typically have a much more racially diverse roster of competitors (e.g., women's gymnastics), this raises interesting questions and fuels intense debate as to the reasons for this dominance (e.g., see Bejan, Jones, & Charles, 2010; Carlston, 2003; Edwards, 2003; Entine, 2000; Saletan, 2008). However, there is a different but equally as interesting observation connected with these events that is often overlooked.

Moments before the beginning of the men's 100 and 200 m races, the cameraman is filming close-ups of each sprinter in the final minutes before the gold, silver, and bronze medalists will be decided. One sprinter nervously paces back and forth, seemingly irritated that the camera is filming him, so he averts his eyes as if to swat away a pesky mosquito. Another runner breaks into a large and engaging smile as soon as the camera zooms in and appears to silently mouth warm personalized greetings to loved ones who may be watching. Another runner poses stoically and looks fiercely into the camera lens, as if to intimidate anyone watching who may doubt his abilities. Another sprinter immediately starts clowning for the camera, as if to communicate to an appreciative audience that he is the unquestioned star among the competitors. Another competitor seems prayerful and lost in his own thoughts. No matter how close the camera zooms in on his face, he does not break his concentration ahead on the track stretching before him.

All of these observations illustrate the palpable tensions between acknowledging group generalizations and averages, on one hand, while appreciating wide individual differences, on the other hand. Despite these natural tensions, the two areas are complementary, and both are indispensable in the study of human characteristics and behavior (see "*From Theory to Evaluation to Instruction: Toward an Ideal Course on Cultural Competency in Applied Psychology*" Chap. 28, this book). The previous chapter addressed the former issue. This chapter discusses the latter issue.

When preservice psychologists graduate from their training programs, they will be applying their training to the problems and concerns of *individuals* – not groups. *Differential psychology* is the name given to that branch of psychology that studies the ways in which individuals differ in their behaviors and the processes that underlie

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such differences (Anastasi, 2007). *Individual difference psychologists* study the behavior of groups, the psychological dimensions shared by all individuals within groups, but focus specifically on the ways in which individuals are both similar and different along these dimensions (Chamorro-Premuzic, 2011).

The phrase "individual differences" is defined more broadly here to mean all of the ways in which elements within a class set can vary. Here, the phrase "individual differences" can refer to differences between and among individuals, groups, situations, interventions, or philosophical and psychological orientations. A comprehensive overview of all of the ways in which differences can be found will not be provided, as this would be well beyond the scope of this chapter. The more modest purpose of this chapter is to provide a smaller number of examples that illustrate the many facets of individual differences in clients, therapists, and client/therapist interactions – particularly those differences that tend to be ignored, downplayed, or overlooked in cultural competence advocacy.

Cultural Differences Within Racial, Ethnic, and Language Groups

It is understandable, though unfortunate, for applied psychologists to read cultural competence advocacy texts and come away with the impression that individuals are little more than "cookie cutter" representatives of their racial, ethnic, or language group. The irony here is that, in the attempt to honor diversity (by showcasing the wide variety of racial, ethnic, and language groups living in America), such texts unwittingly ignore important cultural differences across subgroups within broadly defined demographic groups. Although this principle applies to all racial, ethnic, and language groups (e.g., see Frisby & Reynolds, 2005), nowhere is this more evident than in the case of Native Americans (see special issue of *American Journal of Physical Anthropology, Vol. 146, No.4*).

Cultural Diversity Within Indigenous Peoples

Although Native Americans make up less than 1% of the US population, they represent approximately half of the different languages spoken in the United States (Sutton, 2017). There exists roughly 500 different and distinct Native American tribal groups (some of whom have fewer than 1000 members), each of whom have their own unique language and cultural traditions (Sutton, 2017).

Most scholars subdivide North America into ten separate geographical areas that are correlated with significant cultural and historical differences among Native American subgroups. Beginning at the farthest north, *the Arctic Circle region* is a flat, cold, treeless area in Alaska, Canada, and Greenland. It is home to the Inuit and Aleut people groups. Traveling farther south, *the Subarctic area* is composed of swampy, piney forests and waterlogged tundra and stretches across much of inland Alaska and Canada. Scholars subdivide Native Americans living in this region into two language groups: the Athabaskan speakers (which include the Tsattine, Gwich'in, and Deg Xinag tribes) and the Algonquian speakers (which include the Cree, Ojibwa, and Naskapi tribes).

The Northeast region stretches from Canada's Atlantic coast to North Carolina and inland to the Mississippi River valley. Scholars subdivide Native American groups living within this region into the Iroquoian speakers (which include the Cayuga, Oneida, Erie, Onondaga, Seneca, and Tuscarora tribes) and the Algonquian speakers (which include the Pequot, Fox, Shawnee, Wampanoag, Delaware, and Menominee tribes). *The Southeast* region stretches from the north of the Gulf of Mexico to the south of the Northeast region and includes the geographical area that is modern-day Florida, Georgia, Alabama, Mississippi, Louisiana, South Carolina, and Tennessee. Native tribal groups living in this region include the Cherokee, Chickasaw, Choctaw, Creek, and Seminole tribes.

The Plains area encompasses the prairie region between the Mississippi River and the

Rocky Mountains (east to west) and from present-day Canada to the Gulf of Mexico (north to south) and includes the Crow, Blackfeet, Cheyenne, Comanche, and Arapaho tribes. *The Southwest* area encompasses the huge desert region of present-day Arizona, New Mexico, and parts of Colorado, Utah, Texas, and Mexico. Native tribal groups living in this region are the Hopi, Zuni, Yaqui, Yuma, Navajo, Pueblo, and Apache tribes.

The Great Basin consists of an expansive area of deserts, salt flats, and brackish lakes formed by the Rocky Mountains to the east, the Sierra Nevada to the west, the Columbia Plateau to the north, and the Colorado Plateau to the south. Native tribes living within this region include the Bannock, Paiute, and Ute tribes. The *California* area, as the name implies, covers the geographical region covered by the largest state in west coast America. Native tribes living within this region include the Yokuts, Chumash, Salinas, Serrano, Kinatemuk, and Hupa tribes.

The Northwest Coast area extends from British Columbia to the top of Northern California. Native groups living in the region include the Athapaskan Haida, Tlingit, Penutian Chinook, Tsimshian, Coos, Wakashan Kwakiutl, and Nootka tribes. *The Plateau* area covers present-day Idaho, Montana, Washington, and eastern Oregon. Native tribes inhabiting these areas include the Klamath, Klikitat, Modoc, Walla Walla, Yakima, and Skitswish tribes.

Most persons who have limited or no familiarity with Native American communities are unaware of the tremendous cultural diversity within this broad group. It is not uncommon for popular entertainment and toy manufacturers to inappropriately mix together cultural artifacts such as the teepee from Plains cultural groups – with the totem pole from Northwest Pacific Coastal groups – with colorful woven rugs from Southwest tribal groups as if these artifacts belong to the same indigenous tribe (Michaelis, 1997).

Tradition vs. Modernization Although indigenous peoples may hold similar views as to what it means to be Native American, there are huge individual differences among Native Americans in how they choose to identify with traditional versus more modern lifestyle choices (Robbins, 2011). Some of these differences are related to natural generational differences that tend to occur within all ethnic groups (Fishman & Garcia, 2010; Rojas, 2012; Vathi, 2015). Even within the same generational cohort, some indigenous people choose to live on reservations and/or Indian lands (land owned by a tribe or tribes, the title to which is held in trust by the United States), while others chose to leave reservations and become part of other more ethnically heterogeneous communities (primarily for reasons related to the pursuit of greater economic opportunities). Over a long period of time, those who have moved away from homogeneous Native communities tend to lose touch with the values, attitudes, and beliefs that originate from tribal culture (Lucero, 2010). Many choose to marry persons outside of their ethnic group (e.g., Wang, 2015) and will eventually raise children who have little sustained knowledge of, or contact with, traditional Native practices. Currently, many tribal groups own businesses (including lucrative gambling casinos; Armitage, 2016; Rand & Light, 2014) and colleges (Paul, 2011) and have among their members prominent persons who have become lawyers, physicians, high-level politicians, artists, and academics (Rostkowski, 2012).

In summary, broad group designations (e.g., “Black culture,” “Native American culture,” “Asian culture”) are grossly inadequate (in and of themselves) for enabling applied psychologists to appreciate important aspects of cultural variation among individuals belonging to the same broad racial/ethnic category.

Differences in Levels of Intergroup Contact

It would also be inaccurate to think of racial, ethnic, and language groups as existing in circumstances in which they are wholly isolated in all respects from groups that differ from themselves.

Discussed below are various factors to consider which show that individuals differ considerably in their degree of contact and interaction with, and influence from, others who are different from themselves.

Immigration Status Many persons who currently reside in the United States were not US citizens at birth. The US Census Bureau uses the term "foreign born" in referring to lawful immigrants, temporary migrants (such as foreign students), humanitarian migrants (such as refugees and asylees), and illegal immigrants.

Those who must live their lives with the knowledge that they are in the country illegally face a burdensome set of psychological challenges that are not faced by those who reside in the country legally. The most well-known term for this condition is "living life in the shadows" (Cave, 2014). The qualitative nature of living life in the shadows naturally varies from state to state, due to differences in state laws that either permit or do not permit undocumented immigrants to obtain drivers licenses, pay instate tuition at local colleges, or obtain other public benefits (Cave, 2014). Unlike legal immigrants, law-abiding illegal immigrants must constantly be wary of their immigration status being discovered by the police. Hence, they more often than not find themselves victimized by financial fraud from employers and business vendors – due to an understandable reluctance to report the fraud to police authorities (Cave, 2014; Gonzalez & Ivers, 2017). Since they are not as likely to take advantage of mental health support services, undocumented immigrants are more prone to allow painful psychological stressors to accumulate (Gonzalez & Ivers, 2017).

Even though undocumented persons may be fundamentally law-abiding, the lure of obtaining money through illegal activities is a constant temptation just in order to survive and help support their families. If undocumented immigrants resist such temptations, then they must often work more than one job in order to make ends meet (Gonzalez & Ivers, 2017).

Neighborhood Integration According to the Pew Research Center (2015), between 50% and 60% of Americans surveyed reported that all or most of the people who live in their neighborhood are White. However, members of every racial group tend to live in neighborhoods where their group is overrepresented (see Logan, 2014, Table 1). For example, although Blacks are approximately 10% of the total population of persons living in suburbs in 2010, the average Black suburbanite lived in a neighborhood that was approximately 35% Black in 2010. Although Hispanics are approximately 14% of the total population of persons living in suburbs in 2010, the average Hispanic suburbanite lived in a neighborhood that was approximately 42% Hispanic. Although Asians are approximately 5% of the total population of persons living in suburbs, the average Asian suburbanite lived in a neighborhood that was approximately 19% Asian (Logan, 2014).

School Integration Making sense of the levels of public school, racial/ethnic integration and segregation is extremely complex, owing to (1) inherent advantages and disadvantages of using different quantitative indexes for tracking these trends, (2) how race/ethnic categories are determined (particularly given the rise of children of mixed-race/ethnicity parentage), (3) the rise of the Hispanic population in America across decades, (4) the rise of charter and private schools, and (5) trends in the implementation or abandonment of court-ordered desegregation plans (Whitehurst, Reeves, & Rodrigue, 2016).

Generally speaking, American schools were almost completely segregated by race before the late 1960s. In 1964, for example, only 2.3% of Black students attended schools that were majority White. Stated differently, four in five Black students and four in five White students would have had to transfer schools to make school compositions mirror the proportions of Black and White students in the average district (Whitehurst et al., 2016, p. 21). Between the late 1960s and the late 1980s, however, the segregation of schools *within districts* declined substantially

(particularly in Southern schools affected by federal desegregation mandates), but segregation *between school districts* increased (primarily due to "White flight" to the suburbs and the rise of private schooling; see Wolters, 1992, 2008).

Between 1991 and 2013, Hispanic school enrollment increased from 12 to approximately 25%, while White enrollment fell from 67% to 50% (Black enrollment remained stable at 16%; Whitehurst et al., 2016, p. 24). Over these years, school districts in general have become more diverse (i.e., with fewer majority White or majority Black schools) because of fewer Whites and more Hispanics. According to Whitehurst et al. (2016), the percentage of schools that were majority White and the percentage of Black students who attended majority White schools reached its peak in 1988. Since then, the percentage of majority White schools and the percentage of Black students attending majority White schools have fallen dramatically. As of 2013, the number of majority White schools in the United States fell from 81% to 56% – largely due to the rise in Hispanic school enrollment. The percentage of Black students in majority White schools fell from 44% in 1988 to 23% in 2011 (Whitehurst et al., 2016, p. 25). The point to be made here is that an individual's contact with persons of other racial groups is extremely fluid and difficult to generalize – as the degree of interracial contact / exposure can vary by individual school districts, yearly fluctuations in integration patterns, and the decade in which school enrollment occurred – among other variables.

Acculturation There has been much debate over the definitions for, and the degree of overlap between, psychosocial constructs such as "acculturation," "enculturation," "assimilation," and "socialization" (e.g., see Sam, 2006). For the purposes of this chapter, *acculturation* is defined simply as "all changes that arise following contact between individuals and groups of different cultural backgrounds" (p. 11). The most obvious dimension along which acculturation can occur is in the area of language. Here, some group members retain the language of their native country, other group members eventually learn and speak the language of the host country, and others adopt modified language dialects that integrate the languages of both countries (Ng, 2007; Valdez, Mills, Bohlig, & Kaplan, 2013).

Other variables that have been studied by acculturation researchers include (but are not limited to) the proportion of a respondent's friends belonging to particular racial/ethnic groups, daily habits (e.g., food eaten, preferred music, television viewing habits, clothing preferences, media use), dating/marriage preferences, child-rearing practices, observance and/or maintenance of cultural traditions, beliefs about cultural/ethnic/racial identity, and the strength of, or adherence to, cultural beliefs (Arends-Tóth & van de Vijver, 2006). Acculturation tensions not only can occur between culturally different groups, but conflicts can also occur between persons within families, which appear to stem from generational divisions (Birman & Poff, 2011; Farver, Narang, & Bhadha, 2002; Juang, Syed, Cookston, Wang, & Kim, 2012; Lui, 2015).

The point to be made here is that there exists tremendous variation in the extent to which (as well as the ways in which) any individual may be influenced (if at all) by the cultural characteristics of the broader community.

Second Language Facility For those Americans who are foreign born, fluency in English is correlated positively with greater earnings and occupational mobility (Batalova & Fix, 2010). While many immigrants arrive in America with no proficiency in English, others arrive already knowing how to speak English – especially from countries where English is widely spoken (e.g., Canada, Jamaica, and the United Kingdom) or where English is the official language (e.g., India, Nigeria, and the Philippines). Some learn English through years of study prior to immigrating to the United States or undertake focused study of English immediately upon arrival (Gambino, Acosta, & Grieco, 2014).

There is considerable variation in English language facility and usage among the foreign born residing in the United States. Those who have

lived in the United States for longer periods of time tend to have higher English-speaking abilities, although this relationship is far from perfect (as some still may not be able to speak English well). Those who hold a bachelor's degree or higher are more likely to have higher English-speaking ability than those with less than a high school education (Gambino et al., 2014).

Among adult Hispanics/Latinos living in America who are either foreign or American born in year 2015, approximately 26% reported speaking only English and approximately 73% reported speaking Spanish. Of all Hispanics/Latinos who reported speaking Spanish, approximately 75% reported speaking English "well" or "very well," and approximately 25% reported speaking English "not well" or "not at all" (American Community Survey, 2015). This attests to the tremendous language diversity within American groups designated as Spanish speaking.

Cultural Insularity While unfettered racial/ethnic integration lies at one end of a continuum, *cultural insularity* lies at the other end of the continuum. The adjective "insular" relates to the concept of an island, which is a body of land that is detached, remote, separated, and/or isolated. When a racial, ethnic, language, or cultural group is described as insular, it means that a group is isolated in various ways (not just physically) from the broader culture (however defined). Physical insularity can be manifested in areas as small as individual neighborhoods or in areas as large as entire cities and towns. Native American reservations across the United States (e.g., Frantz, 1999), Chinatowns (Tsui, 2010), and Koreatowns (Kim & LaBonge, 2011) – some elements of which may nakedly pander to tourism – are nevertheless visual symbols of cultural insularity that is localized in a self-contained geographical space.

Even within broad racial and ethnic groups, cultural insularity can occur within specific subgroups, which possess discrepant traditions, practices, and/or worldviews passed down across generations. As an example, the academy award-winning movie *The Godfather* depicted life from the perspective of the Italian-American mafia in the 1940s (an insular subgroup within the broader cultural group of Italian Americans). One of the reasons contributing to the emotional and artistic impact of the movie was its depiction of mafia life "from the inside," where thinking and actions considered to be grossly evil from the perspective of "outsiders" seemed perfectly normal from the perspective of mafia "insiders."

Insular cultures are cut off from sustained exposure to values, knowledge, ideas, viewpoints, or people groups outside of their subgroup (even outside groups who share the same race, ethnic, or language characteristics). Sustained cultural insularity over time results in language, customs, and traditions that may seem odd and "out of place" to outsiders but are perfectly normal to members inside of the subcultural group. A diversity of select examples (among literally hundreds) of culturally insular subgroups are Hasidic Jewish communities (Coleman-Brueckheimer & Dein, 2011), Amish communities (Kraybill, 2001), deaf communities (Reagan, 1995), gang communities (Simpson, 2005; Stewart & Simons, 2010), and professional bodybuilding communities (Denham, 2008) – to name a few. The point here is that the distinctiveness of cultural traits means so much more than just simple racial/ethnic category labels in understanding human variation.

Experiences of Discrimination According to the Pew Research Center (2016), Blacks and Whites are depicted as being "worlds apart" as to what survey statistics reveal about differences in groups' attitudes on racial discrimination and inequality in America. However, what is often overlooked is that differences *within groups* are equally as stark. Among Black respondents, for example, approximately 7 in 10 (71%) Black Americans reported personally experiencing discrimination or having been treated unfairly because of their race. Within this group, 11% (approximately 1 in 10) report that they experience discrimination "regularly," and 60% (approximately 6 in 10) report experiencing discrimination "from time to time, but not regularly," "only one time," or "rarely." This means that 3 in

10 Black Americans *do not* report personally experiencing discrimination or having been treated unfairly because of their race. When asked about specific kinds of discrimination experienced within the year prior to being surveyed, 47% of Blacks surveyed reported other persons acting suspicious of them; 45% reported others thinking that they were not smart; 21% reported being treated unfairly in hiring, pay, or promotions; and 18% reported being unfairly stopped by the police. Although the survey researchers emphasize what they view as significant differences between what Whites and Blacks report on these indicators, what is overlooked is that the *majority* of Blacks surveyed within these indicators *did not* report experiencing discrimination in these areas.

Interracial Friendships Although the United States is becoming increasingly more racially and ethnically diverse with each passing decade, a majority of Whites (approximately 62%) report having a lot in common with other Whites, while less than 10% report having a lot in common with nonwhites (this pattern is similar for the reporting of nonwhites, Jones & Bullock, 2012). Individuals tend to have more friends among their own race group than they do among races that are different than their own. However, a majority of Americans report that they have at least some close friends who belong to another racial group or who are of mixed racial heritage (Jones & Bullock, 2012). In conclusion, the notion that modern-day Americans overwhelmingly live in a "hermetically sealed" environment that is isolated from contact with other groups (in their schooling, professional, and personal lives) does not fully harmonize with the complexities of contemporary realities.

Interracial Marriage/Mixed-Race Population Since 1967, after the US Supreme Court ruled in the *Loving v. Virginia* case that marriage across racial lines was legal in America, rates of interracial and interethnic marriage have increased steadily. As of 2015, one in six newlyweds was married to a person of a different race or ethnicity (a fivefold increase since 1967). Among all married persons in 2015, 10% (approximately 11 million persons) are members of interracial or interethnic marriages (Pew Research Center, 2017).

Beginning in the 2000 US Census, individuals were presented with the option to self-identify with more than one race, which reflects a practice that has continued with the 2010 Census. According to the most recent figures from the 2010 Census, the population of persons reporting membership in more than one race grew from approximately 6.8 million persons in 2000 to 9 million (Jones & Bullock, 2012). The top four most populous mixed-race categories of the US Census (each of which contains over 1 million persons) are White/Black, White/some other race, White/Asian, and White/American Indian and Alaskan Native. The Western region of the United States had the largest number of persons who reported being of mixed racial heritage in its total population (Jones & Bullock, 2012). These complexities make simplistic racial generalizations increasingly irrelevant with each passing decade.

Individual Differences in Psychological Service Setting Variables

Clients differ considerably in the settings within which psychological and mental health services are received. Some of these different settings are described briefly below.

Schools Individual public, private, and charter schools and schools systems differ from other settings in which psychological/mental health services may be delivered – in that schools provide a fairly *standardized set of grade-appropriate behavioral and academic expectations* to which all of its clients must conform (e.g., see Zwiers, O'hara, & Pritchard, 2014). Allowing for individual differences in academic ability and special education-related limitations, generally speaking all students must conform to the classroom and school-wide rules for how they conduct

themselves within the classroom; how they move from classroom to classroom between periods; how they behave in the cafeteria, library, on school buses, and at recess; the quality of the in-class work and out-of-school homework that is completed; and standards for moving to the next grade level and eventually graduating.

Nearly all referrals for school psychological services involve several clients (Fagan & Wise, 2007). The school-aged child receives needed services directly, and is the client who will benefit from such services, and can technically refuse services. At the same time, however, parents are the ones who can directly request services for their child from the school psychologist or mental health counselor and in some instances (i.e., private practice) are the persons paying for services. Teachers are the professionals who actually initiate referrals for services, as the child may not receive needed services were it not for the concerns of teachers. Here, services not only have implications for the child but also have implications for improvement in the smooth functioning of teachers' classrooms. School administrators (e.g., principals) are directly responsible for employing school psychologists and may be held legally responsible for the outcomes of services delivered (Fagan & Wise, 2007).

College Campuses There are no college counseling degree programs per se, hence persons who work as counselors for college students on university/college campuses most commonly graduate from training programs in counseling psychology, clinical psychology, counseling and human services, mental health counseling, counselor education, or social work (Sharkin, 2012).

The most common population served by psychologists who work as college counselors are students between the ages of 18 and 24, who are struggling with developmental tasks related to the difficult transition from late adolescence to early adulthood. During this period of life, clients often engage in high-risk behaviors such as alcohol and/or drug abuse, reckless sexual behavior, or campus political protests. As such, common problems brought to a college counselor's attention frequently relate to issues of autonomy, individuation, identity, money management, and intimacy (Sharkin, 2012, p. 12).

Psychologists who work as counselors on college campuses are trained for competence in "general" clinical skills, in addition to being trained for work with specific problems such as eating disorders, mood disorders, trauma, grief, or substance abuse (Sharkin, 2012, p. 12). Such problems can be addressed through either individual or group counseling. With increasing numbers of students requesting accommodations due to emotional and/or learning disabilities, college counselors are often called upon to review, evaluate, verify, and document such requests (Sharkin, 2012, p. 13).

Hospital and Related Settings Mental health services are provided by psychologists in a number of hospital and medical care-related settings (North Texas HELP, 2017). *Hospital inpatient settings* designate psychiatric hospitals or a psychiatric unit within a general hospital. Psychiatric hospitals treat mental illnesses exclusively; however, physicians are available for addressing medical conditions that are associated with mental health concerns. Psychiatric hospital settings may include specialty units for eating disorders, geriatric concerns, child and adolescent services, and drug/alcohol rehabilitation services (North Texas HELP, 2017). General hospitals may provide treatment to clients who suffer from more serious mental health concerns, the care for whom may involve round-the-clock treatment. The length of stay in these settings can range from one night to up to 30 days (after which clients may be transferred to a psychiatric hospital). *Residential mental health treatment facilities* provide more comfortable environments than hospital wards and generally provide more long-term mental health care for clients who are temporarily living at the facility. As examples, *psychiatric residential centers* are tailored to persons suffering from more serious psychiatric disorders such as schizophrenia or bipolar disorders. *Alcohol and drug rehabilitation facilities*

provide detoxification services for up to 30 days (depending on each facility's policy). *Nursing homes* provide care for elderly persons who do not need to be in a hospital, but whose problems cannot be adequately cared for in a home setting. Nursing homes are staffed by nurses and nurses' aides who are available 24 hours a day to provide medical, physical, speech/language, and mental health care.

Outpatient settings serve clients in settings that do not require overnight stays. Some of these settings are in community mental health centers, and others are located in outpatient clinics within general hospitals. *Outpatient clinics* offer services from a wide variety of mental health professionals. *Community mental health centers* treat clients whose incomes fall below a state-determined level. *Partial hospitalization programs* (sometimes called "day programs") are outpatient programs that are less intensive than inpatient hospitalization programs. Here, clients attend for 6 or more hours per day, every day or most days of the week, and receive group counseling/therapy, educational sessions, or individual counseling. *Intensive outpatient programs* may be offered as part of hospital services. Here, clients attend for only 3–4 hours during the day or in the evenings. Some individuals seek and receive services from mental health professionals who work in either *private practice* (solo or with a group of colleagues) and who provide assessment and/or individual/group counseling. Although many practitioners accept insurance payments, some practitioners accept only personal payment for services.

Finally, *telepsychiatry and telemental health services* refer to the remote delivery of psychiatric assessment, care, and support services via telephone, the Internet, or videoconferencing. These services are designed for clients living in remote geographical areas, or who cannot leave home due to illness or mobility problems (North Texas HELP, 2017).

In closing, psychological services can be provided in a wide variety of settings, which include, but are not limited to, correctional facilities, police departments, military bases, university athletic departments, and religious and social service agencies. Thus, the nature of client/caregiver interactions inherent within psychological services can also be expected to vary simply as a function of the setting within which clients are served (e.g., clients enter therapy with a completely different set of expectations in one setting compared to the expectations of clients served in a completely different setting).

Individual Differences in Client Characteristics

Individual Differences in Factors Influencing Help-Seeking Behavior

The literature on the factors that influence persons to seek help for psychological or mental health problems is substantial (see review by Magaard, Seeralan, Schulz, & Brütt, 2017). There are a variety of factors that influence whether or not a client eventually receives psychological or mental health services from a caregiver.

Demographic Variables One class of studies examines the association between *demographic factors* and help-seeking behaviors.

Age Rowe et al. (2014) reviewed the literature on help-seeking behavior and self-harming behavior in adolescents between 11 and 19 years of age. They found that between one-third and one-half of adolescents who self-harm do not seek psychological help for this behavior. Of those who do seek help, adolescents primarily turned to friends and family for support – with the Internet functioning as a self-disclosure tool for adolescents rather than asking for help. Barriers to help-seeking included a fear of negative reactions from others, fear of confidentiality being breached, and a fear of being seen as "attention-seeking." Other barriers to seeking mental health for young people include poor mental health literacy (not knowing how to recognize symptoms) and a

preference for self-reliance (Gulliver, Griffiths, & Christensen (2010).

The propensity to seek help is also generally associated with higher ages and older samples (Magaard et al., 2017). Analyzing a dataset of over 5600 persons, Mackenzie, Scott, Mather, and Sareen (2008) found that adults between the ages of 55 and 74 were approximately two to three times more likely to report positive help-seeking attitudes than younger adults. However, Brenes, Danhauer, Lyles, Hogan, and Miller (2015) conducted telephone screenings with 478 older adults living in a rural community and found that the most commonly reported barriers to mental health treatment for anxiety and depression were the personal belief that "I should not need help," practical barriers such as the cost of services, not knowing where to go, the distance that needs to be traveled in order to access services, mistrust of mental health providers, not believing that treatment would help, stigma, and not wanting to talk with strangers about private matters.

Gender Being female is positively related to help-seeking behavior but only within samples from certain countries (e.g., United States and Finland) and not within samples from other countries (e.g., Spain, Ethiopia, Canada, Netherlands, and Mexico; see review in Magaard et al., 2017).

Men generally seek mental health treatment less often than women (Addis & Mahalik, 2003; Wang et al., 2007). When a large sample of over 4800 men (aged 20–59 years) were studied, greater mental health-care help-seeking was identified among White men, homosexual men, men who are not in relationships, older men, and more depressed men (Parent, Hammer, Bradstreet, Schwartz, & Jobe, 2016). Further complicating matters are researchers' findings of intersectional patterns among their data. For example, the "income-poverty ratio" was found to be positively associated with help-seeking behavior among White men, unrelated to help-seeking behavior among Mexican American men, and negatively associated with help-seeking behavior among Black men (Parent et al., 2016).

Race Using telephone survey methodology, Brown et al. (2010) studied treatment-related attitudes and behaviors related to depression symptoms in a sample of 449 African-American and White adults aged 18 years of age and older. Researchers found that the relationship between the public stigma of mental illness and attitudes toward mental health treatment was *mediated* significantly by internalized stigma (feelings of shame and devaluation) for the entire sample, but for African-Americans internalized stigma had a more direct relationship with attitudes toward treatment. That is to say, the influence of stigma was determined by the degree to which African-Americans held negative views about themselves due to suffering from depression, not by how they believed others would judge them. However, when race was used as a moderator variable between public or internalized stigma and attitudes toward treatment, results were nonsignificant.

Beliefs One category of studies examines the association between help-seeking behavior and *beliefs* such as feeling comfortable (or embarrassed) with seeking help, having the intention to seek help, attitudes toward taking certain drugs/medications, personal prejudices/feelings about the mentally ill, and having an internal vs. external locus of control (Magaard et al., 2017). Research using both small and larger population-based samples have demonstrated an inverse relationship between perceived public stigma of mental illness (negative beliefs and attitudes held by the general population) and persons' willingness to seek treatment for psychological distress, but other studies found nonsignificant relationships (e.g., Brown et al., 2010).

Social Factors Another category of studies examines the association between help-seeking behavior and individual differences in a variety of *social factors*. For example, after controlling

for relevant factors, more years of education and higher formal academic degrees are positively associated with help-seeking behavior. Different rates of help-seeking are significantly associated with differences in racial/ethnic group membership, although this relationship has been shown in some studies to be moderated by symptom severity. The association between help-seeking behavior and marital status has shown mixed results (Magaard et al., 2017), although one study reported that single mothers with adult children had the lowest odds of seeking treatment in comparison to other women (Gadalla, 2008).

Enabling Characteristics Another set of studies investigates the association between help-seeking behaviors and *individual enabling characteristics*. Studies that investigated the role of personal income and help seeking showed mixed results (Magaard et al., 2017). Studies have also looked at the role of the availability, accessibility, and acceptability of care, as well as the degree of social support on help-seeking behavior. While some studies showed significant relationships for some variables within some samples, other studies did not find a relationship.

Individual Need Characteristics Some studies investigate the role of *individual need characteristics* on help-seeking behavior. According to Magaard et al.'s (2017) review of numerous datasets, persons' severity of depression, the longer duration of an illness, having trouble concentrating, having suicidal thoughts or ideation, psychiatric or somatic comorbidity, having comorbid generalized anxiety disorder, and a panic disorder were all positively associated with help-seeking behavior. However, some of these relationships were present in some datasets but not others. For example, Michelmore and Hindley (2012) reviewed epidemiological studies that examined help-seeking for suicidal thoughts or self-harm in young people up to the age of 26 and found that the majority of young persons in the studies reviewed *do not* seek professional help, even after an overdose.

Ali et al. (2017) reviewed the literature on perceived barriers and facilitators toward help-seeking behavior in persons suffering from eating disorders. They found that the most prominent perceived barriers to help-seeking were feelings of stigma and shame, a denial of and failure to perceive the severity of the illness, practical barriers (such as treatment cost), a low motivation to change, negative attitudes toward seeking help, a lack of encouragement from others to seek help, and a lack of knowledge about help resources. Help-seeking was facilitated when there was the presence of other mental health problems, emotional distress, and concerns about health.

Contextual Factors Some studies investigate the role of *contextual factors* (i.e., urban vs. rural residence, differences between countries, differences between regions within countries). In the numerous datasets analyzed by Magaard et al. (2017), a majority of contextual differences investigated failed to show statistically significant differences in help-seeking behavior.

College Settings Vidourek, King, Nabors, and Merianos (2014) studied 682 college students and found that females perceived a greater number of benefits to having participated in mental health services, as well as having significantly lower stigma-related attitudes compared to males. In addition, students who had previously received counseling perceived counseling as less stigmatizing than students who had never before received counseling. Perenc and Radochonski (2016) found that female status, having a graduate university education, an internal locus of control, and a sense of coherence were significantly related to a more positive help-seeking attitude in a sample of Polish university students.

Masuda, Anderson, and Edmonds (2012) investigated the relationship between attitudes toward seeking professional psychological services, mental health stigma, and self-concealment in a sample of 163 African-American college students. After controlling for gender, age, and previous experience of seeking profes-

sional psychological services, the researchers discovered that greater mental health stigma and greater self-concealment were associated with less favorable help-seeking attitudes. Older students, or those with past help-seeking experience, were found to have more favorable help-seeking attitudes than younger students or those without such experience.

Aditional Factors There are a multitude of other help-seeking factors that do not fit neatly into the aforementioned categories. For example, much of therapy services for children is involuntary. Sometimes parents will initiate the process of bringing their children to therapy, or children are referred to psychological services by teachers in school settings (the permission for which is granted by parents or guardians). At other times, parents are requested to enter the therapy themselves because their children are in therapy. In the context of forensic psychological services, incarceration or criminal courts mandate therapy as a condition for probationary conditions. In pastoral settings, clergy may mandate premarital counseling for couples as a precondition for performing wedding ceremonies.

Age/Developmental Considerations

All human beings grow and develop both physically and psychologically from birth to old age, and this has natural developmental implications for psychological and mental health services (Adler-Tapia, 2012; McConaughy, 2013). Zane, Bernal, and Leong (2016) state:

> [Evidence-Based Psychological Practice] also requires that psychologists pay attention to factors as they relate to lifespan development and the current life stage of the patient. Research suggests that attachment, socialization, cognitive, social-cognitive, gender, moral, and emotional development are just some of the developmental processes that are crucial in understanding psychopathology, particularly in the treatment of children, adolescents, families, and older adults. (p. 24)

Young Childhood Rates of physical, social, and emotional development are accelerated during the preschool years (i.e., developmental changes are more stark and salient when comparing a 3 year old versus a 4 year old, as opposed to comparing a 13 year old versus a 14 year old). The psychometric assessment of preschool-aged children (i.e., children between the ages of 2–5) can be either a "delightful or frustrating endeavor" (Lidz, 1991, p. 18). Children of this age can be described as spontaneous, lacking in self-consciousness, unpredictable, limited in their attention spans, more prone to fatigue, and limited in their language skills (Bracken & Nagle, 2015). Psychologists who work extensively with clients within this age group rely more heavily on taking time to build rapport, using play therapy techniques, administering behavior rating scales and checklists to third parties, relying on clinical interviews with parents and caregivers, and using simpler words to communicate abstract concepts (Bratton, Ray, Rhine, & Jones, 2005; Holmbeck et al., 2008; Schroeder & Smith-Boydston, 2017).

One challenge in the accurate assessment and treatment of early childhood disorders stems from the fact that certain disorders (e.g., internalizing disorders) tend to be viewed as less problematic by parents, teachers, and other caregivers – in addition to being negatively influenced by young children's limited capacity to accurately describe and verbalize their felt internal states (Tandon, Cardeli, & Luby, 2009). Due to these issues, mental health professionals who have many years of experience in serving children of this age are reluctant to make premature diagnoses, as it can be unclear whether problems may be due to disturbed interpersonal relationships with caregivers (which may be temporary) or reflect potential first signs of more enduring psychopathology (Egger, 2009; Klitzing, Döhnert, Kroll, & Grube, 2015; Merten, Cwik, Margraf, & Schneider, 2017).

Middle Childhood to Adolescence Between the ages of 6 and 17, persons continue to mature

physically, socially, and emotionally toward adulthood. On the positive side, persons are better able to accurately verbalize relevant clinical information necessary for more accurate psychological diagnoses as they mature (Macleod et al., 2016), yet in many areas, they are still too immature to successfully negotiate life's many challenges. During this time period, children and youth begin to experience new moods and bodily changes (puberty, menstruation, sexual feelings) that in one sense are entirely predictable but can still create significant social and emotional problems and concerns.

As persons develop through childhood into adolescence, there are greater responsibilities that must be accepted and competencies mastered in order to successfully progress academically through school. They are developing personal convictions about concepts of right versus wrong; they are learning how to negotiate the proper balance between exercising their own personal will versus meeting the expectations of adults in school, family, employment, and/or church contexts; they are learning how to handle pain, surprises, disappointments, and hurts that come from social relationships; they are developing personal interests that will lay the foundation for future academic and/or occupational choices; they are developing a personal (ethnic, sexual, religious) identity within the context of larger social systems; and they often struggle with choices related to establishing independence from parents and pursuing vocational interests (Damon, Lerner, Kuhn, Siegler, & Eisenberg, 2008).

In addition to direct service to individuals, psychologists whose work focuses exclusively on children and adolescents will often serve them within the context of parent training, teacher training, and/or family therapy interventions (Finch, Lochman, Nelson, & Roberts, 2012).

Older Adults As persons age through adulthood, they eventually will face inevitable challenges that are common in later stages of life. *Clinical geropsychology* can be broadly defined as the application of psychological methods to understanding and helping older persons and their families to maintain well-being, overcome problems, and achieve maximum potential during later life (American Psychological Association, 2017b). Clinical geropsychologists are trained to help older persons face and/or cope with a variety of life challenges (e.g., declines in physical and/or mental health, medical illnesses, the loss of loved ones, retirement, changes in residence, the loss of independence), as well as the physical and psychological problems associated with these changes (e.g., depression, anxiety, dementia, Alzheimer's disease, grief and bereavement issues, sleep disorders, and preparing for death).

Geropsychologists assist older adults and their families with interventions and skill sets that are not typically part of psychologists' work with children, youth, or younger adults. As examples, geropsychologists are familiar with environmental design issues (e.g., as applied to home modifications and/or assisted living) and adaptive technologies (see Orlov, 2017) that help older persons cope with the increased challenges of getting older. Community interventions may include efforts to improve public health (e.g., depression screenings; Qualls, 2011, p. 15) for older persons.

Socioeconomic Status

Socioeconomic status (hereafter abbreviated as SES) is a designation that typically consists of the aggregate of a person's occupation, income, education level, and place of residence. *Social classes* are groups of families, more or less equal in rank and differentiated from other families above or below them with regard to characteristics such as occupation, income, wealth, and prestige (Gilbert, 2015). Viewed within the context of human development, SES can be understand as having a binary designation for persons: *SES of origin* vs. *attained SES*. A person's SES of origin refers to the circumstances within with s/he was raised as a child. The attained SES refers to the SES that a person has attained in adulthood.

Defining social class as consisting of commonalities in occupation, income, and education should not be construed as a rigid defining characteristic, as many exceptions exist. For example, a person can earn millions as a professional athlete despite having a limited education. Or a person may have earned advanced educational degrees but choose to work in a low-income occupation for humanitarian reasons (Frisby, 2013).

Upward and downward mobility between social class categories can be influenced by a variety of factors; however, IQ and education are the most well-known factors that influence upward SES mobility (Jensen, 1998). For example, a young child born into a low-income environment, but who has a high IQ, will tend to perform well academically in school (Frisby, 2013). The tendency to do well in school will be positively associated with tangible academic outcomes such as graduation diplomas, good standardized test scores, and offers for admission into top colleges and universities. Successful matriculation through a graduate academic program will yield the appropriate degrees, which in turn are prerequisites for securing lucrative, high-paying jobs. Lucrative, high-paying jobs will pay incomes that will allow individuals to live in more expensive neighborhoods.

There are a number of ways in which the variable of social class can be subdivided into categories (Gilbert, 2015); however, for the sake of simplicity, five qualitatively distinct social classes can be designated as the upper classes, middle classes, working classes, the working poor, and the underclasses (Frisby, 2013). Besides having similar income levels, persons belonging to the same social class tend to live in the same neighborhood types, socialize with one another, and to be similar in lifestyles, parenting and child-rearing styles, social/political attitudes, and behaviors (Frisby, 2013; McCall & Manza, 2011).

A large volume of empirical evidence from a variety of countries demonstrates the link between social class and a number of social and health problems, which include, but are not limited to: infant mortality rates, life expectancy, obesity, heart and lung disease, rates of homicide and violent crime, alcohol consumption, rates of imprisonment, out-of- wedlock birthrates, and divorce rates (see reviews by Herrnstein & Murray, 1994; Hymowitz, 2006; Pickett & Wilkinson, 2015; Rowlingson, 2011; Walsh, 2011).

Those persons who belong to the underclass occupy the lowest rungs of the socioeconomic ladder and consist of persons who tend to be concentrated in urban settings (Auletta, 1999; Wilson, 1987), although the underclass can also describe persons living in poor rural areas (Isenberg, 2016; Vance, 2016). Persons in this category are disproportionately nonwhite, have very low levels of educational attainment, little or no marketable job skills, and work in low-paying jobs (if they work at all). Many in this category survive through participation in the "underground economy" of drug dealing, gambling, prostitution, and other illegal activities. Persons colloquially characterized as "street hustlers," "drifters," and "shopping bag ladies" are disproportionately represented in this category, as are drug/alcohol addicts, current or former mental patients, and families dependent on welfare. Many scholars have argued that the thinking patterns and behavioral characteristics of the underclass reflect a pervasive *culture of poverty* that is not shared among all members of the low SES social strata but transcend race and ethnicity (Cohen, 2010; Dalrymple, 2003; Isenberg, 2016; Lewis, 1968, 1975, 2011; Small, Harding, & Lamont, 2010; Vance, 2016).

Compared to more affluent persons, individuals from lower-income backgrounds are less likely to seek formal mental health services (Levy & O'Hara, 2010). Some researchers argue that the psychotherapy process is rooted in a "middle-class worldview" and hence may not appropriately meet the needs of low-income clients (Falconnier, 2009; Kim & Cardemil, 2012).

Many scholars advocate for therapists to be flexible in adapting service delivery to lower SES clients, which may include incorporating information-providing services into therapy (e.g.,

information on how food stamps work, where to find affordable day care), finding more creative ways to advertise therapy services, increased self-disclosure from therapists, being more explicit in discussing therapy process and outcomes, the provision of food during therapy sessions, finding ways for clients to access services during nonbusiness hours (since many clients have concerns about missing work), and providing home-based services to clients (Kim & Cardemil, 2012).

IQ/Functional Literacy

General Cognitive Ability General cognitive ability is operationalized as the "*g*-factor," the most fundamental and primary source of variation shared by all mental tests (Jensen, 1998). The g-factor is measured best by standardized IQ tests (Jensen, 1998), which provide an unbiased measure of general cognitive abilities in American-born, English-speaking groups (Jensen, 1980; Reynolds & Lowe, 2009). Although the full range of general mental ability levels is represented within every racial and ethnic group, groups differ in their subpopulation averages (Rushton & Jensen, 2005), which result in unequal portions of different racial/ethnic groups that are represented in different categories along the IQ continuum (see Gottfredson, 2005a, Fig. 18.2, p. 541).

General mental ability (operationalized by the IQ score) is correlated positively with a wide variety of life outcomes, which include school achievement (Frisby, 2013; Gottfredson, 2005a; Jensen, 1993; Spinks et al., 2007), occupational status (Gottfredson, 2011; Huang, 2013), job performance (Schmidt & Hunter, 1998, 2004), and personality traits (DeYoung, 2011; Rammstedt, Danner, & Martin, 2016) and is implicated both directly or indirectly in a wide variety of social problems (Burfeind & Bartusch, 2006; Diamond, Morris, & Barnes, 2012; Holley, Yabiku, & Benin, 2006; Yun & Lee, 2013).

Nearly all indicators of physical and mental health favor high socioeconomic status persons (Gottfredson, 2004), and socioeconomic status is significantly correlated with IQ (Jensen, 1998). Health disparities that vary by socioeconomic status are ubiquitous, as they occur "regardless of country, health system, decade, disease, organ system involved, and treatability of [the] disease" (Gottfredson, 2005b). Some scholars argue persuasively that individual differences in general mental ability provide the most robust explanation for fundamental causes of these health inequalities (Gottfredson, 2004). One of the strongest mediators between general cognitive ability and health outcomes is *functional literacy*.

Functional Literacy Functional literacy can be defined as the ability to use printed and written information to function in society, to achieve one's goals, and to develop one's knowledge and potential (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993, p. 2). Although tasks requiring functional literacy are not designed to serve as intelligence tests, the increasing complexity of functional literacy tasks mimics the cognitive complexity of intelligence test items that are increasingly more *g* loaded (Gottfredson, 2004). Such tasks involve, but are not limited to, the ability to successfully complete applications, the ability to accurately read maps, calculating prices in grocery shopping, being able to restate arguments in newspaper editorials, and understanding and following a doctor's treatment plans for managing health conditions. According to Gottfredson (2004), the rates of unfavorable adult outcomes – such as having a weak attachment to the labor force, using food stamps, living in poverty, and not having a high-level job – rise steadily at successively lower levels of functional literacy (p. 177). In a parallel fashion, individuals with lower levels of general cognitive ability practice healthy behaviors less often, will seek less preventive care even when such care involves no costs, are less aware of disease symptoms (e.g., lack of awareness of signs of high/low blood sugar), and adhere less effectively to treatment regimens (e.g., understanding information about when a next medical appointment was scheduled; understanding

directions as to the conditions under which medicines are to be taken; Gottfredson, 2004; Williams et al., 1995; Williams, Baker, Parker, & Nurss, 1998). Gottfredson (2004) writes:

> … [W]hat happens once all are seated in a doctor's office receiving information, one on one, that is directly pertinent to whatever problem brought them into the office? Do all profit equally? No, according to the research on health literacy … [S]ome patients are unable to understand even simple information about their case … Noncompliance or nonadherence to medical regimens has long vexed medical and health workers … Noncompliance of all sorts is particularly a problem in low-income clinic populations … [which] impose high costs in morbidity and mortality … The problem here, then, is not lack of access to care but the patient's failure to use it effectively when delivered. (p. 187)

Similarly, those individuals with higher levels of cognitive resources are better able to "remain vigilant for hazards and recognize them when present, remove or evade them in a timely manner, contain incidents to prevent or limit damage, and modify behavior and environments to prevent reoccurrence" (Gottfredson & Deary, 2004, p. 2).

Trait Personality Variables

Traits can be defined as continuing and habitual patterns of behavior, thoughts, and emotions that are generally stable over time. The trait approach to studying human personality reveals individual differences in the combination of personality traits that make each individual unique. Each individual can be described as having enduring personal characteristics or dispositions which in turn give rise to behavior patterns that can be correlated with important external criteria (Deary, 2009).

Although many different taxonomies of personality traits have been proposed throughout the history of psychology (e.g., Allport, 1937; Eysenck, 1947; Cattell, 1950), *the five-factor model* of personality traits (hereafter abbreviated as FFM) is currently the dominant paradigm in personality research. This has led McCrae (2009) to opine that it is one of the most influential models in all of psychology (p. 148) – in addition to having persuasive evidence of its universality across cultures (McCrae & Costa, 1997; McCrae, Costa, Del Pilar, Rolland, & Parker, 1998). If data from a large number of rating scales (all of which sample a wide scope of traits across large and representative samples) is subjected to a factor analysis, five factors emerge that describe a latent structure within which personality traits can be classified (John & Srivastava, 1999; Judge, Higgins, Thoresen, & Barrick, 1999; Ozer & Benet-Martinez, 2006; for criticisms of this model, see Block, 2010). The five factors are extraversion, agreeableness, conscientiousness, neuroticism, and openness to experience.

Persons scoring high on *extraversion* are excitable, sociable, talkative, emotionally expressive, and assertive. They make friends easily, enjoy interacting with others, and have a wide circle of friends and acquaintances (Ackerman, 2017; Cherry, 2017). Persons who score low on extraversion are characterized as introverts and tend to be more quiet, reserved, and introspective. Introverts are more prone to focus on their internal thoughts, feelings, and moods rather than be prone to seek out external stimulation. They prefer solitude and tend to feel drained and exhausted when they have to socialize a lot. Extraversion is highly predictive of overall job performance for sales and managerial jobs and is particularly predictive of job satisfaction (Ones & Viswesvaran, 2011).

Persons scoring high on *agreeableness* tend to have a great deal of interest in others, have a great deal of empathy and concern for others, and are highly cooperative and able to get along well with others. Persons who score low on this trait have little interest in or empathy for the feelings of others. They are less likely to be trusted and liked by others and are often seen by others as callus, blunt, rude, sarcastic, or ill-tempered (Ackerman, 2017; Cherry, 2017). Agreeableness is highly predictive of overall job performance in customer service jobs (Ones & Viswesvaran, 2011).

Persons who score high on *conscientiousness* are good at controlling their impulses, delaying

gratification, planning and organizing, and being "goal directed." They can be described as persistent, self-disciplined, reliable, resourceful, and hard working. Persons who score low on this trait tend to dislike structure and schedules, are prone to procrastinate, and often fail to complete assigned tasks (Ackerman, 2017; Cherry, 2017). Of the five personality traits, conscientiousness is the best predictor of overall job performance across the widest variety of jobs (Barrick, Mount, & Judge, 2001; Ones, Dilchert, Viswesvaran, & Judge, 2007; Ones & Viswesvaran, 2011). Conscientiousness is also highly predictive (in the negative direction) with counterproductive work behaviors such as organizational rule-breaking, disobedience, misconduct, theft, property destruction, absenteeism, tardiness, and poor quality work (Ones & Viswesvaran, 2011).

Persons who score high on *neuroticism* can be often described as sad, moody, and emotionally unstable. They experience much stress, worry about many things, become easily upset, and often feel anxious. Persons who score low on this trait are more emotionally stable, are able to deal well with stress, rarely feel sad or depressed, and are confident and self-assured (Ackerman, 2017; Cherry, 2017). Persons who score high on neuroticism (emotional stability) report greater intentions to quit their jobs (Zimmerman, 2008) and score lower in overall career satisfaction (Ng, Eby, Sorensen, & Feldman, 2005).

Persons who score high on *openness to experience* can be described as imaginative, insightful, perceptive, and curious. They tend to have a broad range of interests and are daring, adventurous, and creative. Persons who score low on this trait tend to prefer routine over variety, dislike change, are resistant to new ideas, and do not prefer abstract or highly theoretical concepts. A combination of conscientiousness, extraversion, and openness to experience is an excellent predictor of career satisfaction (Fuller & Marler, 2009).

Another level of complexity occurs (within attempts to understand the role of individual differences in personality variables) when the interaction between personality variables and *situational factors* is considered (Asendorpf, 2009; Wagerman & Funder, 2009). Here, it is generally recognized by psychologists that how people behave (i.e., what they do) varies as a function of the specific situation they find themselves in. Attempts to accurately define situations must consider both how situational boundaries are delimited (e.g., being in a country vs. being in a grocery store), as well as the subjective perspective of perceivers (e.g., a person with a fear of flying will describe being on an airplane differently from a person who loves to fly) – in addition to many other factors (Wagerman & Funder, 2009). The same person (with a stable personality trait) will often act differently across different situations, and different persons (with different personality traits) will often act differently in the same situation (Asendorpf, 2009).

Religious/Secular Orientation

According to the Pew Research Center (2014), as of 2014, more than 80% of persons identified as being Christian in 3 out of 50 states, 70–80% of persons identified as being Christian in 28 out of 50 states, 60–69% of persons identified as being Christian in 16 out of 50 states, and 50–59% of persons identified as being Christian in 3 out of 50 states.

Out of a little over 5000 adults surveyed (Barna Group, 2016), approximately 75% of Americans claim to have prayed to God in the week prior to participating in the survey. Out of a little over 2000 adults surveyed, approximately 87% of households reported owning a Bible (Barna Group, 2017). Approximately 20% reported being engaged in bible reading more than four times a week in 2017, with roughly 50% of those surveyed reporting that they read, listen, or pray with the Bible on their own at least three to four times a year (Barna Group, 2017).

The meaning of the data on persons identifying as "Christian" can be misleading. Here, it is unknown whether persons who identify as Christian do so because of a superficial identification with "cultural Christianity" or if they have experienced a deep spiritual conversion where their Christian faith occupies a central

position in their lives (e.g., see Forster, 2014; Manno, 2012; Morris, 2016; Wilson, 2015; Zaimov, 2013).

Jews, Muslims, Buddhists, and Hindus are less than 1% of the population in a majority of states. Persons who report being unaffiliated with organized religion (i.e., those who report as atheists, agnostic, or "nothing in particular") are represented between 12% and 36% within each of the 50 states (Pew Research Center, 2014).

Psychopathology

Semantically, the word "psychopathology" is derived from the Greek words "psyche" (meaning soul) and "pathos" (meaning suffering; Rudd, 2014). The American Psychological Association (2017a) defines psychopathological functioning as disruptions in emotional, behavioral, or thought processes that lead to personal distress or block one's ability to achieve important goals (American Psychological Association, as adapted from Gerrig & Zimbardo, 2002). Nearly all definitions of psychopathology share four features in common, which are referred to as "the Four D's": danger, distress, dysfunction, and deviance (Comer, 2013). Human psychopathology is generally thought to arise from within the person, although modern taxonomies allow for symptoms of psychopathology to have their origins in the environment (e.g., post-traumatic stress disorder). Psychopathological states create symptoms that are largely beyond an individual's ability to ameliorate, unless some kind of help is given and received. The term *mental disorder* is commonly used to characterize the different categories of abnormal psychological functioning, and scholars will note that the development and maintenance of mental disorders are influenced by a complex interplay of cognitive, emotional, spiritual, behavioral, and social/relational factors (American Psychiatric Association, 2013; McRay, Yarhouse, & Butman, 2016).

Biophysical disorders are best understood as having their roots in biological or constitutional dysfunctions and/or dispositions that original from genetic, anatomical, physiological, and/or biochemical factors. A sampling of symptoms include unusual and/or debilitating depression, mania, fatigue, lack of concentration, sleep disturbances, and bizarre thought disturbances. The means for diagnosing disorders within this category involve the analysis of genetic histories, as well as medical, neurological, and physical testing.

Intrapsychic disorders are best understood as having their roots in unresolved conflicts, repressed anxieties, and defense mechanisms developed in childhood or adulthood. A sampling of symptoms include intense and debilitating inner feelings of fear, stress, apprehension, worry, dread, or uneasiness. The means for diagnosing disorders within this category involve projective testing and self-report personality testing, as well as the interpretation of data from memory, dream, and free association analyses.

Phenomenological disorders are best understood as having their roots in effects stemming from trauma and/or the thwarting of self-actualization goals. A sampling of symptoms includes the failure to properly distinguish between "life or death" and "everyday" stressors, enduring problems in interpersonal relationships, emotional lability, employment problems, and feelings of helplessness, despair, anger, and guilt. The means for diagnosing disorders within this category involve the interpretation of self-reports of conscious attitudes and feelings.

Behavioral disorders are best understood as having their roots in deficient or maladaptive learning processes. A sampling of symptoms includes problems with being able to abide by the law, a high frequency of substance abuse, and other harmful habits. The means for diagnosing disorders within this category involve the analysis of observed or self-reports of behavior.

A combination of these factors can contribute to the development of mental disorders (McRay et al., 2016). In addition, the task of differentiating one specific mental disorder from another is made more difficult due to the problem of *comorbidity* (the sharing of symptoms from two or more mental disorders).

Criminality

Although many persons have never broken any civic laws, many adult citizens who would be considered "law-abiding" today may have occasionally broken the law in the past during the immaturity and impetuousness of youth. Even adults who are generally law-abiding are guilty of occasional lawbreaking that most would consider to be relatively minor (e.g., getting an occasional speeding or parking ticket, "fudging" on taxes, occasionally taking work office supplies for home use).

In this chapter, individual differences in criminality refer to a continuum that contains these individuals described earlier, to individuals whose day-to-day lifestyles are marked by serious and persistent criminal activities and lawbreaking. Two qualitatively different types of criminal offenders have been identified as *adolescent-limited offenders* (*ALO*) versus *life-course-persistent offenders* (*LCPO;* Moffitt, 2006). The antisocial behavior of ALO has its origins in social processes that occur only during adolescence. ALO engage in relatively minor situation-specific delinquent acts (e.g., underage drinking, being egged on by peers to vandalize a neighbor's house, occasional shoplifting) and only then for short periods of time. ALO are not committed to an antisocial lifestyle, and such behaviors are eventually replaced by more socially appropriate behaviors as they mature into adulthood. In contrast, the behavior of LCPO has its origins in neurodevelopmental processes that begin in childhood and persist throughout adulthood. LCPO commit crimes across a wide variety of settings, and these crimes tend to be considerably more serious compared to crimes committed by ALO. As they become adults, LCPO are more likely to be divorced as adults, to drop out of school before acquiring a degree, and to experience prolonged periods of unemployment and incarceration (Wright, Tibbetts, & Daigle, 2008).

Some psychologists have argued that career criminals (i.e., LCPO) display qualitatively different and entrenched thinking patterns when compared to the thinking of noncriminals (Samenow, 1989, 1998, 2004). These thinking patterns are marked by a deep-seated denial and lack of insight about themselves or the serious nature and/or consequences of their crimes, a view of other people as pawns to be manipulated and used for personal ends, and a view of the environment as an entity whose weaknesses are to be exploited for personal gain (for a concise summary, see Frisby, 2013, Sidebars 8.4 and 8.5, pp. 377–380).

There are a number of considerations that make criminal justice counseling different and qualitatively distinct from "generic" counseling (i.e., counseling noncriminals). For starters, criminal offender counseling and treatment is largely involuntary, compulsory, and legally stipulated (Masters, 2004). Thus, offenders have a built-in incentive to get through treatment as quickly as possible but will often lack any internal motivation to change their thinking, values, and behaviors to any significant degree.

Secondly, the fundamental principle that underlies criminal justice counseling is the *protection of society*, which at times may supercede the fundamental goal of "client wellness" (Masters, 2004). This is because criminal offenders lose certain rights afforded to other citizens as a consequence of their conviction. Following this principle, state law requires criminal justice counselors in many states to break counselor/client confidentiality when clients may discuss intended harm to another person or persons.

Thirdly, the term "rehabilitation" is no longer taken to mean that counselors are responsible for changing the behavior of clients. More realistically, rehabilitation has been replaced by the more modest concept of helping offenders to more smoothly reintegrate into society with the minimum amount of problems and likelihood to re-offend. If any kind of internal change is to happen, it is most likely to occur when counselors work with clients who themselves have hit "absolute rock bottom" in their lives; are in excruciating physical, emotional, or spiritual pain; and are highly motivated to change destructive behavior patterns. The ultimate purpose is to help clients take personal responsibility for achieving law-abiding behavior (Masters, 2004).

Fourth, criminal justice counselors need to be extra vigilant for signs of deception and manipulation from clients, as those clients with entrenched criminal thinking patterns are exceptionally skilled at identifying counselor weaknesses and vulnerabilities in order to manipulate them more easily, telling counselors "what they want to hear" as a means of earning reduced consequences or easier treatment and evading personal responsibility for problems (Samenow, 1989, 1998, 2004).

Addictions

The state of being an addict is qualitatively different from simply misusing substances, as persons can occasionally drink unsafe amounts of alcohol or consume illegal drugs without developing an addiction (Burgess, 2017). Although addicts will experience a physical dependency for a substance (i.e., when the body adapts to the constant presence of a substance, causing physical withdrawal symptoms when it is discontinued), a physical dependency *in and of itself* does not necessarily reflect an addiction (Burgess, 2017). The presence of an addiction is always accompanied by compulsive urges to consume additional amounts of a substance even while consuming the substance (i.e., urges to light another cigarette before the current cigarette being smoked is finished).

Heather (2017) argues that a satisfactory theory of addiction must address three groups of questions, arranged in a hierarchy from the lowest to highest in explanatory power. At the lowest explanatory level are questions related to the manner in which the brain and nervous system adapt to the repeated ingestion of certain drugs (e.g., heroin, cocaine, nicotine, street methadone, crystal meth, barbiturates, alcohol, certain sedatives, amphetamines, marijuana, and caffeine) or to repeated enactments of certain behaviors.

Behavioral addictions (sometimes called "process" addictions) are viewed by some as having symptoms that closely resemble substance addictions (e.g., tolerance, withdrawal, and loss of control issues), as well as requiring methods of measurement that are typically based on DSM criteria. Although many behavioral addictions have not as yet been formally recognized by the DSM-V (American Psychiatric Association, 2013), a number of the following behaviors have received attention in the mental health literature as causing significant addiction problems for persons: gambling, the Internet, food, sexual activities, love, shopping, exercise, work, smartphones, "joyriding," pornography, psychic hotlines, indoor tanning, street gang activities, approval, and Harry Potter books (for citations to these problems, see Heather, 2017).

At the middle explanatory level of addiction theory are reports by addicts of having abnormal desires to use and feel the effects of addictive drugs or behaviors. These desires are typically stronger than an ordinary, everyday inclination to do or ingest something (Heather, 2017, p. 12). Addictive substances induce heightened levels of euphoria, pleasure, physical pain relief, deep relaxation, feelings of invulnerability, feelings of increased social confidence, improvement in cognitive functioning, and increased alertness and focus – all of which either provide increased performance on valued tasks or a temporary escape from the emotional pain and stresses of everyday life.

According to Burgess (2017), severe addicts experience overwhelming urges to continue using a substance after having had only one "hit" of the substance and a feeling of discomfort (similar to bereavement) if they are stopped from having the substance again once the impact of the initial hit starts to subside. Addicts experience cravings and obsessive thoughts about the substances to which they are addicted.

The third and highest explanatory level refers to the central problem called "akrasia" or a "weakness of will" (Davidson, 1980). Here, the addict is acutely aware of the personal, interpersonal, economic, and social problems caused by his/her addiction. Although the addict persistently resolves to give up or reduce drug usage or destructive behaviors, they nevertheless find that they repeatedly break their resolve and return to the problem behavior (Heather, 2017, p. 12). The fact that an addict may be abstinent at any given moment does not necessarily mean that they are

not an addict. Once they return to taking the addictive substance (or engage in the addictive behavior), they are unable to control their intake and will experience the same compulsions (Burgess, 2017).

There are wide individual differences in the factors that predispose or encourage persons to engage in addictive behaviors. Some persons have biological predispositions for certain addictions (Kendler et al., 2012; Schuckit, 2009). Others display personality factors (whether genetically based or not) for impulsivity, sensation seeking, and a high physical tolerance for certain substances that contribute to addictive behavior (Byck, Swann, Schalet, Bolland, & Mustanski, 2015; Cheng et al., 2015). Familial and other social/environmental variables can protect persons with addictive personalities against substance misuse or can raise the risks for engaging in such behaviors (Hicks et al., 2013; Dick et al., 2013).

Interventions for Addictive Behaviors *Psychoeducational interventions* are designed to help addicts understand and increase their awareness of the cognitive, emotional, and physical dynamics of their cravings (Bickel, Yi, Landes, Hill, & Baxter, 2011; Burgess, 2017). *Pharmacotherapies* are interventions that involve the administration of pharmaceutical drugs that are helpful in preventing withdrawal symptoms and reducing cravings in drug-addicted individuals (Lee, Kresina, Compopiano, Lubran, & Clark, 2015). Pharmacotherapies are most effective when combined with counseling and other psychological and social services (Anton et al., 2006; De Sousa, 2010) – as they can assist clients to hold jobs, avoid street crime, and reduce exposure to sexually transmitted diseases. *Behavioral therapies*, including individual, family, or group counseling, are the most commonly used forms of drug abuse interventions. Such therapies may involve a focus on a client's motivation to change, providing incentives for abstinence, building skills to resist addictive behaviors, replacing addictive behaviors with more constructive and personally rewarding activities, developing and improving problem-solving and mindfulness skills, and facilitating better interpersonal relationships (e.g., Chiesa & Serretti, 2014; Petry, Barry, Alessi, Rounsaville, & Carroll, 2012; Petry, Martin, Cooney, & Kranzler, 2000; Schumacher et al., 2007).

When considered together, these interventions underscore how the descent into addiction and recovery from addiction are determined by the complex interplay of individual differences and not "one-size-fits-all" biological explanations or pharmacological "silver bullets." Satel and Lilienfeld (2014) summarize this point as follows:

> Like many misleading metaphors, the brain-disease model contains some truth. There is a genetic influence on alcoholism and other addictions, and prolonged substance-abuse often damages brain structures that mediate self-governance. Yet the problem with the brain-disease model is its misplaced emphasis on biology as the star feature of addiction and its relegation of psychological and behavioral elements to at best supporting roles … The clinical reality is just the opposite: The most effective interventions aim not at the brain but at the person. It's the *minds* of addicts that contain the stories of how addiction happens, why people continue to use drugs, and, if they decide to stop, how they manage to do so. This deeply personal history can't be understood exclusively by inspecting neural activity … . [T]he daily work of recovery, whether or not it is abetted by medication, is a human process that is most effectively pursued in the idiom of purposeful action, meaning, choice, and consequence. (p. 8)

Individual Differences in Psychological Services

Timing of Prevention Efforts

One method of understanding individual differences in mental health/psychological services received is to examine differences in the timing of interventions relative to the chronological progression of disorders. *Primary prevention* activities seek to improve the emotional, physical, mental health, and psychological well-being and functioning of all persons (McRay et al., 2016). Primary prevention activities that affect individu-

als, but are farthest removed from individuals, include the provision of meaningful and gainful employment, insuring adequate nutrition and health maintenance resources, and improving educational delivery systems for the broadest array of the general public. *Secondary prevention* activities seek to reduce the impact of a problem or disorder once it has manifested itself, by treating it as soon as possible in order to halt or at least retard its progress. Methods used to accomplish this goal include early detection and screening activities (McRay et al., 2016). *Tertiary prevention* activities seek to reduce or "soften" the impact of a condition that is ongoing or has lasting effects, through activities designed to reduce relapses and/or recidivism, and improve treatment effectiveness or treatment compliance (McRay et al., 2016).

Content and Methods of Assessment

A fundamental skill of the psychologist is to gather useful information necessary or helpful for understanding the complex dynamics of cases and ultimately helping clients. Which assessment procedures or instruments are used depends on individual differences in the complex interaction of caregiver, client, case, and situational characteristics. Psychologists use their skills in *clinical observation* to systematically observe client behavior in structured or unstructured situations that are relevant to presenting problems. *Behavioral checklists and rating scales* can be completed by third parties who are familiar with clients' functioning in clinically relevant contexts. *Structured or semi-structured clinical interviews* can be administered directly to clients or to knowledgeable persons in the client's social or academic environment. *Standardized psychological tests* (of knowledge, skill, or self-reports of behavior, attitudes, or personality characteristics) are tasks that are administered to clients under a standard set of conditions. Scores can be compared to averages from a larger more representative group of individuals or against a clinically relevant standard (for a more detailed discussion of these methods, see Cipani & Schock, 2010; Groth-Marnat & Wright, 2016; Sattler, Dumont, & Coalson, 2016; Sommers-Flanagan & Sommers-Flanagan, 2017). Each subspecialty within applied psychology is unique in the ways in which assessment information and practices answer questions of specific interest to the subspecialty. An example is provided below for forensic psychology.

Forensic Evaluations The work of clinicians engaged in forensic evaluations (assessment used to aid legal fact finding) is guided by a set of qualitatively narrower and considerably more focused concerns, as compared to the work of clinicians seeking answers to general questions about broad cognitive, personality, or and/or mental health functioning (Melton, Petrila, Poythress, & Slobogin, 2007). Select examples of forensic evaluations include, but are not limited to, child custody, insanity defense, risk for future violence, competency to stand trial, and fitness for incarceration evaluations.

Gaining an understanding of the client's unique perspective is the primary focus in most professional clinical/therapeutic relationships. In contrast, the primary client in forensic evaluations is the referring party (i.e., attorney, court, employer, or insurer). In these situations, the forensic examiner is concerned primarily with providing the referral source with information about the examinee that it might not otherwise have or be able to obtain (and the examinee's unique perspective is secondary). In forensic fact-finding, the professional interaction is not voluntary, as examinees must submit to evaluations at the request or direction of a third party (e.g., attorney, judge, insurer, or employer) in the context of a legal matter. The objectives and assessments used in forensic evaluations are determined primarily by pertinent statutes or by the issues inherent in the legal dispute. If the examinee has knowledge of how evaluation outcomes connect to legal outcomes, there is an increased incentive for the examinee to distort information in the service of a perceived favorable outcome. In forensic evaluations, the clinician is not ethically bound to nurture the

examinee's perception that they are caring or empathetic. Thus, there is typically more "emotional distance" between the examinee and clinician in forensic evaluations compared to non-forensic evaluations. Since forensic evaluations are constrained by court schedules and time constraints, these evaluations may need to proceed at a more brisk pace and with fewer opportunities for lengthy or frequent evaluation sessions (Melton et al., 2007).

Varieties of Therapies

Just as there are a wide variety of assessment techniques that can be used by professional psychologists to gather useful information, psychologists rely on a wide variety of interventions to assist clients in need. Listed below are some of the common categories within which psychological interventions can be grouped.

Talking (Insight) Therapies As the title suggests, therapies within this category are delivered primarily through verbal discussions carried out between the client and a clinician. The intended purpose is to facilitate client insights that will lead to a change in behavior or a reduction in symptoms.

Psychoanalysis proper is the name given to an intensive form of treatment utilizing sessions that occur three to five times per week for 3–7 years by a certified psychoanalyst (Gelso, Williams, & Fretz, 2014). Here, the analyst typically (but not always) sits behind the client, while the client (called an "analysand") reclines on a couch and "free-associates" (i.e., says whatever comes to his or her mind without editing) or reports on the content of their dreams. The task of the analyst is to suggest interpretations that are close to the client's conscious awareness and experience. The overall goal is to bring the client in touch with motivations and wishes of which s/he is only partially aware or completely unaware before treatment (p. 5).

Psychoanalysis proper can be distinguished from *psychoanalytically oriented therapy* (Gelso et al., 2014), which designates a broader category of interventions. Here, the client and therapist meet for sessions once or twice a week for a few sessions to several years at maximum. In these sessions, the client and therapist usually sit face-to-face. The therapist can be a certified psychoanalyst; however, they may also be psychologists, psychiatrists, counselors, or psychiatric social workers who are not analysts but who have training in psychoanalytic treatment (Morris, Javier, & Herron, 2015, p. 293).

Psychodynamic theories assume that underlying feelings, ideas, impulses, and drives influence overt behavior. These underlying processes, more often than not, exist at the unconscious level. Persons will typically use defense mechanisms to keep anxiety-provoking feelings, ideas, and impulses out of conscious awareness. The word "psychoanalytic," when used as a descriptor for different approaches to treatment, can be characterized by the following common elements (Gelso et al., 2014, p. 303):

1. Human reactions are caused by intrapsychic factors (psychic determinism).
2. Early childhood crucially determines personality, psychological health, and psychopathology. (3) Development occurs in psychosexual or psychosocial stages.
3. Unconscious processes are crucial determinants of behavior.
4. Threatening internal impulses are repressed by unconscious defenses.
5. Humans tend to repeat in the present unresolved issues from the past.
6. The client/therapist relationship is of central importance, especially the working alliance and transference components of the relationship.
7. Interpretation is the key technique of insight-oriented therapy, as insight is the key internal mechanism that instigates and represents change in behavior.

Humanistic-experiential approaches are an outgrowth of dissatisfaction with and severe criticisms of psychoanalytic and behavioral approaches as too deterministic and mechanistic, respectively (Gelso et al., 2014). Humanistic psy-

chology has also been referred to as *phenomenological psychology* (i.e., the psychological study of subjective experience; Langdridge, 2007). Psychologists operating from a phenomenological perspective consider each client to be unique, thus requiring unique approaches to treatment. However, humanistic psychologists see humans as motivated by innate drives toward personal growth – culminating in what Abraham Maslow calls self-actualization (Maslow, 2014). The basic assumptions that run through most humanistic-experiential therapies can be summarized as follows (adapted from Cordón, 2005, pp. 104–105):

1. The therapist does not function as an expert whose function is to provide a cure.
2. Treatment is best described as an encounter between equals, the intent being to assist clients with their own natural growth.
3. Under optimal conditions, people will get better on their own. The therapist's job is to create those conditions.
4. The therapist's role is to help clients feel accepted and welcomed as a human being without any judgment (*called unconditional positive regard*; Rogers, 1951).
5. The role of the therapist is not to tell the client what to do. It is up to the client to decide how to think and behave (a central tenet of *client-centered therapy*; Rogers, 1951).
6. The therapist employs the techniques of active listening, making eye contact, nodding, reflection, and paraphrasing what the client has said. For a more detailed discussion of humanistic-experiential therapies and related empirical studies, see Barlow (2014), pp. 107–112.

Behavioral Therapies While psychoanalytic theories view disturbances in functioning as originating from within the person, behavioral interventions view disturbances as having their source in suboptimal environmental contingencies. However, behavioral interventions vary considerably as a function of the relationship between overt behavior and inner cognitive processes (Gelso et al., 2014). *Applied behavior analysis* is the name given to a scientific discipline concerned with the application of learning principles for changing behavior, primarily by assessing the functional relationship between a targeted behavior and the environment. Once this is done, then intervention plans are developed that provide for new learning opportunities for the client. These learning opportunities may include learning new behavior/reinforcement associations, extinguishing maladaptive behaviors, and/or learning new adaptive skills (Nezu, Martell, & Nezu, 2014).

Neobehavioristic mediational stimulus-response models (Gelso et al., 2014) make use of learning theories but allow for mental processes that occur within the client. In the use of *systematic desensitization techniques*, for example, clients use mental imagery to visualize scenes that arouse anxiety and then practice responses that lessen anxiety feelings (Choy, Fyer, & Lipsitz, 2007).

Social-cognitive models (Gelso et al., 2014) see behavior as function of interactions between external stimuli, external reinforcement, and cognitive mediational processes. However, the manner in which the environment affects behavior differs as a function of how persons uniquely perceive and interpret environmental events and stimuli. In these models, the person is seen more as the fundamental agent of change, rather than as a passive recipient of stimuli (p. 327).

Cognitive-behavioral therapy (*abbreviated CBT*) is the name given to an overarching category of psychotherapeutic approaches that emphasizes the role of cognitions as these impact both feelings and behavior (Sperry, 2010). Although several different approaches and/or models of CBT exist, all share the following common characteristics (pp. 28–9):

1. Clients' emotions and behaviors are influenced by their beliefs and thoughts. The goal of therapy is to help clients unlearn unwanted responses and to learn new ways of responding to life's challenges.
2. Therapists typically take a more directive role in setting session agendas, determining and

planning in advance what is discussed during sessions, and actively directing discussions of specific topics and tasks.
3. Therapists teach clients skills necessary for helping them cope more effectively with difficult situations.
4. Therapists engage in explicit discussions of the rationale for treatments and the specific techniques being used.
5. Homework and between-session assignments and activities are provided in order to give clients opportunities to practice skills learned.
6. Therapists engage in discussions with clients about the impact of clients' present maladaptive thoughts on current and future functioning.

In summary, the attention given to the modification of overt behavior is a fundamental feature of all behavioral approaches, regardless of where they fall on the behavior-cognition continuum. Even cognitive-behavioral therapies that put significant emphasis on cognitions are considerably more behaviorally oriented than psychoanalytic therapies.

Religious and Spiritual Therapies Wide individual differences exist in scholars' views as to the appropriate interface between religious institutions and "secular" psychological interventions – as well as the appropriate interface between secular psychological/mental health institutions and interventions that integrate religious concepts (Worthington, Hook, Davis, & McDaniel, 2011). On one end of this continuum is advocacy for the idea that the physical, psychological, and spiritual aspects of man are to be kept separate. What naturally follows from this perspective is the conviction that churches (synagogues, temples, mosques, etc.) are relevant only to the spiritual component of persons (see McRay et al., 2016, p. 25), while secular institutions have the expertise for addressing the physical and psychological aspects of persons. Both secular and religious scholars argue that the rigid compartmentalization of the physical, psychological, and spiritual aspects of man is misguided (Greggo & Sisemore, 2012; Worthington et al., 2011). This view acknowledges that many medical conditions that originate from the physical component of persons can only be understood and treated by professionals who possess the appropriate medical training. However, there is an integration of these perspectives. In both religious teaching and "secular" research, for example, adherence to the biblical concept of forgiveness is acknowledged to have psychological benefits (Enright & Fitzgibbons, 2015; Jeffress, 2000; Toussaint, Worthington, & Williams, 2015; Worthington & Sandage, 2015).

A thorough treatment of different views from the perspective of Christian writers on the integration of a biblical worldview with secular psychology is beyond the scope of this chapter (e.g., see Entwistle, 2015; Greggo & Sisemore, 2012; Moriarty, 2010). However, even secular psychology acknowledges (to some degree) religious or "faith-based" perspectives in counseling and therapy (for an opposing viewpoint, see Cummings, O'Donohue, & Cummings, 2009). For example, the term "religious and spiritual therapy" (RST) can be defined as the use of existing therapies that take into account the religious beliefs and insights of the clients. There are a number of different approaches to this type of therapy (see Hook, Worthington, Davis, Jennings, & Gartner, 2010). One approach maintains the features of the secular theory/therapy but places the therapy within a religious context (e.g., using biblical teaching and religious imagery with cognitive restructuring and guided imagery techniques; following a five step program for forgiving others that encourages clients to draw from their religious beliefs and/or draw on religious sources of support; integrating Buddhist principles with cognitive-behavioral treatments). Alcoholics anonymous therapies employ a 12-step format (see Hazelden Betty Ford Foundation, 2016), in which the steps represent a set of succinct guiding principles that purportedly outline a course of action to follow in life for dealing with alcoholism, drug addiction, and related compulsive behaviors. At least five of

these steps make explicit reference to "God as He is understood" or a "higher power." Other approaches encourage clients to discuss religious issues in the context of therapy (e.g., reading verses from the Koran; using the Prophet Mohammed as a model for changing one's lifestyle; or encouraging clients to pray; discussing eating disorder issues from a Christian perspective). Some approaches are rooted in body/muscle relaxation techniques that encourage clients to pray and/or meditate on scripture passages.

Intersection of Ethnicity and Multiculturalism There may be occasional instances in which clinicians must struggle with ethical tensions between multicultural principles promoted by cultural competence curricula, versus deeply held ethical principles that they hold personally (e.g., how should a physician respond to a parent's request for a clitorectomy for their young child?; Paasche-Orlow, 2004, p. 349). There may be individual differences among clinicians in the salience of this struggle in their professional decision making and how such struggles are ultimately resolved in specific circumstances. Paasche-Orlow (2004) describe the following four movements in Western moral theory that are implicit in these ethical tensions:

Absolutism holds that moral truths exist which are independent of culture, are "self-evident," and which transcend the confines of geographical locations, people groups, or time (e.g., "It is always wrong under any circumstances to remove the clitoris from a young child"). *Fundamentalism* holds that a basic constellation of human rights exists which may be articulated differently in different cultural groups, but are nevertheless shared in common by all cultural groups (e.g., "All groups agree that removing the clitoris from a young child is wrong"). *Multiculturalism* (or *Relativism*) holds that different cultural groups have different moral systems that guide values, thinking, and behavior (e.g., "In some groups, it is morally OK to remove the clitoris from a young child, but in other groups, it is not"). *Postmodernism* holds that all views held by different cultural groups are equal in principle and thus have equivalent moral worth (e.g., "Removing or not removing the clitoris from a young child are morally equivalent positions, as no position is inherently more moral than another position").

Individual Differences in Treatment Success or Failure

There can be any number of reasons why psychological or mental health treatments fail (for a thorough discussion, see Sperry, 2010). *Client factors* include difficulties caused by the client's disturbed personality dynamics, transference problems, treatment refusal, therapy resistance, chronic missing of appointments or habitual late arrivals to treatment, and failing to do homework between sessions. *Therapist factors* include problems with countertransference, inaccurate case conceptualization, failure to use appropriate assessments or selection of inappropriate assessment instruments, difficulties caused by conflicts of interest, therapist/client boundary violations, or breaches of confidentiality. *Treatment and intervention factors* include client comorbid conditions that may disrupt treatment effectiveness, clients' financial limitations, clients being arrested, or clients relapsing into drug use that may cause premature termination. Conversely, the success of treatment can logically be attributed to the absence of some or most of these factors.

Concluding Thoughts: Is Race/Ethnicity Primordial?

The science of individual differences holds that every human being is different (to some unspecified degree) from every other human being along multiple dimensions, even when they may belong to the same racial group (LoConto & Francis, 2005; Thao, 2005; Worrell, 2005), grew up in the same country (Soto-Crespo, 2009; Wilkinson, 2008), were raised in the same family (Plomin, Asbury, & Dunn, 2001; Plomin &

Daniels, 2011), or are identical twins (McKie, 2013; Miller, 2012).

It is indeed laudable that the Ethics Code of the American Psychological Association encourages psychologists to respect and honor individual differences as a function of clients' group membership (e.g., see Barnett & Sedrak, 2017; but see also O'Donohue, Chapter 5 this text, for problems with this). Unfortunately, even when psychologists acknowledge differences between a person from Group A and a person from Group B, this in itself is limited as to what can be generalized – as the very process of drawing inferences about differences between these two individuals can erroneously assume homogeneity within each of their respective groups.

Between-person individual differences are not the only variable of interest for applied psychologists. People also differ in the circumstances that ultimately result in a face-to-face interaction with a caregiver. Some individuals have limited autonomy and are brought to therapists by their parents or by the court system. Others experience devastating crises that drive them to a therapist's office, and cost is of no concern for them. Others are sincerely puzzled by an unexpected life event and see the therapist as having the necessary key to "unlock the puzzle" for them.

The quality of help that is received differs for individuals among many dimensions. Some receive therapy for as little as one or two sessions to as long as 1 or 2 years. Some just sit in a therapist's office and talk, while others are required to complete strict behavioral regimens outside of therapy as a condition for continued service. Some enjoy private meetings with their therapist, others must complete therapy with a spouse, and still others experience therapy with a small group of compatriots who are in the same life circumstance as they are.

The previous material has provided a brief sampling of the many ways in which persons differ in variables that are relevant to caregiver/client interactions in applied psychology. The material presented in this chapter barely "scratches the surface," as many more clinically relevant individual difference variables could have been discussed were it not for page limitations.

Individual differences within human groups, therapist characteristics, and mental health service variables are often considered to be "irritating noise" (e.g., see Kanai & Rees, 2011) in the quest to oversimplify the nature of psychological services as being solely a function of clients' racial or ethnic characteristics. This is not surprising, as the consideration of individual differences is more difficult to study and challenges the validity of vague generalizations, easy recipes, and lazy stereotypes. Despite its laudable intentions, cultural competency advocacy is particularly vulnerable to this trap.

The Primordial Nature of Race? Weinrach and Thomas (2002) offered a trenchant critique of the multicultural counseling competencies created by the Association for Multicultural Counseling and Development for members of the American Mental Health Counseling Association and other counseling practitioners (Arredondo et al., 1996). One among many of the conceptual flaws they discussed in the competencies was the underlying philosophy of the "primordial nature of race" (p. 33).

The term "primordial" derives from the Latin words *primus* (meaning "first") and *ordiri* (meaning "to begin"). Primordial means the state or quality of being "first," "earliest," "basic," or "fundamental." As examples, persons may apply this concept to beliefs that God is the *primordial* entity in all of existence, the solar system is *primordial* in creation, cells are *primordial* in the formation of individual organisms, and the *primordial* needs of human beings are for air, food, and water.

There are articulate voices outside of applied psychology that argue in support for the primordial nature of race and ethnicity. For an example of this viewpoint, Taylor (2011) reviewed decades of social observations on race and ethnic relations in the United States. An undeniable theme in his review is the utter failure of America's efforts to promote racial integration along the

lines of Martin Luther King's *I Have A Dream* speech – as well as America's failure to achieve equal racial/ethnic outcomes (e.g., in academic achievement, employment, housing, educational attainment, crime, and income statistics). His analyses led him to conclude that racial diversity is a fundamental source of conflict rather than strength; people of all races generally prefer the company of people like themselves; Whites must begin to develop a consciousness of group identity similar to racial minorities; the celebration of "diversity" is a mind-set that inherently works contrary to White interests; and efforts to create a racially and ethnically harmonious society are an exercise in futility (pp. 286–295).

In applied psychology, the move toward "social justice" as a fifth force in counseling psychology (Chung & Bemak, 2012; Crethar, Lewis, Toporek, & Hutchins, 2013; Ratts, 2009) is an implicit endorsement of the primordial nature of race/ethnicity, as gleaned from the unilateral designation of all nonwhite, non-English speakers as members of oppressed groups (D'Andrea & Daniels, 1999, 2001; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016).

The material from this chapter argues against this position for applied psychologists. The evidence for this argument comes directly from the core competencies inherent within each of the many subspecialties within applied psychology. For the school psychologist, the accurate interpretation of psychometric data that would qualify a student as eligible for special education services is "primordial." For the geriatric psychologist, teaching elderly clients how to successfully manage their personal affairs while coping with the ravages of Alzheimer's disease is "primordial." For the Christian counselor, encouraging the client's adherence to biblical teaching in working through life's problems is "primordial." For the college mental health counselor, finding the best combination of compassion and sensitivity for helping young female students cope with the devastating consequences of a campus rape is "primordial." For the addiction counselor, guiding the client to a prolonged state of permanent sobriety is "primordial." For the forensic psychologist, marshalling one's clinical skills to make an accurate assessment of a client's suitability for gaining custody of his/her young children is "primordial." For the mental health counselor on a suicide hotline, doing what is necessary to prevent a client from committing suicide is "primordial."

Obviously, when clients speak a language that is different from the language spoken by a caregiver, language is indeed "primordial" – in the sense that no progress can reasonably be expected to occur unless there is a matching of language skills between the client and the caregiver. However, cultural competency advocacy implies that there is something so primordial about race and ethnicity in and of itself, that psychologists must master a qualitatively different set of competencies (over and above the competencies that are central to their specialty) in order to be effective.

Given what is known about the staggering array of individual differences in psychological specialities, service settings, theoretical orientations of caregivers, and clients, the primordial nature of race and ethnicity may very well be a moderating or interactive variable. That is to say, race and ethnicity may be a primordial factor only for certain conditions, certain presenting problems, certain settings, certain clients, and certain circumstances – but not for others. The burden of proof, however, is for cultural competence advocacy to clearly, consistently, and above all *empirically* establish such relationships – if they can be established at all.

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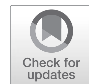

15 Poverty: Implications and Strategic Options for Applied Psychologists, Clinicians, and Service Providers

Gloria M. Svare and Jeanne Wendel

Poverty: Implications and Strategic Options

Poverty is associated with both low education and adverse health outcomes (Zonderman, Mode, Ejiogu, & Evans, 2016) for all demographic groups. These disparities in education and health outcomes pose substantive challenges for social policy and for practitioners working to help all individuals achieve high-quality education and health outcomes. The documented correlation between health, income, and education raises serious concerns about both inequality issues and pragmatic strategies for ameliorating the impact of low income and low education on health.

We will begin by considering the federal definition of poverty and statistics on the incidence of poverty in the United States. In Section I of this chapter, we will examine statistical evidence that provides insight about the causes, duration, and consequences of poverty and the array of systemic factors and individual behaviors linking poverty, education, and health. In Section II, we will consider the question: why is it so difficult to achieve good outcomes for individuals with low income and low education? We focus on studies addressing health outcomes to streamline the discussion; parallel issues face professionals working in education. We discuss five pathways by which system-level issues constrain individual decisions and behaviors and the implications of these constraints for professionals providing services to individuals and families with low income and low education.

Federal Definition of Poverty

The US government publishes an income-based definition of poverty, to provide a starting point for delineating eligibility for federal programs. As shown in Table 15.1, a single adult supporting a child would be living in poverty, if he or she earned less than $15,930 per year in 2015. Relevant earnings include earned income before taxes and tax credits but exclude capital gains and noncash benefits such as Supplemental Nutrition Assistance Program (SNAP) benefits and assistance from housing programs.

An adult living in a one-person household who worked full-time in a minimum wage job would not meet this criteria for "living in poverty" (see Table 15.2), and two adults living in a two-person household and working full-time in minimum wage employment would not be considered to be living in poverty. However, a

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full-time working adult supporting a non-working child with full-time work at the minimum wage would meet the criteria for "living in poverty." This definition assumes that the household does not own substantial assets such as a house or financial assets.

Who Lives in Poverty?

Based on this definition of poverty, US Census data indicates that 46.7 million people (or 14.8% of the population) lived in poverty in the United States in 2014. The poverty rate for children is higher than the rate for adults: 21.1% of children under age 18 lived in households with income below the federal poverty line, 13.5% of working-age adults lived in poverty, and 10% of individuals age 65 or older lived in poverty. The 2014 incidence of poverty varies across demographic groups:

- Ten percent of whites and Asians lived in poverty, compared to 24% of blacks and Hispanics.
- Fourteen percent of native-born citizens lived in poverty, compared to 24% of foreign-born noncitizens.
- Seven percent of full-time year-round workers lived in poverty, compared to 16% of people who worked less than this amount.
- Twelve percent of individuals age 18–64 with no disability lived in poverty, compared to 29% of individuals of similar age who have a disability.
- Five percent of adults age 25 or older with bachelor's degrees lived in poverty, compared to 29% of adults in this age category who did not have a high school diploma.
- Six percent of married-couple families lived in poverty, compared to 31% of households headed by single females.

It is important to interpret these percentages carefully. Consider, for example, the fact that 24.2% of foreign-born noncitizens lived in poverty in 2014. This does not imply that foreign-born noncitizens constituted a high proportion of all individuals living in poverty. Instead, foreign-born noncitizens accounted for only 12% of all individuals living in poverty. The difference between the two percentage numbers (24% vs. 12%) occurs because foreign-born noncitizens only constitute 12% of the US population. (See Box 15.1.)

Table 15.1 2015 Poverty Guidelines: 48 contiguous states and the District of Columbia

Persons in family/ household	Poverty guideline
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8 or more	40,890 + $4160 for each person above 8

Office of the Federal Register https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines#t-1

Table 15.2 Annual income in full-time minimum wage employment

Federal minimum wage = $7.25/hour	*	40 hours/week	*	52 weeks/year	=	$15,080/year

Box 15.1 Interpreting Statistics Carefully

% of individuals living in poverty who are foreign-born noncitizens

vs.

% of foreign-born noncitizens who are living in poverty

		Total	Number living in poverty	Percent living in poverty
Native born		273,628	38,871	14%
Foreign-born noncitizens				
	Naturalized citizens	19,731	2347	12%
	Noncitizens	**22,444**	**5439**	**24%** =100*(5439/22,444)
Column total		315,803	**46,657**	15%
% of individuals living in poverty who are foreign-born noncitizens			**12%** = 100*(5439/46,657)	

Source: DeNavas-Walt, Carmen and Bernadette Proctor. Income and Poverty in the United States: 2014. Current Population Reports. September 2015. P60–252. Table 3: People in Poverty by Selected Characteristics: 2013 and 2014

Section I: Causes, Duration, and Consequences of Poverty

Income is correlated with a broad array of health and education measures, and it is also correlated with behaviors (such as smoking). The relative roles of individual decisions and system-level factors underlie substantive debates about policy strategies for addressing inequality issues in society. We focus here on the relationship between income and health, as we examine evidence about the roles of behaviors and system-level factors. However, parallel issues underlie the relationship between income and education, and the factors that underlie the two correlations (income and health, income and education) intertwine.

Correlation Between Income and Health

Social Security data indicates that life expectancy is significantly correlated with income. A 60-year-old male born in 1941 with earnings in the top half of the distribution could expect to live another 25.4 years, while his counterpart with earnings in the bottom half of the distribution could expect to live only 19.6 additional years (Waldron, 2007). In addition, this life expectancy gap has been growing over time. From 1972 to 2001, 60-year-old males in the top half of the US income distribution gained 6.5 years of remaining life expectancy, while males in the bottom half of the income distribution gained only 1.9 years (see Fig. 15.1). This issue is not unique to the United States: health disparities by education and income have also been documented in other developed nations with well-established systems of single-payer universal health insurance coverage (see, e.g., Currie and Stabile (2003), Johnson and Schoeni (2007)).

At a more granular level, the Centers for Disease Control and Prevention (2013) reports data for a wide array of types of process and outcome measures. The association between low educational attainment and health reflects an array of factors, including levels of health insurance coverage, compliance with screening recommendations, health status, healthy behaviors, and successful self-management of chronic conditions. (See Table 15.3).

This correlation between income and health is troubling. Financial inequality has received notable news media attention; however, this evidence suggests that health inequality is also

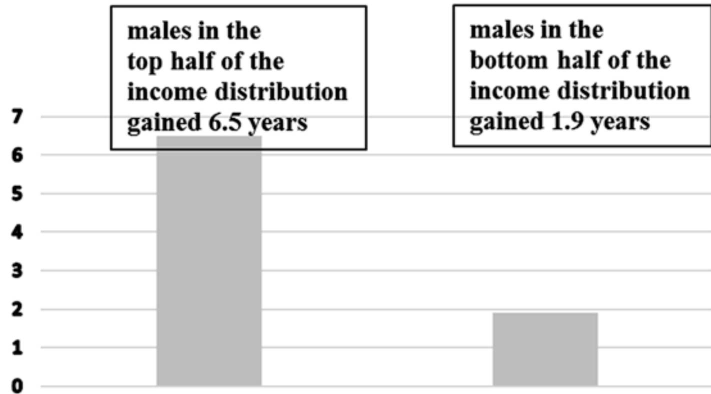

Fig. 15.1 Increase in expected remaining years of life for males attaining age 60 in 1972 vs. males attaining age 60 in 2001 (Data for male workers covered by Social Security; Source: Waldron, 2007)

Table 15.3 Process and outcomes measures of health disparities

	Age-adjusted prevalence	
	Income	
Sample measures	**< 100% federal poverty level**	**> = 400% federal poverty level**
Financial barriers to health care: no health insurance during 2014 (Table 105)	23%	4%
Screening recommendation compliance: colorectal cancer screening up to date, age 50–75, 2013 (Table 072)	41%	63%
Health status		
Diagnosed and undiagnosed diabetes, age >= 20, 2011–2014 (Table 040)	12%	6%
Self-rated health fair or poor, adults, 2014 (Table 045)	20%	4%
Successful management of chronic conditions: glycemic control, age >= 20, 2011–2014 (Table 040)	27%	14%
	Education	
	< high school diploma	**> = college degree**
Behavioral issues: current smoking among adults age >= 18 (Table 047)	24 %	7 %

Source: Centers for Disease Control and Prevention. Health, United States, 2015 – Individual Charts and Tables. http://www.cdc.gov/nchs/hus/contentws2015.htm#040

an important issue. The correlation between income and health raises two important questions:

- Does poverty "cause" poor health, does poor health "cause" poverty, or are the two variables correlated because they are both caused by more fundamental factors?
- Does the correlation between income and health reflect the consequences of individual behaviors, or does the correlation reflect the action of system-level factors that lie outside the control of individuals?

The term "health disparities" summarizes the relationship between health, income, and education. People with low income have lower life expectancies than people with high income (see Fig. 15.1), and an array of additional evidence indicates that the people with low income and low education tend to have lower health status across a wide set of health measures. Prominent organizations now target the reduction of health disparities as a high-priority goal:

- The American Psychological Association designated the issue of health disparities as

one of "society's grand challenges" (Kazdin, 2008).

- Healthy People 2020 articulates four overarching goals, including "*achieve health equity, eliminate disparities, and improve the health of all groups*" (CDC, 2013).
- The National Institutes of Health is placing increased priority on research to understand and reduce health disparities: "*Two decades of work to bring attention to the unequal burden of illness and death experienced by racial and ethnic minorities, rural and poor populations in this country has culminated in the creation of the National Institute on Minority Health and Health Disparities at NIH*" (National Institute on Minority Health and Health Disparities, 2015).
- The Federal Reserve System's Healthy Communities Initiative aims to facilitate coordination among community-level programs, to tackle socioeconomic causes of health disparities (Federal Reserve Community Development Resources, 2018).
- The American Academy of Pediatrics designated poverty and child health as a strategic priority in 2013. In answer to the question, "*Can Pediatricians do anything to help reduce the negative impact of poverty on child health?*", *this group urges pediatricians to address this issue at the practice level, the community level, and the policy level:*
  - "*Acknowledge the facts about child poverty in your own community, including existent disparities,*
  - *Determine if there are any potential practice changes that you can make,*
  - *Work with community agencies directly or through your state chapter,*
  - *Advocate, advocate, advocate!!!*" (American Academy of Pediatrics, 2013)

Individual Behaviors, System-Level Factors, and Interactions Between the Two

Designing effective strategies to accomplish the goals articulated by these groups requires a clear understanding of the mechanisms that underlie the correlations among health, income, and education. Researchers have used several strategies to estimate the degree to which the correlation between poverty and health reflects individual behaviors and system-level factors that lie outside the control of individuals.

Life expectancy in the United States increased substantially during the 60 years from 1950 to 2010: life expectancy at birth increased 16%, from 68 to 79 years. Using statistical analysis of a large dataset, Cutler, Rosen, and Vijan (2006) conclude that 90% of this gain in life expectancy stems from reductions in infant mortality and deaths from car-

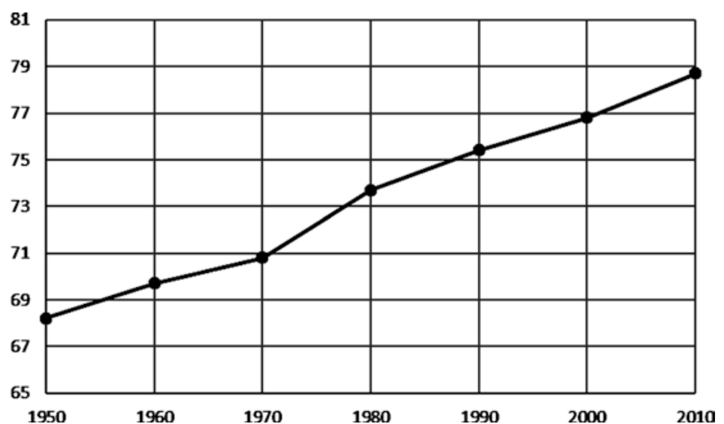

Fig. 15.2 Life expectancy at birth 1950–2010 (Source: http://www.cdc.gov/nchs/data/hus/2011/022.pdf)

diovascular disease. For example, infant mortality decreased 72% during the years 1950–1990 (Cutler & Meara, 1999). Analysts have used a variety of strategies to examine the relationship between an individual's income and the extent to which that individual benefited from the life expectancy gains of the last half century (Fig. 15.2).

Cutler et al. (2006) present evidence indicating that the answer to this question is multifaceted. Half of these gains are estimated to stem from improvements in healthcare technology, while the remaining portion of the gains stem from changes outside the healthcare system. Thus, we must consider both characteristics of the healthcare system and factors that lie outside that system. Grossman (1972) provides a framework for analyzing the wide array of factors that impact health. He draws an analogy between the production of manufactured goods, such as cars, and the production of health.

- Cars are produced by assembling a diverse array of inputs to produce engines, tires, seats, sound systems, windshields, and car bodies. Some of these inputs are produced by the auto manufacturer, while others are produced by independent companies. Each of these production processes relies on infrastructure goods and services such as reliable electricity, highway and rail transportation, and an educated workforce.
- Health is also produced by combining a diverse array of inputs supplied by individuals (e.g., diet and exercise), healthcare providers (e.g., healthcare visits and assistance with at-home self-management of chronic conditions), and communities (e.g., safe drinking water and public safety measures). In addition, an individual's health is also shaped by genetic factors that lie outside the control of all of these entities.

McGinnis, Williams-Russo, Knickman et al. (2002) tackled the question: what portion of early deaths reflect individual behaviors, and what portion reflect factors outside the control of individuals? These authors conclude that differential behavior patterns account for the 40% of early deaths, while the remaining early deaths are triggered by factors that are not controlled by individuals. These authors also caution (Fig. 15.3):

> *"… more important than these proportions is the nature of the influences in play where the domains intersect. Ultimately, the health fate of each of us is determined by factors acting not mostly in isolation but by our experience where domains interconnect."* (McGinnis et al., 2002, p 83)

Individual Behaviors that Contribute to Health Disparities

Individuals and families produce health through diet and exercise, avoidance of risky behaviors such as smoking, at-home activities that contribute to chronic disease management, and appropriate utilization of preventive healthcare services. Family members also provide parenting for children and home-based caregiving services for family members with adverse health conditions. Unhealthy behaviors that contribute to early deaths include smoking, drinking alcohol, using drugs, engaging in unprotected sex, and failing to adhere to regimens that include healthy diets and exercise. Moreover, correlations between income, education, and these health behaviors are well established: compared with individuals with higher levels of income and education, people with low income and education are

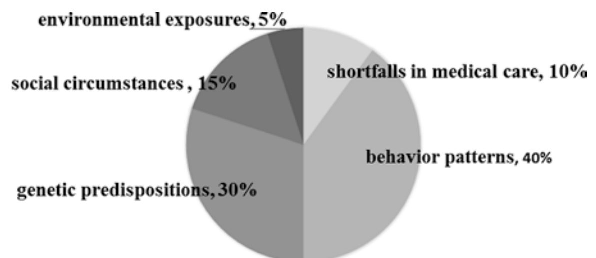

Fig. 15.3 Causes of early deaths (Source: McGinnis et al., 2002)

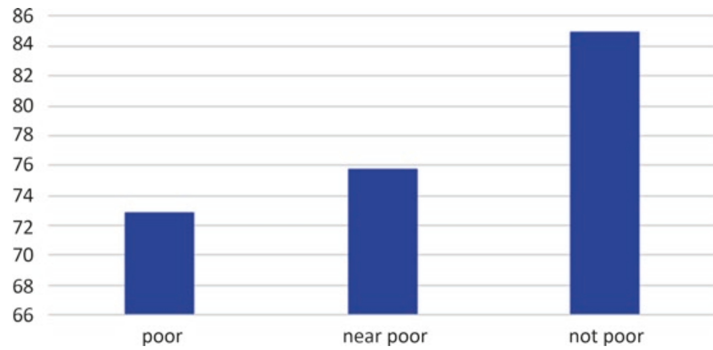

Fig. 15.4 Age-adjusted rates of non-smoking: USA, 2012 (Source: Blackwell, Lucas & Clarke, 2014)

more likely to engage in unhealthy or risky behaviors and less likely to engage in preventive behaviors such as wearing seatbelts or obtaining preventive screenings (Blackwell, Lucas, & Clarke, 2014; Cawley & Ruhm 2011). The correlation is particularly strong for tobacco use (see Fig. 15.4 for non-smoking rates by income level). However, the relationship between income and obesity is nonlinear, and the pattern is not well understood. Evidence also suggests that individuals with low income and education exhibit healthcare utilization patterns that differ from the utilization patterns of individuals with higher levels of income and education. For example, individuals with low income and education are more likely to utilize emergency departments for non-emergency care (Kangovi et al., 2013).

The relatively high incidence of unhealthy behaviors among individuals with low levels of income and education raises difficult issues. The first question is whether effective public policies can be designed to induce individuals to adopt healthy behaviors. One approach for tackling this problem is to incentivize behavior change. The Centers for Medicare and Medicaid Services (CMS) has funded pilot grants to explore strategies for incentivizing Medicaid enrollees to increase their efforts to produce health, and some states are implementing incentive programs (CMS.gov 2015). These initiatives are controversial for two reasons. From the fairness perspective, some analysts are concerned about the impacts of incentive programs on disadvantaged individuals. From an analytical perspective, some question whether small monetary incentives will successfully induce behavioral change (Galewitz, 2014; Galewitz, 2015).

Recent work in behavioral economics supports focusing, instead, on efforts to restructure the framework within which individuals make decisions. One famous non-health example illustrates the central point. Participation in an employer retirement savings program increased dramatically when the participation decision was restructured from an opt-in decision to an opt-out decision (Madrian & Shea, 2001). Participation was voluntary in both situations. In the initial opt-in situation, employees completed paperwork to opt-in to the program. In the subsequent opt-out situation, employees were automatically enrolled in the program when they were hired; however, they could elect to opt out of the program by completing paperwork. This approach has been applied to health decisions such as diet and exercise (Cabinet Office Behavioural Insights Team, 2010). Google Health is working to apply this logic to the prescription refill process, by using information technology to shift from an opt-in system in which patients must request the refill to a (partially) opt-out system that minimizes effort required by the patient (Health Mart Systems, Inc., 2015). Advocates of this approach argue that policy-makers should recognize that individuals have limited time and energy for organizing financial and health decisions. In contrast to strategies aimed at educating consumers and patients in an effort to alter their behavior within a fixed system, this strategy aims to restructure the system to maximize the convenience and attractiveness of the “healthy” decision.

The second key issue is whether healthcare payers, such as CMS, can incentivize healthcare providers to develop strategies to help their patients adopt healthy behaviors. CMS is implementing a pay-for-performance (P4P) system that will reduce reimbursement to physicians who do not successfully meet quality targets. To meet these targets, physicians will need to address the issue of unhealthy behaviors. It is widely recognized that low-SES patients have lower compliance rates; hence widespread implementation of this type of quality-based incentive payments raises concerns about the impact on resources available to those physicians (Sabaté, 2003). The possibility that fewer resources will be available to these providers is particularly critical, given that a substantial proportion of physicians are not currently accepting new Medicaid patients. This concern has sparked debate over the question of whether physicians with high proportions of low-income patients should have different quality targets. This is clearly a two-sided issue: a two-tiered system of quality targets would increase the likelihood that providers treating low-income patients will earn the bonus payments, and it could also foster acceptance of two-tiered quality in our healthcare system (Pear, 2014; Cassel, 2014). A federal panel convened in 2014 to consider this issue has recommended implementation of a two-tiered quality target system. Similar questions have been raised about the impacts of incentive programs targeting student test scores on teachers and schools serving low-SES students.

Factors Shaping Health and Educational Attainment that Lie Outside the Control of Individuals

Growing bodies of research document an array of factors shaping health and educational attainment that lie outside the control of individuals. We consider two sets of these factors:

- Community characteristics, public health services, and job opportunities available to low-SES individuals offer fewer opportunities to build health than similar opportunities available to people with higher SES.
- Prenatal and early child health influence an individual's educational and health potential, before the individual is old enough to begin making independent decisions.

Social and Environmental Factors that Impact Adult Health

Communities and government agencies build health by providing clean air and drinking water, sanitation services, restaurant and meat inspections, occupational safety requirements and inspections, law enforcement, and safe highway design. These entities also provide social services such as education, recreational opportunities, food and housing programs, and income support programs. A substantial body of evidence indicates that low income and low education are associated with greater exposure to specific types of pollution that impact health (e.g., lead and carbon monoxide), risk for work injury or long-term chemical exposure, crime, secondhand smoke, food insecurity, stress, and residence in neighborhoods that lack convenient access to neighborhood grocery stores or safe opportunities for recreation and exercise (Bharadwaj et al., 2014; Mickle, 2015). Furthermore, a growing body of research demonstrates that these issues have significant consequences for health.

Long-Lasting Effects of Prenatal and Early Child Health

The evidence discussed above indicates that the correlation between health and low income reflects both individual decisions and system-level factors: low income is associated with fewer healthy behaviors, residence in communities with lower-quality health-producing amenities (such as public schools, grocery stores, clean air, and convenient recreational opportunities), and lower levels of health insurance and healthcare utilization (Aron et al., 2015). In addition, statistical analyses of large datasets present thought-provoking results about long-lasting

interconnections between income, education, and health. We will summarize the results of studies that conclude:

- Early child health exerts long-lasting impacts on educational attainment (Figlio, Guryan, Karbownik, & Roth, 2014).
- Childhood exposure to concentrated neighborhood poverty exerts long-lasting adverse effects on adult health (Johnson, 2011).
- Health, income, and education are determined jointly, and the impacts of health and low income are transmitted across generations (Johnson & Schoeni, 2007).
- Programs that invest in prenatal and early child health are likely to provide greater impact per dollar invested than programs designed to remediate problems later in life (Heckman, 2006).

Johnson (2011) concludes that a child's family, neighborhood, and school conditions explain approximately 60% of adult health disparities. Peterson, Rauh, and Bansal (2015) provide evidence of one specific effect: prenatal exposure to specific types of air pollutants can disrupt fetal brain development, and this disruption contributes to subsequent learning and behavioral problems. Figlio et al. (2014) highlight the importance of child health at birth in a general context. These researchers merged birth certificate and longitudinal school records for all children born in Florida from 1992 to 2002. They focused on twins to observe pairs of children with similar genetic and family backgrounds but differences in birthweight. The dataset allowed them to observe the educational attainment of these children through middle school. These authors conclude that a child's health at birth exerts long-lasting impacts on that child's educational attainment through the elementary and middle school years:

> *"We make use of a new data resource – merged birth and school records for all children born in Florida from 1992 to 2002 – to study the relationship between birth weight and cognitive development. Using singletons as well as twin and sibling fixed effects models, we find that the effects of early health on cognitive development are essentially constant through the school career; that these effects are similar across a wide range of family backgrounds; and that they are invariant to measures of school quality. We conclude that the effects of early health on adult outcomes are therefore set very early."* (Figlio et al., 2014)

Research in biology and genetics is providing evidence of the mechanisms through which prenatal health impacts an individual's subsequent health as a child and then as an adult. A recent article in the Journal of the American Medical Association summarized the implications of this body of research:

> *"A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring during the early years of life. … confronting the origins of disparities in physical and mental health early in life may produce greater effects than attempting to modify health-related behaviors or improve access to health care in adulthood."* (Shonkoff, Boyce, and McEwen, 2009, p. 2252)

Johnson and Schoeni (2007) show that the impact of early child health on educational attainment has significant implications for adult health and income and for the health status of the next generation. These researchers analyze data from a large nationally representative survey in which individuals and samples of their family members were followed for more than three decades. These analysts conclude that poor health at birth and limited parental resources exerted a negative impact on the child's cognitive development, childhood health, and probability of completing high school. These adverse impacts subsequently reduce the income and health of that individual as an adult. When this individual becomes a parent, his/her low income and low health status influences the birth outcomes of his/her children. The study authors describe this process as a "*negative reinforcing intergenerational transmission of disadvantage*" (Johnson & Schoeni, 2007, p.2).

Similarly, in an article in *Science*, Heckman (2006) argues that prenatal and early child programs offer substantially higher rates of return

(measured as improvements in subsequent health, education, and income-earning potential) than school or job training programs designed to intervene later in life.

Conclusion to Discussion of Socioeconomic Determinants of Health

Health disparities are well documented. The origins of these disparities reflect an array of causal mechanisms; hence reducing or eliminating disparities is likely to require a multidimensional array of strategies. Evidence indicates that income and education influence health both directly and indirectly, through their influence on the likelihood of engaging in healthy behaviors and successfully implementing at-home self-care regimens to minimize the health impacts of chronic conditions. In addition, evidence increasingly indicates that prenatal and early child health can exert long-lasting effects on educational achievement and health in childhood and on adult health.

These findings raise important issues for social policy. They also pose critical challenges for social service, education, and healthcare providers. We consider the implications for these providers, and potential strategies for addressing them, in Section II.

Section II: Why Is It So Difficult to Impact Health Behaviors at the Individual Level?

Financial access to healthcare is an important issue; however, two types of evidence point to additional factors that contribute to income-based disparities in healthcare utilization and health outcomes. First, income-based disparities in healthcare utilization are reported in countries with universal health insurance such as Scandinavia and Great Britain. Second, low-income individuals do not always fully utilize healthcare, when coverage is available. Prior to implementation of the PPACA, a substantial proportion of uninsured children were eligible for coverage through state Medicaid or CHIP programs but were not enrolled (Aizer, 2007). Similarly, in a sample of 16,651 low-income individuals with unstable housing, half of these individuals had basic health insurance but did not use it (Kushel, Gupta, Gee, & Haas, 2005). In another, smaller study of homeless adults, the researchers found that these participants delayed obtaining healthcare during the early stages of an illness because they viewed non-urgent healthcare as "discretionary" and less important than the "competing priorities" of food and housing (Gelberg, Gallagher, Andersen, & Koegel, 1997).

The most prudent decision would be to access both healthcare and food when available. In this section, we explore the question: Why don't low-income individuals take this practical approach?

Factors Influencing Health-Related Behaviors

We consider five factors that illustrate the range and complexity of issues contributing to health disparities. Each factor creates barriers to achieving good health outcomes but also opens possibilities for solutions. The set of factors contributing to health disparities includes both factors that lie within the control of individual patients and providers and factors that constrain individual decisions.

The diverse and complex issues that low-income patients bring to healthcare and behavioral healthcare settings can engender frustration, skepticism, and emotional detachment among healthcare providers. These responses, which are associated with workplace burnout, are not consistent with the impulses that motivated their decisions to enter these helping professions. Developing an understanding of the constraints on patient and provider decisions imposed by system-level factors can help providers proactively strengthen service quality and prevent these burnout reactions. In this section, we will explore the array of system-level issues that constrain decisions made by low-SES individuals and the healthcare providers who work with them. Increased understanding of the range of issues that

challenge low-income patients can help professionals maintain an empathetic approach, focus on assessing the issues underneath the missed appointments and non-compliant behaviors, and formulate a realistic treatment plan.

Resource Constraints

Low-income individuals and families make some decisions that appear shortsighted or illogical: they utilize the Emergency Department rather than primary care (Cheung, Wiler, Lowe & Ginde, 2012), they smoke at higher rates than others (Land, et al., 2010), Mojtabai & Olson, 2003). In contrast to people with sufficient resources, poor people appear to be focused on the present at the expense of opportunities to improve the future. However, examination of the resource constraints shaping some of these decisions indicates that many of these decisions are actually quite logical. We provide four examples:

- Low-SES patients are more likely to obtain non-emergent care at a hospital emergency department (ED). Researchers, policy-makers, and payers refer to this care as "inappropriate," "low value," and "unnecessary"; however, interviews with patients reveal that ED utilization may be a logical choice. EDs typically have convenient access to public transportation, extended hours, drop-in availability, and "one-stop shopping" that obviates the need for travel to multiple locations for lab work or X-rays. In addition, most EDs accept Medicaid insurance, and they typically allow patients to pay the co-payment amount after the healthcare services are delivered. These qualities are important to patients with limited access to transportation, inflexible or unpredictable work hours, and limited cash on hand for unexpected bills. Thus, even if the ED requires a co-payment that exceeds the co-payment required for a primary care physician visit, accessing care at the ED may be a wise strategy that minimizes the individual's total cost of care including transportation and lost wages (Cheung, Wiler, Lowe, & Ginde, 2012; Kangovi et al., 2013; Lega & Mengoni, 2008).
- Low-income women are at higher risk for osteoporosis than women with higher levels of income. One explanation focuses on the impact of family income on childhood nutrition. The basis for strong adult bones is established in childhood; hence children who receive insufficient calcium are at risk for osteoporosis when they become adults. If children growing up in low-income families receive low levels of calcium, the risk for subsequent adult osteoporosis is established before the child is able to make independent health decisions (Lyles, Schafer, & Seligman, 2014).
- Cancer treatment can be harsh and intense and occur over a prolonged period of time: patients need a nutrition-rich diet to support postoperative healing. Good nutrition can support the patient's immune system to fight the disease, improve quality of life and mood, provide energy and motivation to continue treatment, and ultimately improve the patient's chance of survival. However, a study of 404 low-income (mostly immigrant and minority) cancer patients in 10 New York hospitals found high levels of food insecurity. Participants who were going through chemotherapy needed nutritious food but were unable to consistently maintain such a diet throughout the month, as the patients utilized their limited financial resources for extra gasoline to travel to appointments and for medication co-pays (Gany et al., 2014).

The lack of resources constrains the choices available to low-income patients who may lack nutritious food, convenient and reliable transportation, employment, housing in a safe neighborhood, and access to healthcare. These resource constraints have important implications for professional service providers. When patients are non-compliant with treatment appointments or recommendations, it is important to assess the degree to which resource gaps underlie non-compliance. If, for example, patients lack transportation to a healthcare appointment, appointment reminders may not help. Social workers, nurse navigators, and other human

service workers may be able to work with the patient to address resource obstacles to care.

The key here is to assess each patient's situation, to design a solution that matches the needs of the individual patient. Some patients may need help with transportation or applications for Medicaid or other social services. Intense case management that addresses multiple issues, including resource gaps, may be needed for other patients. Individuals dealing with homelessness or chronic mental health or substance abuse issues may be using hospital resources to cope with the myriad social and economic problems they are facing. Working with patients to identify specific barriers can be the first step in engaging patients in treatment and increasing compliance.

Bandwidth: The Psychology of Scarcity

Some decisions made by low-income people appear to be counter-productive. Economists and psychologists have studied this issue from a cognitive processing perspective. These researchers focus on the impact of the mental effort that is required to live in poverty:

- People with low incomes fret about which bills to pay, as they consistently run out of money at the end of each month.
- They complete numerous small tasks to utilize social services. To access food bank services, for example, they may complete a long bus ride with a transfer, they wait in line, they juggle bags of food on the trip home, and then they deal with family members who do not like some of the items in the food bag (Wimer, Wright, & Fong, 2013).
- They may want to improve their health by eating more fresh, nutrient-rich foods from a farmer's market. Coupons may be available: the low-income people will need to first calculate the amount they will spend, then stand in line to get the correct amount in food stamps and then decide what food to buy (Chaufan, Constantino, & Davis, 2012).
- Low-income individuals who work in industries such as fast food, retail, and other service jobs, may experience frequent changes in work hours. These schedule changes can occur with short notice. This creates instability and the need for frequent problem solving about such issues as childcare arrangements, transportation, and health care appointments (Ben-Ishai, 2015).

All of these small decisions keep the poor focused on seemingly minor decisions that significantly impact the present but do little to improve the future. As individuals focus on numerous small decisions that are critical in the present moment, they have little time and attention to devote to long-term plans.

Some researchers use the term "bandwidth" to describe the mental capacity required for cognitive processing. This group of researchers suggest that we all have a finite amount of bandwidth. When our bandwidth is used to address numerous small decisions, little processing capacity is available for making larger, long-term, future-oriented decisions.

Mani, Mullainathan, Shafir and Zhao (2013) have tested this cognitive processing theory in the laboratory and in the field. In a field study in India, data was collected on 464 sugarcane farmers just before they sold their crops (when they were poor) and again after they received payment for their crops (when they were well-off). Scores on an intelligence test were lower before these farmers sold their crops than after they received this revenue. Prior to receiving the revenue, they also pawned more items and took out more loans than after the crops were sold. While these actions generated short-term benefits for the farmers, they weakened the farmers' long-term financial situations.

In a field study conducted in a New Jersey mall, the same group of researchers asked two groups of mall shoppers – one lower income and one higher income – to think about two scenarios. The first scenario involved a small car repair costing $150 and the second a large repair costing $1500. The researchers used the Raven test to measure the fluid intelligence of both groups. Fluid intelligence is a component of IQ that is related to problem-solving abilities. The cognitive abilities of the two groups were equal before the experiment and while the two groups contem-

plated the small car repair. However, the lower-income group's cognitive scores fell while they thought about the large car repair. The lower-income group's bandwidth was already occupied with coping with poverty; hence it was not available to solve more complex problems.

These two examples of cognitive processing studies are part of a larger body of research that address the question of whether self-defeating behaviors lead to poverty, or whether it may be the other way around. Cognitive processing researchers provide evidence that the problems that attenuate financial stress may generate cognitive processing overload, which, in turn, can lead to self-defeating behaviors (Spears, 2011).

These ideas about cognitive processing overload can inform health care service approaches with lower income patients. Professional service providers may simplify instructions and organize information, to avoid overwhelming people who are already cognitively overloaded. To return to the example of "inappropriate use" of the ED, social workers and other healthcare navigators can use a "soft handoff" to increase the probability that a client will subsequently obtain care in a physician office rather than returning to the emergency department (Thomas, Burstin, O'Neil, Orav, & Brennan, 1996). This means that the client will leave the ED with an appointment time and location in hand rather leaving the ED with a phone number and instructions to make an appointment. If someone is already cognitively overwhelmed, the additional task of making the appointment is not helpful, because it adds to the existing cognitive load.

Health Literacy

A growing body of research shows significant relationships between health literacy, healthcare utilization, and health outcomes. Individuals with low health literacy are more likely to report their health as poor and more likely to lack health insurance. They are also more likely to have higher rates of hospitalization and use preventative services less frequently compared to people who have proficient health literacy (US DHHS Quick Facts).

In the past, health literacy has been defined by education level. During the 1960s, an eighth grade education was considered a standard for functional literacy. Since then, expectations for patient participation in the care process have increased, and increasingly sophisticated skills are needed for communication and decision-making about health issues. In response, definitions of health literacy have expanded. The 2003 National Assessment of Adult Literacy (NAAL) suggests that health literacy is broad and required at each step as patients access and engage with health care providers to understand (1) health concerns and recommendations for treatment; (2) prevention guidelines; and (3) navigation strategies for accessing health care. According to the NAAL, three main types of literacy skills are needed in each of the above areas:

- Math skills affect the ability to follow medication prescription guidelines.
- Reading comprehension skills are critical to choosing medical insurance plans, obtaining medical payment reimbursements, and following medical instructions. Because of the implications of misunderstanding insurance, medical, and government documents, health literacy research has spawned a federal Plain Language Action and Information Network to promote simplification of complex medical insurance and medical care information (www.plainlanguage.gov).
- Communication skills can impact an individual's ability to navigate the medical system to obtain appointments and medication refills.

All three skill sets may be needed to successfully manage illnesses that involve integration of health information and self-assessment, such as at-home self-care for advanced congestive heart failure (Macabasco-O'Connel, Crawford, Stotts, Stewart, & Froelicher, 2008).

According to the NAAL, only 12% of adults have proficient health literacy. Fourteen percent have below basic health literacy. Poor health literacy is more likely to be found among people with low education levels, non-native speakers of

English, and older adults. Health literacy can be a problem in a wide range of situations, such as when giving discharge instruction and asking the client to complete forms or complete complex at-home instructions. Providers need to be aware of how much information a patient understands. Providers can use graphics to help convey information and work to organize and simplify the information. Health literacy proponents advocate aiming to convey information at a sixth grade level and asking the patient to repeat back the information so the provider can clarify any information that was not understood.

Interactions with Healthcare Providers

Low-income individuals do not get the same healthcare as people with higher incomes. The care is less likely to be consistent with medical guidelines. Cancer care for low-income individuals is less aggressive and less successful (Skinner & Zhou, 2004). Research has focused on why such disparities exist, examining many factors including the possibility of physician bias. While doctors may be prejudiced, a recent Medscape survey of 15,000 physicians indicates that the issue is more complex. Among the physicians that self-report bias, the most common biases focused on patients with emotional problems and obesity (Medscape.com, 2016). Self-reported bias based on patient income and education is substantially less common. This survey suggests that doctors hold biased opinions about a number of issues and that health disparities stem from complex and nuanced issues rather than prejudice on the part of providers. We consider three cognitive processes here:

- Stereotyping, in which the individual utilizes categories to summarize information and formulate opinions and is reluctant to modify those opinions
- Statistical discrimination, in which the individual utilizes categories to formulate initial opinion and then "updates" those opinions when additional information becomes available
- Trust

Stereotyping

Cognitive science suggests that we all think in categories that are comprised of idealized representations of what is considered normal for a person or situation (Lakoff, 1987). As idealized representations, cognitive categories do not have direct correspondence in the real world. For example, the sight of a woman with a baby may bring up a large amount of information about the category of "mother" as a person who is self-sacrificing and protective of the child. This scenario is not based on information about the actual woman and child; for example, the woman may be the child's mother, or the woman may be a babysitter, neighbor, or aunt. Despite the potential for inaccuracy, this unconscious process is useful in navigating our daily lives. It allows us to quickly sort what could be an overwhelming amount of information about the world into recognizable patterns that allow us to make inferences and decide how to respond to people and situations.

Stereotyping flows naturally from our use of cognitive categories based on the in-group/out-group status of other individuals. People who are more like ourselves (in-group people) are viewed as distinct individuals. In contrast, people who are perceived to be less like ourselves (out-group people) are viewed in generalizations or stereotypes that do not reflect the nuanced reality of individual members of groups. Stereotypes can be positive or negative. A man wearing a suit might be positively stereotyped as a successful person, and a poorly dressed individual may be negatively stereotyped. Media portrayals of individual members of demographic groups may contribute to inaccurate stereotypes: while 60% of poor people are white (Macartney, Bishaw, & Fontenot, 2013), an analysis of media portrayals of the poor found that poor individuals were disproportionately represented as being black (Clawson & Trice, 2000). In addition, negative stereotypes are reinforced by selectively noticing behaviors that are attributed to the individuals' group membership, creating a self-fulfilling prophecy.

Stereotypes play an important role in healthcare delivery processes. If a physician views a patient as an "insider," he or she is more likely

to hold a multifaceted and empathetic perception of that patient's behavior. Patients who are perceived as different from them are likely to be viewed more negatively and less empathetically. These perceptions may have important implications for physician assessments of the likelihood that a patient will comply with medical advice and successfully implement a treatment regimen.

Stereotypes are ubiquitous, even among professionals. A survey of 389 physicians who were attending an international conference on obesity provides an example of this cognitive process, even among professionals whose careers focus on impacting obesity. The physicians were surveyed about their attitudes toward obese individuals. These physicians exhibited negative stereotypes of obese people: the physicians were more likely to use positive terms to describe thin people, while the descriptors used for obese individuals were more likely to have negative connotations such as "lazy." However, physicians who had overweight friends, or personal experiences of being overweight, were less likely to exhibit negative stereotypes of obesity, suggesting an insider/outsider effect (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003).

Statistical Discrimination

In contrast to decisions based on "stereotypes" that rely on information about the patient's demographic or health category, "statistical discrimination" refers to a decision-making process in which an individual uses category-based information to develop an initial opinion – and then "updates" this opinion when he or she receives additional information about the specific situation. The distinction is important in the clinical setting. Medical guidelines outline a treatment protocol for a "typical" patient exhibiting specific sets of symptoms; however, physicians are expected to use additional information about the patient to customize the treatment recommendation.

Communication is a 2-way process. Communication can be influenced by numerous factors including education, income, age, and race (Siminoff, Graham, & Gordon, 2006). Communication can impact treatment recommendations. If the patient-physician communication process is effective, the physician's recommended treatment will take into account the patient's medical condition as well as contextual factors, such as motivation and ability to follow complicated medical treatment guidelines—all of which may be used to determine treatment recommendations. Research shows that disadvantaged patients are less likely to provide the needed information, and this sets in motion a chain of subtle interactions that engender health disparities (Balsa & McGuire, 2003).

An economically disadvantaged patient may provide less information and ask fewer questions that reveal his or her personal symptoms and concerns. The patient's lack of rapport and questions about the illness may be perceived as a lack of engagement in treatment. Given this lack of information and the consequent physician perception of the patient's motivation, the physician may assess the patient as a poor risk for a complicated, multistep treatment. Thus, the low level of information provided by disadvantaged patients can result in a mismatch between what the patient needs and the recommended treatment.

Trust

Communication between patient and provider is a key factor in healthcare. Communication is complex and multilayered with both patient and physician mutually influencing each other in either a positive or negative direction (Street, Gordon, & Haidet, 2007). One key factor in the direction of communication with disadvantaged patients is trust. There are many definitions of trust. One element that is commonly included in conceptualizations of trust is a sense of vulnerability, which is associated with illness. An additional layer of vulnerability for disadvantage groups may come from the experience of being marginalized and lacking a sense of control over life events. Studies of trust and service provision among low-income women receiving prenatal care, and among HIV-positive patients, report strategies that build trust: utilizing collaborative communication (including listening), expressing concern for patients as individual people, and

incorporating the patient's concerns into the treatment plan. In contrast, patients mistrust physicians that they perceive as condescending or patronizing (Mallinson, Rajabiun, & Coleman, 2007; Sheppard, Zambrana, & O'Malley, 2004). To the extent that a patient trusts his/her physician, he or she will also feel satisfied with and comply with that physician's treatment recommendations (e.g., see Cochrane.org).

Physicians may enhance trust through patient-centered communication strategies; however, patient trust is also shaped by multiple factors outside the control of individual physicians. Results from a qualitative study of SES, health-care systems, and satisfaction with health care found that middle-income patients were more satisfied with their care compared to low-income patients. Middle-income individuals, who were being seen in private offices or HMO clinics, had minor complaints but were generally satisfied with their care. In contrast, many low-income individuals felt that they were getting second-rate care. Some individuals using low-income clinics reported that high turn-over rates of medical personnel kept them from attempting to get acquainted with their physicians (Becker & Newsom, 2003). To add further to their dissatisfaction, some busy, overburdened front-office workers in low-income clinics were perceived as rude or unhelpful (Sheppard et al., 2004). This issue is important for understanding the association between income and healthcare compliance if negative experiences with front office workers are more prevalent in low-income clinics with fewer resources and overworked staff.

Awareness of the issues of cognitive processes and patient trust can help professionals develop proactive strategies to enhance communication and build trust. If a client comes to an appointment and exhibits behaviors of mistrust such as a lack of engagement in the interview, a provider can pay special attention to the style of communication during the appointment. According to the research reviewed in this chapter, all patients want similar things. They want to be regarded with concern as individuals and be treated with respect. They also want continuity with their providers. Low-income clinics are often training sites where residents and other medical students complete supervised clinical training. When it is not feasible to provide continuity of physicians in low-income clinics, other, permanent members of the medical team such as nurses or social workers can help compensate by getting to know patients and their issues. The more vulnerable individuals feel, the more sensitive they may be to the relational aspects of care. In this situation, trust may be particularly important for compliance and motivation to continue treatment. Of note in the studies reviewed, the tone and behavior or the front office workers can impact patients' feelings about the treatment experience.

Conclusion to Section II

All of these strategies focus on dealing with seemingly counterproductive patient behaviors and decisions by gathering information about the constraints that shape those decisions and then addressing those issues. In addition to the issues discussed above, healthcare professionals may consider whether the healthcare system itself contributes to the problems that must be addressed. For example, the healthcare insurance system inadvertently promotes the use of emergency departments by low-SES people: patients covered by Medicaid can obtain care at a hospital ED, while they may have difficulty locating a physician who will accept Medicaid payment. In addition, our current system is organized by setting (emergency, primary care clinics and doctor's offices, and home) which is out of sync with the needs of patients with chronic conditions such as diabetes and congestive heart failure who have a high need for continuity of care across settings. This issue is likely to be particularly salient for low-SES patients with limited health literacy, limited access to transportation, and difficulties locating providers willing to accept Medicaid payment.

Chapter Conclusion

Evidence published about the impact of income and education on the incidence, diagnosis, treatment and self-management of diabetes illustrates the issues discussed in this chapter. Compared with individuals with higher levels of education, individuals with low levels of education are more likely to develop obesity and diabetes, they are more likely to experience delays in diagnosis of this condition, and they are less successful in implementing treatment recommendations (Goldman & Smith, 2011). This three-level association between income, education, and the health consequences of diabetes may reflect both individual decisions and factors that lie outside the individual's control. While individual decisions about diet and exercise are clearly relevant, system-level factors are also in play. For example, Hoynes, Schanzenbach, and Almon (2016) report that children who receive food stamps are less likely to develop obesity and diabetes than children from families with similar income who do not receive this assistance. In addition, Smith (2007) provides evidence that cognitive skills play a role in successful self-management of diabetes, and the complexity of the self-management task has been growing over time. At the same time, patient trust has been found to engender self-efficacy and positive expectations for improved health among a group of patients with diabetes, whose treatment depends on following complex self-care regimes (Lee & Lin, 2009).

Further, substantial evidence indicates that income and education are playing an increasing roles in the production of other aspects of health. For example, Goldman and Smith's (2011) analysis of data from the US National Health Interview Survey documents the impact of income on health. They focus on white adults age 40–64, to isolate the impact of education, and avoid confounding factors associated with the changing proportion of nonwhite groups during the last three decades. These authors report that the positive correlation between income and self-reported health status has been growing over time. Similarly, Cutler and Lleras-Muney (2006) review evidence on causal factors that underlie the correlation between education and health. These analysts conclude that cognitive skills required to understand instructions, adopt new technology, and implement at-home treatment regimes are likely to be important factors.

The evidence discussed in this chapter pose significant challenges to professional service providers: instructions must be clear and well organized, social services must be coordinated to help mitigate resource gaps, and communication with clients must be strengthened. While we streamlined the discussion by focusing on healthcare providers in this chapter, parallel issues challenge professionals in the education sector. Developing proactive strategies for tackling these challenges will help providers maximize the value of services delivered to clients and patients.

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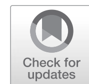

16 The Culture of Poverty: On Individual Choices and Infantilizing Bureaucracies

Joshua D. Phillips

Introduction

In October 2013, *60 Minutes* ran the news story "Disability, USA" (Kroft, 2013). The story highlighted the drastic increase in the funding and claimants to the Federal Disability Insurance Program since its conception in the 1950s. Ideally, the program is in place to help those who absolutely cannot work, not for those who simply cannot find a job or who are unwilling to work certain jobs. However, as the *60 Minutes* piece reported, in 2013, the Federal Disability Insurance Program "serves nearly 12 million people – up 20 percent" since 2007 "and has a budget of $135 billion. That's more than the government spent last year on the Department of Homeland Security, the Justice Department, and the Labor Department combined" (Kroft, 2013, para. 2). To put these numbers into perspective, *60 Minutes* traveled to a lower-class community along the Kentucky and West Virginia border where upward of 15% of the population collected disability payments. In his interview with reporter Steve Kroft, Oklahoma Senator Tom Coburn discussed how these disability insurance payments to a substantial portion of residents are essentially "propping up the economy in some of the poorest regions in the country" (Kroft, 2013, para. 28). In short, each person receiving disability insurance received about $1,100 a month, which in turn was spent at local grocery stores, gas stations, diners, and other retailers. Any novice economist would recognize this as an unstable market and unsustainable economy because it is disproportionally dependent on one source of revenue. If the government ever reduced or abolished payments, then a significant percentage of the economic environment would come to a halt.

During his own nationwide investigation as the ranking Republican on the Senate Subcommittee for Investigations, Senator Coburn and his staff concluded that 25% of randomly sampled disability claims should not have been approved by doctors and/or judges since the claimants in question had also applied for and/or collected unemployment benefits. Unemployment benefits are for people who can work but cannot find a job. Legally, there should be no overlap between those seeking unemployment benefits and those applying for disability (see "Senators Introduce," 2013). However, *legal representation* for disability claimants is a growing and lucrative business. National law firms like Binder & Binder collected $70 million in legal fees from the US government in 2012 helping people apply for, appeal, and collect disability insurance

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(Kroft, 2013). Along the Kentucky-West Virginia boarder, lawyer Eric Conn "collected more than $13 million in legal fees from the federal government over the past six years" and "paid five doctors roughly $2 million to regularly sign off on bogus medical forms" (Kroft, 2013, para. 89). With these examples in mind, Senator Coburn elaborated on the commercialization of the disability insurance industry where lawyers use media such as television ads and billboards to solicit clientele. As Marilyn Zahm, a judge who adjudicates disability claims, told *60 Minutes*, "In 1971, fewer than 20% of claimants were represented. Now, over 80% of claimants are represented by attorneys or representatives" (Kroft, 2013, para. 9).

In the closing minutes of the exposé, Senator Coburn laments the inefficiency and corruption within the Federal Disability Insurance Program and places much of the blame on the US Congress. Senator Coburn empathizes with the "desperate" measures people take in these types of regions and under these types of economic circumstances. However, when the system is abused, it neither has the funds to fully address the needs of those who actually need the system nor are the economic needs of the poor who abuse the system addressed in any sort of meaningful way. Ostensibly, the only subjects within this labyrinth for whom financial needs are meaningfully addressed are the doctors and lawyers who successfully diagnosis and shuffle paperwork for disability claims.

In no way is this *60 Minutes* news story summarized as a way to malign the poor but rather to illustrate the complete breakdown between the poor and the welfare bureaucracy. As noted, the beneficiaries of this particular breakdown receive an average of about $1,100 per month – hardly a fortune. However, the lawyers, doctors, and social workers who manage the abundance of these cases stand to make quite the living through federal reimbursement. Ultimately, these are money, time, energy, and resources that are not going toward addressing the underlying causes of generational poverty. For $1,100, a poor person can survive to the next month, but these handouts do nothing to address the long-term solutions needed for financial independence, community revitalization, and the self-worth that comes from hard work and accomplishment. These virtues can only be actualized through large structural and cultural changes.

As such, the purpose of this chapter is to discuss the cultural habits of the poor as well as the relationship between the poor and the welfare bureaucracy. One important reason to do this is that, at times, concerns about culture and race are conflated with concerns about the poor. Arguably, there is a justifiable concern in the social sciences about the intersections of culture, race, and poverty because blacks, Hispanics, and American Indians are overrepresented in the poorest segments of the US population. Over the last decade, the US Census Bureau found that just under 15% of the total US population lived in poverty at any given time. However, whites lived in poverty at a consistent rate of about 10%, while blacks, Hispanics, and American Indians lived in poverty at a consistent rate of approximately 25% (Farrigan, 2017; Macartney, Bishaw, & Fontenot, 2013; "Poverty rates," 2015).

Yet, like any good social scientist, it is important not to confuse correlation with causation. Just because blacks, Hispanics, and American Indians happen to live in poverty at a higher rate does not mean that race is innately connected to poverty (nor, at the very least, is race the primary factor that drives poverty). This is important to the fields of psychology and counseling especially when social scientists begin to contribute problems within a racial group to that of "oppressive whites" vs. "oppressed minorities." Within these models, social scientists look to inform "clueless" whites (counselors) about the "victimization" of minorities (clients) as if having more insight about race will lead to better mental health outcomes. For evidence of this type of counseling approach, one can look at Sue's (2010) work on microaggressions, Robinson-Wood's (2016) work on identity convergence, or Smith's (2010) work on social exclusion and multiculturalism in counseling. Yet, what this chapter will argue is that race is not a primary factor in the perpetuation of social enclaves stuck in a cycle of destitution. While there is a correlation between poverty

and race, there is little evidence to support that these two factors are strongly symbiotic. There is much stronger evidence that poverty is linked to universal self-defeating behaviors that undermine life success regardless of one's race. Therefore, instead of focusing so extensively on "microaggressions," "identity convergence," and "multiculturalism," it would behoove counselors and academics to spend more time learning about the social behaviors of the underclass and work to help clients change these behaviors. An extensive vocabulary on *du jour* multicultural lexicon might help a counselor get ahead with colleagues, but a commitment to understanding and changing underclass behaviors will do far more to help poor clients succeed, regardless of race.

It is worth repeating that this research is not an attempt to malign the poor or to pompously critique those habits that contribute to generational poverty. Still, those habits ought to be discussed truthfully and dispassionately. Likewise, not everyone who lives in poverty is poor for the same reasons. People can be poor because of (1) indolence, laziness, and other controllable behaviors, (2) limited skills or mental abilities, (3) tragic circumstances such as a family death or natural disaster, (4) legalized oppression such as political refugees or caste systems, and (5) voluntary decisions such as religious oaths or missions work. This research is primarily concerned with addressing reason number one. Additionally, the poor do not live in a vacuum, and thereby, their decisions to behave in certain manners are influenced by those who are not poor, e.g. policymakers, educators, lawyers, pundits, celebrities, and politicians. Therefore, while this chapter will highlight some of the destructive individual behaviors that lead to a life of poverty on a micro-level, this chapter will also highlight some of the affluent influence that perpetuates macro-systems that maintain enclaves of poverty by making it difficult for the poor to make more constructive decisions that would alleviate their poverty. In the end, poverty is driven by cultural behavior, both the behavior of the individual as well as the behavior of the bureaucracy. Thus, to address poverty, one must address the culture at every level.

The Culture of Poverty

One of the earliest records of in-depth coverage of the poor in America is Jacob A. Riis' book (1890) *How the Other Half Lives: Studies of the Tenements of New York*. Riis was a journalist who made it his mission to document the environment and behaviors of New York City's slum dwellers in an effort to force politicians to deal with the unconscionable living standards. Making his work even more dramatic, Riis printed dozens of pictures to accompany the text. This included pictures of overcrowded boarding houses, trash piled in alleys, drunkards in the streets, and mug shots of known criminals who had been terrifying residents for years. Through his ethnographic work, Riis not only shone a light on the plight of these residents, but he also documented the black-market world of gambling, prostitution, drug-dealing, and pickpockets. For Riis, the rampant crime in these areas did not necessarily indicate rampant pathology among the poor but instead was a larger critique of how the politically and socially well-connected used zoning laws and police protocol to push criminal behavior into the least desirable areas of the city. With crime and poverty were neatly tucked away into the slums of the city, New York's elite could deal with the political, social, and economic issues that more personally resonated.

As it was over a century ago, still today the poor are oftentimes tucked away and hidden from the view of polite society (Goldsmith & Blakely, 1992; Murray, 2012). This public segregation not only makes it easier to ignore the problem of poverty, but it also fosters the development of "divergent" cultural norms between the poor and affluent (Daniel, 1970, p. 17; Sowell, 2015). In the 1970s, the field of communication experienced a spike in analyzing class-status through intercultural communication. Up until this point (and still oftentimes today), research on class-status is mostly relegated to the field of economics. Scholars and pundits see things like living standards, wage gaps, and family assets and assume that the narrowly defined research question ought to be "how can we get more money from point A to point B?" Yet, what if money

(or the lack thereof) is merely a symptom of poverty? Perhaps culture could better explain the root causes of this social ill.

In the 1970s, scholars such as Daniel (1970), Philipsen (1976), and Whiting (1971) explored the class-divide through a more cultural and sociological lens. In his article "Places for Speaking in Teamsterville," Philipsen (1976) explored the social behaviors and speech patterns of a lower-working-class white neighborhood. In regard to culture, there were two results that were revealing. First, "few Teamsterville men or women reported that they had participated in social events during the previous year with anyone who lives more than ten blocks from their home" (p. 17). Homogenized cultural experiences only work to strengthen existing cultural norms and provide little opportunity for exploring different norms that may lead to better economic outcomes. In places like Teamsterville, this manifest in the generational pattern of "I do this because my parents do this and their parents before them." While there is nothing inherently wrong with carrying on a community legacy, this attitude can lead to long-term plight if the social behaviors of the community are perpetuating poverty, relative inferiority, or even destructiveness. Holding onto the past also hinders new learning when communities embrace isolationism and ignore the obvious changes taking place around them in the otherwise interconnected world. Learning and implementing advantageous social behaviors are particularly needed when dealing with the rapid cultural changes perpetuated by expeditious technological advancements. To stay economically afloat, communities must adapt to burgeoning norms in the globalized economy.

The second revealing norm from Philipsen's (1976) research dealt with speech patterns. Within Teamsterville, there were accepted communication norms. Residents recognized their speech as "inferior to the Standard English of middle class people…but superior to the speech of, respectively, 'hillbillies,' 'Mexicans,' and 'Negroes'" (p. 18). This self-created hierarchy put Teamsterville residents high enough on the social ladder where they felt it unnecessary to modify their speech. Their speech patterns were "good enough." Interestingly, this "good enough" attitude caused a thought-provoking community dialectic. Since the distinct speech pattern was culturally valued, any young person who went to college or attempted to speak in Standard English was viewed with skepticism by the community. Therefore, to remain a part of the community, people had to know how to speak the language of the neighborhood. Desiring a sense of belonging, most people continued speaking broken English even at the (unknowing) expense of social upward mobility.

Beyond social mixing and language quirks, there are also distinct cultural ways the poor must navigate the educational system. In reality, these norms are likely the most destructive and contribute the most to long-term generational poverty. Whiting (1971) characterized the "culture of poverty" as having "an anti-intellectual bias" (p. 37) and used the work of Oscar Lewis (1965) to substantiate the claim that many poor children enter school with conflicting communication codes regarding values, attitudes, and behaviors. Moreover, Lewis (1965) and Daniel (1970) discussed the suspicions levied against those many professionals with middle-class background who claim to have a set of solutions for dealing with uneducated, undisciplined, and delinquent children. For these students and their parents who have been immersed in a system of social workers constantly promising to "help them," these well-intended efforts are "like trying to walk up to a wild lion and petting him. As soon as the offer is made to help, the poor person might become suspicious and begin to look for the 'catch'" (Daniel, 1970, p. 19).

Notably, "anti-intellectual" does not necessarily mean that poor people are against formally educating their children. Instead, this points to the notion that poor people are less likely able to foster and support their children's educational growth if the parents themselves are unfamiliar with the vocabulary, curriculum, and behaviors needed to succeed. Unfortunately, if the poor are unfamiliar with the cultural norms that lead to educational success, they oftentimes fall back into destructive patterns that inhibit long-term social mobility, but offer a short-term means for

survival (Dalrymple, 2001). In “Black Students’ School Success: Coping with the ‘Burden of ‘Acting White”,” Fordham and Ogbu (1986) discuss how this survival trait manifest in some segments of black America when academically gifted students suppress their intelligence and succumb to the “social pressures against striving for academic success” for fear that they will be viewed as “acting white” (p. 177). In *Black Education*, Sowell (1972) refers to the myth of “true” black identity and analyzes how black American culture has elevated “the ‘authentic’ ghetto black” by rejecting traditional white institutions, educational or otherwise (p. 155). Again, rejecting perceived “white education” might boost a young black man’s street credibility in the ‘hood, but it retards his ability to move up the economic ladder.

One of the more egregious examples of this type of rudimentary cost-benefit analysis was documented by *The New York Times* columnist Nicholas Kristof. In the 2012 essay, “Profiting From a Child’s Illiteracy,” Kristof stated that, as a liberal, it was “painful” for him to admit that “conservatives have a point when they suggest that America’s safety net can sometimes entangle people in a soul-crushing dependency” (para. 4). In all, Kristof’s (2012) column discussed how parents in poverty-stricken “Appalachian hill country [were] pulling their children out of literacy classes” in order to ensure their child qualified for a few hundred dollars a month for an intellectual disability (para. 1). Fully “8 percent of all low-income children” (para. 9) were enrolled in a federal program for disability in 2012 and “a 2009 study found that nearly two-thirds of these children make the transition at age 18” onto adult disability payments (para. 10). This essentially means that nearly five-and-a-half percent of all low-income children are destined for Federal Disability Insurance and a life of idleness before even leaving elementary school. Due to educational retardation these children experience at the behest of their parents, local principle Ron Combs commented (with support from several teachers), that “by second or third grade, you have a pretty good feeling about who’s going to drop out” of school (Kristof, 2012, para. 24).

When a person is subjected to these types of placating cultural systems at such a young age, it is likely that they will inherent a sense of “learned helplessness.” Reddinger (2016) defines “learned helplessness” as a person’s “mistaken belief (derived from the social institutions in which they live) that they cannot get ahead even if they were to try” (para. 1). This was one of the central themes in J. D. Vance’s 2016 book *Hillbilly Elegy: A Memoir of a Family and Culture in Crisis*. In the aftermath of Donald Trump’s presidential victory in 2016, Vance became somewhat of a media darling. While his book is apolitical, the media valued the personal insight he provided into the cultural behaviors and mind set of poor – Midwestern – whites; the very demographic that ushered Trump into the White House. Unapologetically, Vance (2016) argued that the people from his community are stuck in the cycle of generational poverty because they are always looking for the next outside savior, albeit sometimes in the form of a new government program, a new corporate factory, or a new President Trump. “In a state of learned helplessness, people who are suffering consistently feel like something has been *done to them*, rather than seeing how their economic difficulties can stem from not having done enough for themselves” (Reddinger, 2016, para. 4). Under this philosophy, people feel incapable of bettering themselves and instead must constantly negotiate their personal survival with those in positions of power. If those in power fail to negotiate, then there is no point in learning a new skill, furthering one’s education, or working 40+ h per week. Imbedded poverty breeds a cultural mindset where outsiders are seen as responsible for the suffering, and therefore, outsiders must alleviate the suffering. When a person has learned to live on the government dole his entire life, then government incursion is the only reality that makes sense. Forgoing this norm seems foreign, and not demanding more funding for such programs seems foolish.

Of course, there are plenty of critics aghast at theories that ponder whether widespread “learned helplessness” or “victimhood” might negatively affect the possible prosperity of a culture.

Hesitantly, Larson (2016) described the rampant stereotypes in Vance's memoir as a place where poor whites are depicted "as shiftless, destructive, and unwilling to do the hard work necessary to change their lives" (para. 1). Defending these types of stereotypical depictions is columnist Kevin Williamson (2016) who had a similar poor-white upbringing. Williamson stated that, "the culture of the white underclass in America is horrifying….and it's cowardice" to refuse "to look at the thing squarely as it is and to do what it is necessary to do. When I think about my own upbringing, one of the thoughts that comes to me most often is: 'Why didn't someone say something?'" (para. 1). In sum, the destructive habits of the poor in Western civilization have metastasized for long enough without critique. If the larger society is truly committed to alleviating poverty, then it must be honest not only with regard to collective economic systems but also to the individual habits that keep the poor tethered to a life of poverty.

One book that unabashedly critiques those habits of the poor is Theodore Dalrymple's (2001) *Life at the Bottom*. The book is a collection of 22 short essays complied by a British doctor that recalls his ethnographic observations on the habits of those underclass patients of whom he treated for decades. From the back cover, the book is described as a "searing account of life in the underclass" where "Dr. Dalrymple's key insight is that long-term poverty is caused not by economics but by a dysfunctional set of values." In 2016, economist Thomas Sowell recommend *Life at the Bottom* as one of his top book to read during the US presidential election cycle because "it is about the actual consequences of the welfare state in England" (para. 3). For Sowell (and others), one of the values of Dalrymple's work being disseminated in the United States is that it removes discussions over racial differences since the vast majority of England's underclass are white. In the United States, conversations about the poor are usually wrapped in layers of racial history and racist discrimination – with good reason. However, by removing race, ethnicity, and immigration status as a variable, Dalrymple is able to focus solely on the habits of poor white Englanders to discover what cultural behaviors might drive generational poverty. What he discovered is that "racial determinism" does not predict poverty, but instead the white British underclass "demonstrates all the same social pathology as the black underclass in America" (Dalrymple, 2001, p. viii). Therefore, the fact that some people of various racial demographics are more likely to be poor in certain areas of Western civilization is inconsequential compared to the individual habits in which they engage.

Throughout *Life at the Bottom*, Dalrymple brazenly comments on destructive behaviors such as gambling, cigarette smoking, getting tattoos, watching television, consuming intoxicants, high-fat diets, and committing domestic violence. For example, Dalrymple (2001) writes about the "thick cigarette smoke" in the bingo halls where he watched "women with the physiques and mobility of beached whales refresh themselves constantly (as they mark their cards) with large piles of cholesterol-raising fried food and large volumes of tepid, watery English beer" (p. 105). Beyond these types of shocking prose, Dalrymple's main thesis is that, in each of the aforementioned categories, those in the underclass participate far more frequently in these behaviors than those with financial stability.

In 2012, Charles Murray published similar findings on the habits of poor white Americans using quantitative methods in his book *Coming Apart: The State of White America, 1960–2010*. While Dalrymple's work commented on the habits of a mostly white demographic by happenstance, Murray intentionally focused on whites in an effort to control variables. Essentially, by controlling for racial demographics, Murray could isolate individual habits and show that these habits led to poverty. Thus, for Murray, poverty is a function of social behavior, not a function of racial background or racial determinism. Highlights from his work include the following: First, while religious participation is down for the country as a whole, it is down significantly more for the poor, which can be interpreted as a gap in moral conviction and universal values. Second, between 1985 and 2005, the leisure time for non-high school graduate men increased by 8 h per

week, and that extra leisure time went toward watching more television: a whopping 36.7 h per week. Murray notes that excess leisure time did not go toward more productive behaviors such as reading, education, vocational training, or child-rearing, which further indicates that these behaviors are a choice and not derived from a set of predetermined circumstances. Conversely, the lower class' civic engagement in community organizations, such as lodges and fraternal orders, decreased. Third, in 2010, 43–48% of poor children were born outside of marriage. This compared to only 6–8% of nonpoor children. Furthermore, 22% of poor children grew up in single-parent households compared to only 3% of nonpoor children. In 1960, the nonmarital birth rate was less than 10% for all economic groups, and single-parent households were less than 2% for all categories. It can hardly be said that these statistics are driven by cultural circumstances as the access to birth control, abortion, and sex education have drastically increased over the past 50 years. Personal choices are the only plausible explanation, and these patterns have dire long-term consequences. As will be discussed later, a child who grows up in a two-parent household is one of the biggest predictors for future earnings. Finally, over the past 50 years, crime is up in poor neighborhoods, and the proportional population of poor people in prison has increased nearly fivefold (Murray, 2012). Arguably, in 2010, the poor were not in more need for basic means of survival as compared to 1960. Therefore, increased crime is probably more an indicator of choice as opposed to a need for survival.

Given the fact that Murray (2012) and Dalrymple (2001) used different research methods, in different countries, over a different period of time, and reached similar conclusion, says something about the validity of the claim: personal habits drive poverty. Furthermore, by focusing on these types of personal behaviors, Murray and Dalrymple extend agency to the poor and provide them an option for individual empowerment. Negating the importance of personal behavior only leaves unwanted economic stratification as a problem to be solved by those with the education, tools, resources, and government/corporate connections. As Murray (2012) writes, the wealthy elites want to manage the lives of the poor, but they don't want to give the poor any responsibility. This is disempowering and paternalistic. Even for those who place more emphasis on the economic systems, it would hardly be unreasonable to encourage the poor to stop using intoxicants, watch less television, read more books, not have children outside of marriage, and eat healthier food, while "income inequality" is theorized upon in the interim. If nothing else, the poor will be better prepared for entering the workforce at a good starting salary once the wealthy elites figure it out (if they ever do).

One of the criticisms levied against scholars who suggest that the poor need to change their behavior in order to gain economic security is that the critics are being culturally insensitive. Dalrymple (2001) argues that the philosophy of cultural relativism has infiltrated the mindset of the societal elites, much to the devastation of the underclass. No longer do many of the well-to-do politicians, academics, and financially secure individuals within Western society shun or stigmatize bad behavior. Instead, the bad behavior of society's underclass is viewed as culturally quaint. In the introduction to *Life at the Bottom*, Dalrymple (2001) comments on the damaging effects of cultural relativism in Western education, and his observation is worth quoting at length:

> The climate of moral, cultural, and intellectual relativism – a relativism that began as a mere fashionable plaything for intellectuals – has been successfully communicated to those least able to resist its devastating practical effects. When Professor Steven Pinker tells us in his best-selling book *The Language Instinct* (written, of course, in grammatically correct standard English, and published without spelling mistakes) that there is no grammatically correct form of language, that children require no tuition in their own language because they are destined to learn to speak it adequately for their needs, and that all forms of language are equally expressive, he is helping to enclose the underclass child in the world in which he was born. (p. xi–xii)

Later, in the chapter, "We Don't Want No Education," Dalrymple (2001) discusses how, in many schools, teaching the "correct way of speaking and writing is to indulge in a kind of bourgeois cultural imperialism; and to tell children that they have got something wrong is necessarily to saddle them with a debilitating sense of inferiority from which they will never recover" (p. 71). He goes on to mention that some teachers try to ignore such absurd pedagogical encouragements but that it can be difficult to find a dispassionate academic foundation when dealing with the pressures of cultural inclusivity from other teachers, parents, and headmasters.

Beyond the divergent academic standards Western society has created between the poor and the nonpoor, there is also a need to address the lowered expectations society has come to accept regarding basic civility in poorer schools. In the United States, poorer schools are disproportionately found in black neighborhoods and far more likely to witness violence, and without evidence, this violence is too often excused as youthful reaction to racist oppression (see Williams, 2012). However, the disproportionately high number of uncivil behavioral similarities found between the poor white schools of England, and the poor black schools of America indicate that cultural norms are more closely linked to poverty, not race (see Sowell, 2016). As Williams (2012) writes about his own experiences growing up as a black American in the 1940s–1950s in Philadelphia, he is appalled that in 2010 nearly 700 Philadelphian school teachers were assaulted. While Williams (2012) concedes the "occasional after-school fight" during his upbringing, he emphasizes that "within the school, there was order. Students didn't use foul language to teachers, much less assault them" (para. 2).

In juxtaposing his school-days' stories with the violent norms of the modern-day Philadelphia School District "that makes a school police force necessary" (para. 1), Williams surgically debases contemporary arguments that fallaciously rely on noncausal factors such as racism, funding, and role models. Philadelphia in the 1940s–1950s was obviously more racist, had less funding for schools, and had fewer opportunities for blacks, and "most Philadelphia principals, teachers, and counselors were white" (para. 4). Yet, the schools were not bastions of violence. Therefore, to argue that racism and poverty drive violence in the twenty-first-century classrooms is a non sequitur and "sheer lunacy" (Williams, 2012, para. 3). Chiefly, Williams grew up in a school district that was non-violent because the culture demanded civility and "the fact that black parents, teachers, politicians and civil rights organizations tolerate and make excuses for the despicable and destructive behavior of so many young blacks is a gross betrayal" (Williams, 2012, para. 6).

In total, the elites understand which behaviors and tools are necessary to succeed, and they use them on a regular basis: standard English, rigorous education, marriage *before* children, temperance, showing up on time, discipline, etc. However, many of the elites have refused to promote these ideas to society's underclass for fear of being viewed as culturally insensitive. To appear culturally inclusive, the elites champion the idea of cultural relativism where all cultural behaviors and traditions are considered equal or, at the very least, destructive cultural behaviors among the poor are overlooked. The elites' failure to condemn bad cultural behavior only hurts those at the bottom who are engaged in such injurious behaviors. A poor child's weak grasp of English grammar will never effect the likes of Professor Pinker, but it most certainly will cause great damage to the child for the rest of his life. Likewise, a student's yelling, cursing, violence, and acting "hostile to the education process" will have no economic impact on lenient administrators and policymakers, but uninhibited incivility in the classroom "makes education impossible for other students" (Williams, 2012, para. 5). Of course, this all changes for the better if such damaging behavior is swiftly corrected by a dispassionate educator. In the end, poverty flows from a rather predictable pattern of cultural behaviors (Murray, 2012). Therefore, to propel themselves onto a path that leads out of poverty, the underclass must be willing to change many of their current cultural behaviors – and the elites must be intellectually honest with the underclass about the superiority of some cultural behaviors over others.

The Challenges of Poverty

Up until this point, this chapter has largely focused on the cultural trends exhibited by those living in poverty. While this essay stands by the findings and critiques of those scholars cited thus far, it is important to unearth the complexities of these critiques so as not to fall into what Goldsmith and Blakely (1992) refer to as Pathology Theory: a theory which would assume that people who are poor are somehow mentally or genetically deficient. What scholars such as Dalrymple (2001) and Murray (2012) put forth is no doubt stark, detached, and dispassionate, but it would be intellectually dishonest to charge their observations as a disparaging attack on these people. In criticizing their work, scholars who blur the line between valid cultural critiques of behavior and assume that this is somehow a de facto attack on people's humanity ought to carefully reread the scholarship.

Be that as it may, there is plenty of evidence suggesting that people who are poor do feel worthless, or of less worth, when compared to the culture at large (Goldsmith & Blakely, 1992). When living in a society that places emphasis on generating material and social value for one's community, it is reasonable to assume that people who have little to offer materially or engage in impeding social behaviors might feel marginalized. This becomes even more apparent when considering the ways family units operate and contribute to a community. Dual-income households generate more wealth in a community and two-parents are in a better position to rear and discipline children. However, poor households are far more likely to be headed by a single parent, which means that there is only the possibility of one-adult income, and managing time for child-rearing becomes increasingly cumbersome. Additionally, women are far more likely to head poor households, and thus, single-parent mothers carry a large majority of the poverty burden in the United States (Albelda & Tilly, 1997).

In his criticisms of Murray, and the "culture of poverty thesis" altogether, Greenstone (1991) sympathizes with the archetypal poor, single mother, but instead of blaming cultural behaviors, Greenstone blames society's misunderstandings about "ghetto-specific gender roles" and the "constraints on employment" that have "effectively prevent[ed] many inner-city men from becoming traditional breadwinners, husbands, and fathers" (p. 401). Notably, Greenstone's perspective fails to define these so-called constraints: statistically speaking, they are likely either a lack of education or a criminal record or both. Nor does Greenstone mention anything about the damaging economic consequences that overwhelming encumber women who have children with men with whom they are not married. It's as if these personal choices (having children before marriage, dropping out of school, and committing crimes) have nothing to do with the economic turmoil in many US communities.

Unfortunately, the fact remains that children who grow up in poor households (for whatever reason) are most likely going to pay the highest price for this economic instability. In her book, *No Shame in My Game*, Newman (1999) collected surveys and interviews from more than three hundred of the working poor in New York City. In her interviews with young adults, a common theme spoke to the difficulty young people have working long hours at minimum-wage jobs while trying to stay current with their education. One respondent, Ianna, said, "I don't want to work – I fear that if I work I might be setting myself up to fail [in school]" (p. 137). Another participant, college student Brad, had "tried to combine school and work by taking a night job on top of his day classes, but he found the combination too difficult" (p. 135). Newman (1999) goes on to summarize a significant amount of research indicating "that teenagers who work more than fifteen or twenty hours per week get lower grades, fight with their peers, have problems with their parents and teachers, and, most important, tend to disengage their energies from educational performance" (p. 122). These conclusions about working 20 h or more per week and its inverse relationship to a student's educational performance have remained consistent over the years (Bachman, Staff, O'Malley, Schulenberg, & Freedman-Doan, 2011; Perna, 2010; "Working more," 2011), and in 2013, it

was reported that nearly half of college students and approximately 8% of high school students were working these types of hours (O'Shaughnessy, 2013).

While these conclusions are generalizable across all economic demographics, the differences are found in a student's agency. In sum, a student from a financially stable household can quit his job because this student was likely only working for deposable income. At worst, this student's grades may have slipped to the point where the student has to settle for his second-choice college. However, a poor student might be working to pay rent or put food on the table. Arguably, this student cannot quit and thereby might accrue grades that make it difficult to attend community college or, God forbid, cause the student to drop out of high school. At this juncture, the student retards his education and may end up stuck at an entry-level job for far longer than his middle-class counterparts (Newman, 1999).

The intersection between family structure and one's early-life choices is a key element to understanding the cyclical nature of generational poverty and why ending the cycle of poverty can be so difficult. While the poor are more likely to belong to an unstable family unit, "we should not assume that 'irregular' household structures suggest a diminished regard for the importance of family life" (Newman, 1999, p. 195). Children from impoverished household love and idolize their parents just as much as those children from financially stable households. Yet, what remains unique is how children are socialized across various economic backgrounds and what children come to view as "normal" behavior. In the aptly titled *Marriage and Caste in America: Separate and Unequal Families in a Post-marital Age*, Hymowitz (2006) discusses the growing cultural and economic divide between traditional two-parent households and single-parent households. On average, two-parent households out earn single-parent households and children raised by two parents outperform children of single parents (Haskins, 2006; Haskins & Sawhill, 2003; Hymowitz, 2006; Murray, 2012). As the rich and poor become more culturally and geographically divided, children from poor households have fewer opportunities to observe the constructive lifestyle choices and social behaviors of people who are financially secure. So, messages such as "getting married before you have children is the best path toward educational and financial success" become foreign to teenagers who have never witnessed a functioning two-parent household. They simply do not know there is a difference between the behaviors of the poor and the behaviors of the rich.

Unfortunately, children's early behaviors in school and young adults' choices about sex and school/work balance can have long-term repercussions. Quite frankly, one cannot hold a 9-year-old accountable for his inadequate school performance if his parents are indifferent about his education (see Kristof, 2012). It is also difficult to hold a 16-year-old accountable for having a baby if she lives in a fatherless house with her 32-year-old mother. So, while the behaviors of each child are likely to lead to a life of poverty, it's really the adults' modeled behaviors that bear responsibility. Regrettably, many people are not in a position to fully understand and reflect upon their juvenile choices until they are well into adulthood. At this point, it becomes difficult for a person to "go back" and make more constructive choices (Riemer, 2001). Twentysomethings who did not complete their education might now have children of their own with piling economic and parental responsibilities.

Once a person has found herself in the thralls of the poverty, it becomes difficult to dig out. Suggestions on constructive social behavior are valuable, but if a person has forgone those suggestions either intentionally or unintentionally for the first few decades of her life, there are real obstacles regarding how one transitions from welfare to financially stable work. For the working poor, they may live in the oscillating state between meager wages and welfare, constantly hopping from one to the next. In the event a poor person has a steady, entry-level job, she still might find herself "one sick child away from getting fired" or "one missed rent payment short of eviction" (Newman, 1999, p. xiv).

While controversial, perhaps one unmentionable obstacle the poor face in an ever-increasing knowledge-based society is mental competence as measured by assessments such as IQ scores. In her exhaustive paper on the relationship between intelligence and social class, which includes nearly 170 references, Gottfredson (2004) writes that "much research has shown that [the general intelligence factor] actually plays a rather substantial role in practical affairs, especially in performing jobs well" (p. 174). In sum, there is link between genetics and general intelligence, and general intelligence can "predict the quality of self-maintenance and self-care in daily life" (Gottfredson, 2004, p. 177). Outside of work, general intelligence predicts a person's ability to perform daily tasks such as tracking credit scores, creating budgets, making travel plans, filling out forms and applications, and understanding basic economics for surviving in the global economy (Gottfredson, 2004). For instance, failure to grasp basic financial literacy can cause a person to fall prey to disreputable payday loans with egregious interest rates, which non-coincidentally happen to set up store fronts in poorer neighborhoods. Additionally, fundamental banking concepts like compound interest, credit card debt, car loans, insurance, security deposits, and financial aid may be lost on a person with rudimentary intelligence. Therefore, being poor can get expensive when calculating all the carried interests, debt, and liability from normal, everyday services (see Kornbluh, 2007).

Much to the dislike of this research, Kornbluh (2007) refers to credit access and welfare payments as a "right." And while this research strongly disagrees with that characterization for both moral and legal reasons, Kornbluh (2007) does offer compelling narratives about the difficulties faced by those on welfare trying to achieve a financially stable life. In order to successfully transition out of poverty, a person must obtain marketable skills. However, for adults, this can be extremely difficult. The most advantageous time to learn marketable skills is during adolescence while living under the auspices of a two-parent household that promotes education. Under these circumstances, a young person can fully concentrate on educational matters with little regard for having to financially manage food, shelter, or care for dependents. This adolescent lifestyle parallels the "welfare rights" system Kornbluh (2007) envisions for adult welfare recipients: a system that secures food, housing, and childcare for impoverished adults so they do not have to live at the mercy of economic uncertainty. The difference between the traditional adolescence system and Kornbluh's (2007) "adult welfare system" is that the traditional system promotes the acquirement of marketable skills so that young adults can become financially independent. Conversely, Kornbluh fails to mention anything about adults transitioning from financially dependent to financially independent. Instead, Kornbluh's work, sadly, positions the securing of "welfare rights" as the end goal.

The final problem that will be discussed here regarding how one transitions out of poverty is pointedly captured is the subheading "Welfare to What?" (Albelda, 2002). In the chapter "Fallacies of Welfare-to-Work Policies," Albelda (2002) makes the case that people have a difficult time transitioning off of welfare because entry-level jobs don't pay enough for working adults with families to sustain basic needs. This is especially true when one considers the disproportionately high number of single-mother households living in poverty (Albelda & Tilly, 1997). For example, between 1984 and 1990, two-thirds of the women who moved off the welfare rolls and into the workforce ended up working in low-paying jobs: Jobs where the employee earned less than the government defined poverty level even when working 40 h per week (Albelda, 2002). Frankly, many of these individuals simply are not "job ready" for a job that would pay enough to sustain a household, and that is mainly the reason these individuals are on welfare in the first place.

Furthermore, "employers, especially those who employ low-wage workers, will not tolerate workers who come in late because a school bus did not show up, miss days because there was no child care or a kid was sick, or worry about their children at 3 p.m. instead of doing their work" (Albelda, 2002, p. 87). Entry-level workers are disposable and easily replaceable, and welfare

recipients know this. Therefore, faced with family demands, it is easily justifiable to remain on welfare and have flexibility, than worry about getting fired or finding the money for a babysitter. There are also welfare-to-work programs that do not pay anything and instead demand a person participate in "unpaid community or public service" (supposedly to gain skills) as they transition off of welfare and into the workforce (Albelda, 2002, p. 82). This transition period is commonly referred to as "workfare," and it is obvious as to why this "unpaid" program would be considered unattractive.

Finally, there is a real concern about breaking up families. As Albelda (2002) writes:

> One way that some people without public assistance or income from other family members support themselves is to give up their children – by choice or by force. Newt Gingrich was lambasted for floating the idea of orphanages in the mid-1990s, but it seems totally plausible that the state will be seriously discussing this option soon. Newspaper accounts across the country often report on overloaded child protection agencies increasingly removing children from families for poverty-related reasons….child-only cases on the welfare rolls has increased steeply in a short period of time, from 17 percent in 1994 to 29 percent in 1999. (p. 82)

Overall, both quantitative data (see Albelda, 2002; Albelda, Folbre, & The Center for Popular Economics, 1996) and qualitative surveys (Conyers, 2016; Harvey & Conyers, 2016; Newman, 1999) indicate that there is a real temptation for individuals to remain on welfare in order to keep what little they have. Many welfare-to-work programs ask people to shed a lifetime of poverty-inducing habits in a short amount of time with little certainty as to whether their efforts will be fruitful. Notably, it is unlikely that people want to remain on welfare. To the contrary, most people want financial independence. However, many welfare recipients have been socialized in a culture of dependency *their entire lives*, and many programs are asking them to step out in faith into an ethic of which they have never been exposed. Financial independence might be ideal, but it can also be terrifying to someone who has been saturated in the welfare system since birth. Staying on welfare may have disastrous long-term consequences, but it is a far better, and far safer, alternative in the short-term.

The Poor Versus The State

In 1992, Marvin Olasky wrote the consequential book *The Tragedy of American Compassion*. While working on a grant from a Washington D.C.-based think tank, Olasky took a year-long sabbatical from his teaching responsibilities at the University of Texas to study the tombs of Congressional legislation. The summation of Olasky's research is often credited with greatly influencing the 1996 Welfare Reform Act; a law passed by a Republican congress and signed by a Democratic president, Bill Clinton. The so-called tragedy Olasky's work highlighted was that America was overwhelming generous with its welfare system but demanded little accountability from its recipients. In turn, people's basic needs were being met, but people had little resources or incentives to move off of welfare and into a financially independent life. As far back as the 1970s, sociologists and economists were commenting "that the basic needs of all people who involved themselves in the welfare system – and it was very easy to do – were being met" (Olasky, 2008, p. 184). The problem was that once people got onto welfare, they were not leaving the rolls. The 1996 Welfare Reform Act purported to help people move off of welfare and into financial independence.

But the 1996 Welfare Reform Act was not without controversy, and people continue to debate its effects. In the 2010 book, *Living on the Edge in Suburbia*, Lawinski decried the "severe time limits" welfare reform placed on programs like Temporary Assistance for Needy Families (TANF), which allocates funding mostly to single mothers to help supplement food and childcare expenses (p. 87). With some state and individual exceptions, TANF is a welfare program that can be utilized for up to *5 years*. However, Lawinski writes that "five years is far from adequate and is socially inequitable given poor people's circumstances" (p. 87). Even

before welfare reform was passed, organizations like The Center for Popular Economics not only disapproved of cutting and restructuring welfare benefits but actually advocated for more welfare spending (Albelda et al., 1996). In 1996, they demagogically titled their alternative policy book *The War on the Poor: A Defense Manual*, just to make sure people knew how much House Speaker Newt Gingrich, Marvin Olasky, Charles Murray, and other critics of the welfare state, must hate the poor.

Of course, when one gets into the actual details regarding welfare spending as well as the qualitative effects of this spending, it's clear to see how this "war" rhetoric is rather misguided. In speaking on the unintended consequences of the welfare system, Michael Tanner stated:

> The poverty rate has been effectively flat for almost fifty years, suggesting that the welfare system has done little to increase self-sufficiency among the poor. In essence, our welfare programs are not fighting poverty by helping people escape to the middle class through work and education; the programs are merely making the terrible situation of living in poverty more endurable. We are throwing these people a life preserver to keep them afloat, but not pulling them into the boat. We are effectively creating and perpetuating a dependent class. (as cited in Conyers, 2016, p. 39)

The ineffectiveness of welfare programs is even more alarming when one considers the fact that there are upwards of "five hundred different categorical social service programs under federal auspices" (Olasky, 2008, p. 189).

Naturally, a system with such a plethora of programs can be extremely complicated and unmanageable. In *Homeless: Narratives from the Streets*, one interviewee reported that the system was so complicated that "he thought it was a good idea to 'apply for everything and see what [he got]'" (Phillips, 2016, p. 128). There is no forethought with regard to which program is appropriate for their situation or which program will most likely help them transition into financial stability. It is simply a mind set of "I have an immediate need and no time to deal with trivial paperwork." Even Lawinski (2010), an advocate for more welfare bureaucracy, catalogued these types of stories. One of her participants, Shayleen, became so frustrated with running "back and forth" from the Department of Social Services to the homeless shelter in order to figure out her benefits that she eventually said "fuck it" and just "relinquished her public assistance" (p. 70). Shayleen got by in the interim by utilizing friends, family, and selling drugs, and eventually she reenrolled in a few different welfare programs. But with staggered time limits and different criteria for different family structures for different states, chances are Shayleen will have "exhausted federal aid" before she finds economic stability (Lawinski, 2010, p. 71). While some interpret these data to mean that America needs more welfare spending and should allow people to stay on welfare for longer, this research is convinced that these data indicate a need for streamlining efficiency and investing in a restructured welfare state where people can spend their time honing job skills instead of spending their time navigating an impossible bureaucracy.

Amazingly, the complicated welfare system isn't just a challenge for the poor in need of benefits. The complicated welfare system is also *a challenge for social workers!* Citing various national publications, Olasky (2008) relayed interviews from well-intentioned, good-hearted social workers desperately wanting to help the poor. One social worker remarked that "the paper work is just amazing. There are copies and copies of everything, dozens of forms to fill out….All we have time to do is move paper. I have yet to solve any social problems" (p. 189). Former journalist Nathaniel Dunford quit his job at "the *New York Times* to take a position at half the pay as a caseworker with New York City's Child Welfare Administration" (as cited in Olasky, 2008, p. 189). Dunford said, "I lasted two months…. Paperwork ruled the office; social work was secondary. I got more forms and documents on my first day than I had seen in seven years at *The Times*" (as cited in Olasky, 2008, p. 189).

Even when paperwork is managed properly and benefits are obtained, it is possible that "the welfare system backfires – actually harming the people it is supposed to help" (Conyers, 2016, p. 37). For example, many welfare programs calculate benefits based on income and assets. As a

person's income and assets fluctuate, benefits change. Unfortunately, a onetime spike in either category can derail what had been steady welfare payments. This can cause a beneficiary to temporarily lose all benefits and have to go back to the beginning and start all over again – at the expense of retarding or obliterating all personal progress toward financial independence. For example, Shauna was a welfare recipient living in the Bronx who received her grandfather's car when he died. As Shauna told it, "it was a Cadillac, and worth about $8,000. Unfortunately, he left it to just me, with the understanding that I'd share it with my sisters – but that doesn't work. In the eyes of the welfare office, I had an asset worth $8,000 and that was going to disqualify me from benefits – I was going to lose my housing voucher, Medicaid, food stamps, cash assistance…all of it" (Conyers, 2016, p. 41).

Markedly, these types of qualitative responses are not unique, nor are the frustrated narratives exclusive to New York. In Seattle, Frank received $200 a month in food stamps, and most of his work was "low-wage, seasonal, or temporary, which means that from month to month, if he were to work, his income could fluctuate dramatically" (Harvey & Conyers, 2016, p. 12). If he earned more than $500 during any given month, he risked losing his benefits even though the following month he may earn $0. So, in the interest of securing his benefits during slow-work months, Frank chooses not to work as much as he could during months when work was plentiful. "Earning money is thus a threat to his well-being" (Harvey & Conyers, 2016, p. 12). Analogously, in Georgia, a part-time waiter named Ryan got flagged and temporarily lost his food stamp benefits because he failed to disclose a Christmas gift check from his aunts (Harvey & Conyers, 2016). In Carbondale, Illinois, Kristen shied away from job opportunities because she did not want to lose her place in line for public housing (Phillips, 2016). If Kristen got a job, she would immediately be kicked off the public housing list, and she worried that if the job did not work out, she would have to go to the back of the line and wait another 18 months for an opening.

All of this unaccountable bureaucracy breeds dependency. Some scholars and advocates have a distaste for the term "dependency" because of its negative connotations toward the poor: essentially, an interpretation that the poor wish to be dependent. However, its use should not be misinterpreted. For this research, "dependency" describes the condition where welfare recipients are entwined to the system because bureaucrats have created a system that is difficult to exit once a person steps over the threshold. As seen in the previous examples, the poor must forgo work, inheritance, and even gifts in order to stay wedded to welfare. To successfully move off of welfare, the poor need to be able to try new jobs and take advantage of small loans. However, the welfare system makes it clear that any infidelity will be punished. Jobs, inheritance, and gifts are only temporary, but government benefits are forever. It's safer to stick with a sure thing.

The poor's dependency on the jealous welfare system is found nowhere clearer than in the drastic decline of marriage among poor single mothers (see Murray, 2012). Again, this does not necessarily mean that poor single mothers wish to raise children on their own. What it means is that the government propagates dependency by providing single mothers with a choice: get married and lose benefits or don't get married and continue to receive benefits. For young mothers, "to gain a full share of government-funded social services, pregnant teens had to be on their own, without support from either family or the child's father" (Olasky, 2008, p. 187). Even couples who remain unmarried but want to live together to jointly share rent, food, and child-rearing do so at the risk of the mother losing her benefits. Therefore, if the father of her children is a good man but struggles financially, then it is better for the mother to remain unwed and live alone with the children because the woman knows "that the government [is] required to be faithful" with monthly welfare checks (Olasky, 2008, p. 187). Without a father in the house, the children grow up "emotionally impoverished" not knowing "what it is like to have a father who could love them and discipline them" (Olasky, 2008, p. 187).

This is a terrible predicament for the mother, father, children, and community, and this predicament provides no certain path toward a successful exit. Ironically, it actually provides a path toward more and more dependency as families are broken, work skills atrophy, and communities decay. In the face of all these new problems, someone will inevitably say "we need a new government program!" Arguably, this type of government dependency is nearly impossible to escape from.

Changing the Culture

Poverty continues to persist in the United States despite the copious amount of national wealth poured into the welfare state. In 1992, $190 billion was spent on federal welfare programs (Murray, 1992). Today, approximately $700 billion is spent on federal welfare programs yearly (Harvey & Conyers, 2016). This does not even include state and local contributions. At this juncture, it seems the only reasonable solution one could argue for is a seismic cultural shift in America's approach to poverty; both a shift in the cultural behaviors of the poor as well as a shift in the entrenched welfare bureaucracy. First, this section will deal with the personal habits of the poor.

In 2013, Ron Haskins, a long-time welfare policy wonk from the left-leaning Brookings Institute wrote a short article titled, "Three Simple Rules Poor Teens Should Follow to Join the Middle Class." The brevity, clarity, and simplicity of these solutions were astonishing given Haskins' decades of work and thousands of pages written on the subject. Haskins (2013) wrote the following: "Let politicians, schoolteachers and administrators, community leaders, ministers and parents, drill into children the message that in a free society, they enter adulthood with three major responsibilities: at least finish high school, get a full-time job and wait until 21 to get married and have children" (para. 2). Haskins goes on to cite that "research shows that of American adults who followed these three simple rules, only about 2 percent are in poverty and 75 percent have joined the middle class (defined as earning around $55,000 or more per year)" (para. 3). Furthermore, a previous economic simulation by Haskins and Sawhill (2003) showed that following these three rules could reduce the current rate of poverty by 71%.

Arguably, the second rule, get a full-time job, is the most deliberated solution since outside factors seemingly play a role in a person's employment status. However, statistically speaking, work opportunities are not the primary reason the nonpoor *work twice as many hours* as the poor since these numbers stay consistent in both good and bad years for the national economy (Haskins & Sawhill, 2003). Instead, poor adults may work half the hours of the nonpoor because entry-level work does not pay as much as welfare subsidies and starting on the bottom rung of the economic ladder is arduous in the short-term. Yet, if these "work a job, any job" habits are encouraged from a young age, then by the time a person reaches adulthood, they will more likely have the necessary skills to obtain a better paying job that will allow them to support a family.

This leads to Haskins third rule "wait until 21 to get married and have children." Particularly, the order of this rule is extremely important: "get married" is listed before "have children." On the changing demographics in the rise of unwed mothers, Haskins (2006) commented that America is "flirting with disaster" if it does not address this "significant factor" that perpetuates generational poverty (p. x). Fathers are not only important for income, child-rearing, and emotional support, but *marriage* is important because couples who simply cohabitate are twice as likely to split and "once a father ceases to cohabit with the mother of his children, that father tends to become disconnected, both financially and psychologically, from his children" (Horn & Sawhill, 2001, p. 426). While some antipoverty advocates might find these types of behavioral solutions as moralistic or victim-blaming (see Albelda, 2002; Albelda et al., 1996; Kornbluh, 2007), the fact is that welfare payments are always only a temporary solution to a much bigger cultural problem: the problem of impoverished communities unable to independently sustain themselves. There is no

doubt that the poor need assistance to help pay for basic needs. However, money is not the root problem nor a long-term solution. Instead, money (or lack thereof) is only a symptom of several destructive cultural behaviors. The government has money and has been pouring it into poverty programs for decades with little results. Without changing the habits of the poor by encouraging education, work, and marriage, there is little hope for attaining long-term financial independence within these enclaves.

Second, in addition to addressing the personal habits of the poor, America also needs to drastically address the culture of the welfare bureaucracy and shift its focus from simply providing basic needs to people to "treating people as people" (Olasky, 2008, p. 233). In this regard, Murry (2012) makes a distinction between "welfare" and the "welfare state." In none of the literature on the topic of "welfare reform" do any scholars or politicians call for the elimination of welfare to those most vulnerable. There is no "war on the poor" (see Albelda et al., 1996). Everyone wants to reduce the number of people living in poverty. What this research rejects is the paternalistic nature of the "welfare state" that is impersonal and unaccountable and allows beneficiaries to engage in irresponsible behavior with no consequences. Without consequences, irresponsible behavior among the poor persists, and there is no hope for long-term solutions.

As one of its fundamental *raison d'être*, the welfare state resolves to create more programs, promote more programs, and justify its very existence through further expansion and longer clientele lists. This is anything but social work. This is narcissism, self-expansion for the illusion of self-importance. Those who reject this type of welfare state expansion argue instead that welfare should promote work and give people the authority over their resources. That is why ideas such as eliminating welfare programs altogether and replacing them with either direct cash benefits or an expansion of the earned income tax credit (EITC) have grown in popularity (Conyers, 2016; Murray, 2012; Stoesz, 2000). The EITC is "a tax credit for the poor which essentially tops off workers' wages at a certain income level by giving them rebates on their taxes if their income falls below a certain level" (Conyers, 2016, p. 50). In these types of programs, people are encouraged to work as much as they can and make as much money as they want without worrying about losing benefits because their monthly income temporarily exceeds an arbitrary number. At the end of the month, the government will help supplement a person's income if they did not make a set amount of money. Because this is done through payroll, it is easy to determine if a person made a set amount money each month; just look at his paycheck. In the current welfare state, things like income and assets are irregularly assessed by social workers at the welfare office who have to file endless paperwork for the approval, denial, or elimination of benefits. If someone loses his benefits due to a temporary spike in income, it could take several months to have them reinstated even if next month's income is $0.

Realistically, some people don't want to work, will avoid work their entire life, and always cash in on the maximum government benefit. However, remember that currently some people who want to work are avoiding work because they are afraid of how the welfare state will interpret their new income. People in general, and poor people especially, should never be afraid to take a job for fear of losing financial security! For the majority of poor people who want a better life for themselves and their families, programs like the EITC allow them to stay in the workforce, gain work skills, and move up the economic ladder.

EITC programs also accomplish two other major items. First, it nearly eliminates the need for the welfare state and its cumbersome bureaucracy. Second, it gives poor people control and responsibility over their lives (Murray, 2012). Currently, the welfare state tells adults that food stamps can only be used for food, Medicaid can only be used for healthcare, and housing vouchers can only be used for rent. This is infantilizing. EITC programs give people a choice as to how to spend money. Imagine this: instead of mandating that a $1,200 housing voucher must be used to pay rent for awful public housing, a poor person could use that $1,200 to invest in a small mortgage, which turns into a lifetime of equity.

No longer do social workers and the welfare state get to dictate spending habits and, thus, create dependency, e.g., "You must use this $1,200 for public housing or I'm not going to give it to you." Instead, people are free to make their own decisions, and since their finances are their own, they are encouraged to invest wisely. A substantial problem with the current welfare state is that it continues to send checks as long as a person remains poor but regardless of a person's behavior. Thus, people have no incentive to change. However, when a person controls her own money, bad cultural behaviors are no longer tolerated since she now has to pay for her mistakes. In the end, poor people are moved away from a culture of paternalistic dependency towards a culture of mature independence.

Conclusion

The book, *Homeless: Narratives from the Streets*, ends with a quote from economist Walter Williams that bears repeating (Phillips, 2016). Discussing the welfare state in *Race & Economics*, Williams (2011) wrote:

> Decent people promote policy in the name of helping the poor and disadvantaged. Those policies can make their ostensible beneficiaries worse off, because policy is often evaluated in terms of intentions rather than effects….Compassionate policy requires dispassionate analysis. Policy intentions and policy effects often bear no relationship to one another. (p. 3)

These words are needed during contentious debates on poverty and welfare where rhetoric gets heated and people's quality of life is at stake. Scholars from various political, social, economic, and religious backgrounds are engaged in the much needed research aimed at alleviating poverty, and all of them engage in this debate because they want to improve the lives of the poor. We might come to very different conclusions that leave each other impassioned, but as Minow (2000) reminds us, "the public square should be filled with boisterous, conflicting views about how to address these questions" (p. 171).

It is best to never ascribe motive to someone's honest scholarly opinion but instead to vigorously debate ideas with the hope of reaching the best solution. There is no doubt that certain patterns of behavior (intoxicant use, television viewing habits, educational commitment, reading habits, work ethic, nonmarital births, marriage, and crime) are correlated with poverty. The debate among scholars is whether or not this relationship is causal and, if so, in what direction? Do these behaviors cause poverty or does poverty lead to these behaviors? If it is the former, which I assume it is, then society should work to change these behaviors in order to alleviate poverty.

In numerous other areas of life, people encourage others to change behavior in order to improve productivity and quality of life. Bosses encourage employees to try new strategies, teachers encourage students to read more, coaches encourage athletes to work out more, and parents encourage children to say "please" and "thank you." So why ought it to be viewed as egregious to encourage the poor to adapt the habits of the nonpoor? There is an overwhelming amount of evidence that certain patterns lead to a financially independent life. There is also an overwhelming amount of evidence that the welfare state is broken and needs to be drastically reduced and restructured in an effort to give control of their lives back to the poor. To be clear, I do not want to abolish the welfare state because I have a secret agenda for cutting the size of government, and thus, reducing my tax bill by an unnoticeable amount. I want to abolish the welfare state because it fosters dependency, retards work ethic, and destroys one's sense of self. To end with the words of Conyers (2016):

> Welfare doesn't end poverty. Work does. And with work comes identity, pride, self-esteem, self-control, and yes, happiness. As I learned from the many Americans I interviewed, the fleeting feelings of security and safety to be had by turning over our lives and destiny to the government pale in comparison to the feelings of freedom and control we experience when we take full responsibility for our lives. As those Americans taught me, the alternative – the lost autonomy and loss of responsibility that comes with government oversight and control – is ultimately destructive to the human spirit. (p. 51)

Let's end dependency, encourage life-producing behaviors, and create an environment where the poor are allowed to take responsibility for their lives. Productive work and autonomy give meaning to life. And life is too short not to begin immediately.

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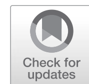

17 Cultural Competence, Identity Politics, and the Utopian Dilemma

Daphne Patai

Cultivating Sensitivity

Imagine that you are trying to build a good society, one characterized by social harmony, stability, civility, mutual understanding, and fairness. Would individual freedom and autonomy be part of that picture? Or might they create the very conflicts and tensions the good society was designed to resolve? What would you be willing to give up for the utopian vision? And what are your chances of attaining it once you have made those concessions?

Today, in the academic world and outside of it, a vocabulary has arisen that, in the most positive reading, reflects the age-old desire for a better world. Universities, in many ways self-enclosed entities despite their dependence on federal, state, and/or private largesse, routinely proclaim their commitments to terms that are largely interchangeable, each defined by reference to ideologically related terms: multiculturalism, cultural competence, diversity, equity, and inclusion. These terms all rapidly shade off into moralistic claims for, most broadly and vaguely of all, "social justice."

The result is that the modern university, ostensibly devoted to free intellectual inquiry in service to the pursuit of knowledge, has become the location most vulnerable to the pressures and consequences of sweeping utopian aspirations. This is particularly pernicious in the context of higher education, where time is short and each new shift in focus necessarily occurs at the expense of something else. In fields such as applied psychology, teacher training, social work, and similar programs, social justice ideology has, in recent decades, come to play a powerful role, increasingly embracing a narrow and highly problematic perspective that in fundamental ways works against the very notion of creating autonomous individuals capable of determining their own political and moral commitments.

The institutional politicization of education might be somewhat acceptable in an academic setting presenting a spectrum of views on important political and social issues. But this is rarely the case. Instead, left-liberal ideas, often derived from a threadbare Marxism, are routinely promoted as the only possible legitimate perspectives. This has created the phenomenon that is referred to as "political correctness," a term whose use was originally inflected with irony but that has become a straitjacket, inhibiting dissent and even overtly attacking the very notion of free speech. Such a subjugation of educational aims to ideological ones has made American universities come perilously close to destroying the very values that made them famous all over the world.

In conjunction with the reality of shorter semesters and lowered expectations for student

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performance, the new politics of education carries significant consequences: precious time and resources are diverted from education proper, which is instead explicitly subordinated to the political passions of the moment. Entire programs these days proudly proclaim their social justice agenda and require conformity on the part of students and faculty. The constantly repeated retort to critics of such an agenda is that "politics is already everywhere" (a perspective popularized by Foucault) and all that matters is who has the power to impose their own interests by making them pass for truth (Gitlin, 2005, p. 403), a view that effectively characterizes totalitarian regimes. It is something new, however, to see professors in liberal western democracies assert that they are merely doing openly what (so they claim) has always been done surreptitiously – politicizing the classroom – and being proud of it. Such statements efface the crucial distinction between the schooling mandated by societies in which debate is stifled and that promoted by liberal arts universities in western democracies, where education rather than indoctrination is or should be the goal.

The role of the university – it cannot be repeated often enough–ought to be to teach students *how* to think, not *what* to think. Universities fail to fulfill their function if, while opening their doors to more and more people and groups in search of higher education, they simultaneously close them to the exploration of competing ideas and opt instead for the inculcation of currently favored dogma. This has taken the form of prohibiting certain speech (through speech codes and so-called harassment policies)[1] but also, and increasingly, compelling approved speech. In other words, avoiding the supposed harm of hurtful statements and dissenting views is but one pole of the new bureaucracies; the other is forcing expressions of obeisance to particular ideas. Both are regularly found in the entire "social justice" agenda.

As Jonah Goldberg observes in his book *The Tyranny of Clichés* (2013), "One simply cannot be in the do-goodery business without making reference to the fact that you're fighting for social justice." The result, he states, is that the term "social justice" is now used as merely "a placeholder for goodness" (pp. 132–34).[2] But how, one may well ask, can anyone be opposed to social justice? Goldberg explains:

> The fundamental problem with social justice is that there are no limiting principles to it. It is an open-ended license for the forces of goodness to do what they think is right *forever*. It is an empowering principle for the high moral ground in all political debates. There are no boundaries, no internal checks, no definitional roadblocks. It's social justice for as far as the eye can see. (p. 144, his emphasis)

For their part, universities have been actively engaged in promoting such an agenda for years, under a variety of names. In 2002, the National Council for Accreditation of Teacher Education (NCATE) made the term "dispositions" part of the accreditation process of every teacher. Nor was this a vague suggestion. KC Johnson, an accomplished scholar and teacher, was initially denied tenure at Brooklyn College on the pretext of being "uncollegial" because of his criticisms of current campus orthodoxies, in particular the weeding out of teaching candidates for not having the right "disposition," meaning commitment to "social justice" (Johnson, 2005; Editor, 2016, March 22).

Despite criticisms of this trend from people of varying political persuasions, the demand

[1]The numerous analyses and rankings of cases and speech codes/harassment policies on American campuses, detailed at the Foundation for Individual Rights in Education's website (www.thefire.org), give a thorough portrait of the crisis of free speech on American campuses over the past two decades, as does FIRE president Greg Lukianoff's book *Unlearning Liberty* (2012).

[2]"Social justice" is almost never defined by those who embrace the term. A Google search of the phrase in early November 2016 turned up nearly 30 million links; by February 2018, the number had swelled to over 42.5 million links. Definitions vary, from vague references to fairness or respect for human rights, to explicit appeals for redistribution of wealth, privilege, and status. It is hardly an encouraging sign that even the United Nations General Assembly, as Goldberg (2013) reminds us, starting in 2009 designated February 20 as an annual World Day of Social Justice. The world, it appears, has not noticed.

that students and faculty manifest specific political commitments has only increased, matched by a corresponding decrease in the actual intellectual and ideological diversity of higher education. Programs in "social justice education," for example, are not shy about declaring their convictions and insisting applicants share them. At the University of Massachusetts Amherst (2009), students wishing to enter the Master's and Doctoral programs in social justice education must demonstrate their "applied social justice experience." The all-encompassing goal of these programs is plainly laid out: "Students in social justice education study the inequities that people experience on the basis of their social group memberships, through systems of constraint and advantage reproduced through the social processes of exploitation, marginalization, powerlessness, cultural imperialism, and violence."

Thus does a contentious interpretation of what causes social inequality get recast as truth, to be communicated to students as unquestionable fact. From there, social justice activism spreads throughout the country as graduates take their training into teaching, school counseling, special education, research, and school administration – positions from which they will train future generations in the same narrow perspective.

New faculty appointments are being defined in similar terms: A recent listing for a tenure-track position in "Diversity and Community Studies" at Western Kentucky University (2016) states: "While disciplinary training and area(s) of research are open, candidates should have experience with community-based participatory action research and social justice scholarship." Candidates must, furthermore, demonstrate "commitment to transformative pedagogies and social justice approaches." Contributions to the goal of "diversity" are also crucial. At Texas Women's University (2016), the Department of Multicultural Women's and Gender Studies, which offers a PhD, MA Graduate Certificate, and undergraduate minor, is seeking a chair to lead its "exciting multicultural curriculum that integrates diverse perspectives and critically applies feminist/womanist scholarship on behalf of social justice."[3]

Nor are such commitments demanded only of faculty entering a few particular fields. At the University of California, San Diego (2016), a "knowledge of diversity, equity, and inclusion" (DEI) has been required of all candidates for a Bachelor's degree as of 2011. Furthermore, elaborate institutionalization of DEI throughout the university in all its aspects is spelled out, including through evaluation of faculty members' "contributions to diversity." The University of Cincinnati, inspired by UC San Diego, announced that starting on July 1, 2016, a "diversity and inclusion" statement will be required of applicants for faculty and staff positions (Reilly, 2016). As the university's senior associate vice president and chief human resources officer sanctimoniously and repetitiously explained: "This application request recognizes that the university is a diverse environment and signals that diversity and inclusion are important enough that we're asking applicants about contributions or potential contributions up front. We're all better off with diversity in our lives, [as] part of demonstrating our commitment to diversity and inclusion and setting expectations and priorities." Using more up-to-date language, Cincinnati's Office of Diversity and Inclusion at the College of Medicine stresses that the College has "enhanced our curriculum to incorporate integrated cultural competence activities" and that "cultural competence is infused into the curriculum." As if this were not sufficient, it also requires a "class oath" to diversity (University of Cincinnati College of Medicine, 2015).

For those who remember the loyalty oaths of the 1950s imposed by some states on public school teachers, who in many cases were also required to affirm that they were not members of the communist party, the current demands for ideological conformity should be disquieting, not to mention a clear violation of First Amendment

[3]For a general view of the reigning ideology of similar programs, see the job listings for Women's Studies at HigherEdJobs (2016, October 24). Retrieved from https://www.higheredjobs.com/faculty/search.cfm?JobCat=96

rights. In a democratic society, citizens participate in civic affairs without being forced to declare their politics any more than their religious beliefs. Open debate – and dispute – about such issues is crucial, as is the freedom to express unpopular opinions without fear of punishment. Although education, even if intended primarily to transmit skills and information, is not entirely value-neutral, that is a far cry from setting education up as a system for the indoctrination of young people into the unquestioned and unquestionable beliefs of the moment. Free inquiry evaporates in a climate in which the "right" ideas cannot be challenged and, instead, must be adhered to as articles of faith transformed into a condition of entering public schools and civic life.

The spread of declarations of commitment to "diversity" throughout educational institutions in the United States has been an extraordinary phenomenon. "In the marketplace of political culture," as Randall Kennedy notes, very few terms have acquired influence as quickly as "diversity" – and that influence continues to grow (cited in Baehr & Gordon, 2017).

Interestingly, all these terms tend to be defined by reference to the other like-minded terms. Thus, after decades of usage of "multiculturalism" in many contexts, the term was recently defined by Kenan Malik (2015) as "the embrace of an inclusive, diverse society." He goes on to note: "Multiculturalism has become a proxy for other social and political issues: immigration, identity, political disenchantment, working-class decline." In other words, like Goldberg's definition of "social justice," multiculturalism stands in for "goodness," that is, manifesting the correct attitudes about a whole range of issues.

Within the "social justice" agenda, the vocabulary of "cultural competence" is a fairly recent addition, not yet as widespread as the far more familiar "multiculturalism" and "diversity." Nonetheless, a Google search in February 2018 of the terms "cultural competence" plus "UMass Amherst" – the university from which I recently retired – turned up nearly 20,000 links. Like the other current touchstones, however, "cultural competence" is an accordion phrase, capable of expansion as needed.

But there are important distinctions to be drawn between it and the earlier terms. Though they all reflect a similar ideology, now overtly proclaimed in academe, "cultural competence" has a certain cachet lacking in mere "diversity," "inclusion," and "multiculturalism," for it implies an effort to acquire and act on professional expertise and knowledge, ostensibly to meet the legitimate needs of certain clients. Ironically, in the age of Foucault (1977), for whom knowledge is inseparable from power (hence his coinage "knowledge/power") – diffuse, ubiquitous, and conceived above all as the negative power to coerce, oppress, and control – the very concept of competence (akin to that of "expertise") can be and often has been used to delegitimize those whose access to knowledge necessarily makes them guilty of having "privilege" of one sort or another.

If "cultural competence" today nonetheless carries a positive connotation (a good to be acquired), "privilege" – whether material or not – implies the reverse. It is one of the nefarious sins that must constantly be sought out and identified, taking its place alongside "microaggressions" and other dangers purportedly besetting academe. These dangers seem to have multiplied in recent decades, so that students now require "trigger warnings" and "safe spaces," in and out of the classroom, to guarantee the comfort of those unable to live without perpetual vigilance over their daily lives. Only in this manner can they spot the interminable affronts that need to be denounced and rooted out, so as to usher in the better society hovering just out of sight.

Cultural competence, then, in addition to the uncomfortable whiff of privilege the term ironically exudes, cannot escape the shadow of its opposite: cultural *incompetence*, not something anyone would wish to display. In much the same way, "multiculturalism" evokes its nemesis, the specter of *uniculturalism*, as if, without endless propagandizing, this is what American society would indulge in. In the academic world and beyond it, most people know which side of these rhetorical divides they must be on. So far reaching is this nomenclature that merely to question the concepts or point out their slipperiness is already

to have committed grievous social and ideological sins that invite name-calling, ostracism, and possibly job loss.

Even university presidents and other high-level administrators have discovered this in recent years (e.g., Lawrence Summers, former president of Harvard; Tim Wolfe, former president of the University of Missouri; or Mary Spellman, former dean of students at Claremont McKenna College). Forced resignations or summary dismissals usually follow abject apologies worthy of Soviet reeducation camps or Maoist "self-criticism" sessions, designed as rituals of public humiliation and object lessons to others who might consider straying from the official path of righteousness. In business, the media, and virtually all other arenas, the same consequences may occur when a comment deemed offensive to one or another protected group or cherished belief is uttered.

Leaving aside the thorny question of just how "culture" is to be defined, however, there is nothing to prevent the recognition that it is socially useful for people to understand basic rules of conduct that may prevail not only within their own but also in other groups. That is why entrepreneurs and politicians, for example, seek instruction from the scores of cultural competency trainers and experts easily found online, rather than risking gaffes that will scuttle the very things they are trying to accomplish in their national and international endeavors. Indeed, an Internet search (February 2018) readily produced over half a million links and resources dealing with cultural competence training, experts, curricula, and consultants and hundreds of thousands of links to articles, textbooks, manuals, and guides on the subject of acquiring or building cultural competence.

If all of us obviously benefit from having some degree of "competence" in dealing with people of other cultures, this has always been so, and humanity has nonetheless managed to survive without special training by professionals in this arena. As Denis Dutton (1995) observes, "Multiculturalism is, after all, something that simply happens whenever cultures live with each other, a fact continuous through recorded history." The novelty, he goes on to say, is that "in European and American society today, the term has come to denote not a social given, but a political imperative: multiculturalism is ideology." And in its name, protests, grievances, demands, and accusations currently flourish.

Through a series of pointed contrasts, Craig Frisby demonstrates why "multiculturalism research" is an oxymoron, "*a sociopolitical ideology, not a science*" (2013, his emphasis). He also provides a useful chart to help clarify the features distinguishing sociopolitical ideologies from objective empiricism (2013, Table 10.3) The goal of empiricism, he explains, is to discover objective truth, whereas the goal of multiculturalism is simply to advance multiculturalism, and to do this it relies on the "claim that cultural groups determine their own versions of reality" (p. 518). Such a postmodern view is then used to bolster current orthodoxies that allow no challenges whenever a minority group member claims to have been the victim of, say, racism or sexism – the mere assertion of which is taken as truth. Similarly, research, however sound, daring to question multiculturalism's core beliefs is regularly condemned, along with its authors. The ensuing problem is that when truth and falsity are adjudicated by who speaks and who feels aggrieved, not by the relationship such charges bear to empirical evidence, we're in free fall and can expect that those who yell the loudest and claim the greatest oppression will rule. "Gotcha" becomes the predominant game; free speech withers and intergroup relations deteriorate – not a pretty picture and certainly not the way a democracy is supposed to function.

In practice, however, only some identities are credited, and these, unsurprisingly, turn out to be associated with oppression, as if today's activists believe in what Bertrand Russell (1950) ironically referred to as the "superior virtue of the oppressed." Russell followed through on the logic of this delusion, arguing that if the left really believed it, they should want to promote the conditions (such as poverty) that produce this oppression. But logic is not the point. Rather, what carries the day is a moral ranking of identities, a mere reversal of the traditional ranking that

placed the wealthy and powerful at the top of the heap. Today, such identities, while secretly envied and emulated, are taken as a negative, as is the mere fact of being white and male, hence the wholesale disparagement of "white male culture" and the now commonplace emphasis on "toxic masculinity." This is reflected as well in the very different curriculum found in Men's Studies programs with their emphasis on guilt and shame (Raphael, 2016), as opposed to Women's Studies, which are devoted to celebrating women and denouncing "heteronormativity." If to Foucault knowledge is power, to the politically correct, an identity involving oppression is advertised in an effort to acquire power and position.

Thus, in jarring contradiction to the project of overcoming ethnocentrism by embracing multiculturalism and cultural competence, we are instead fostering a society fragmented into identity groups loudly proclaiming their oppressions, real or imaginary, and all insisting on redress.

The notion of identity politics is thought to have developed as Marxism, with its focus on the working class and call for economic justice, fell out of favor. Though at times used by social scientists in a neutral way to describe how social movements "alter the self-conceptions and societal conceptions of their participants" (Anspach, 1979, p. 765), the term quickly came to characterize race and gender struggles rooted in individual identity but that could be leveraged into a political weapon. As its use spread, it proved of great political utility for any group attempting to press its case and browbeat others into submission, allegedly as compensation for claims of past or present oppression. While it is still used most commonly in relation to race, gender, class, and sexuality, it morphs and expands as groups break down into more and more specific delineations of identity, always insisting on recognition that the more oppressed identities an individual can claim, the better.

The use of identitarian labels, it turns out, does not lead to an appreciation of cultural difference. Instead, the potential celebration of other cultures veers into a solipsistic preoccupation with one's own suffering, taken as a point of pride and always attributed to a devalued group identity, while actual diversity of perspectives and political positions is discouraged if not disallowed. As Peter Wood noted in his book *Diversity: The Invention of a Concept*, the most familiar form of diversity ideology today:

> asserts that American society is a hierarchy in which whites oppress other groups, and that individuals participate in the perpetuation of this hierarchy by harboring hurtful stereotypes about the members of the oppressed groups. The word "diversity" in this context refers to the set of beliefs that liberates the individual from his attachment to these stereotypes by allowing him to see the worthiness of the oppressed groups. (2003, p. 93)

With such persistent emphasis on the suffering of minority groups at the hands of the majority, it's no wonder, as Kenneth Minogue (2010, p. 89) wryly notes, that the number of oppressed people in the west today by some counts "greatly exceeds the entire population of Western states." Far from being oppressed by oppression, then, the very claim to being oppressed turns out to be an effective bludgeon. Thus the "oppression sweepstakes," as Noretta Koertge and I labeled the unseemly competition for most oppressed status, seem destined to continue unabated (Patai & Koertge, 2003).

The impressive growth in claims of oppression and discrimination may be further explained by the fashion today of insisting that many people suffer from multiple oppressions, a view that has been a cornerstone of Women's Studies programs for some time. Here too, however, the terminology has changed. What feminists used to call an "integrated analysis" (of race, class, sexuality, ethnicity, ability, etc.) has been replaced by an "intersectional" analysis, lately spreading well beyond the academy. This verbal magic has the advantage of being able to incorporate the ever-expanding categories of oppression, which have been transformed into a viable political currency, while suggesting that a sophisticated analysis is at hand, instead of the rather simplistic view of identities that is in fact being promoted. It is also likely to keep a lid on competition among the oppressed or at least to reshape it.

The belief in "the superior virtue of the oppressed," of which Bertrand Russell wrote in

1950, developed so rapidly thereafter that by 1985 Joseph Epstein could excoriate the rising tide of "virtucrats" – those "empowered by the unfaltering sense of their own virtue," who identify with the oppressed and thereby gain a sense of moral superiority (the only kind of hierarchy apparently still allowed). As an example, Epstein mentions a young reporter who grilled him about a supposedly antigay comment he had made 15 years earlier. She was, he says, "truly flying on virtumatic" and "ablaze now with her own goodness." But even if "you can't make a convincing case for being virtuous on your own, perhaps you can climb aboard one or another wagon of group virtue." As further inducement, many virtucrats "do a brisk business in awards, honors and other riches of this earth."

Nor is it difficult to spot a virtucrat, notes Epstein (1985):

> Whatever he may ostensibly be saying, what he is really saying is, "I'm fundamentally a damn fine person." Understanding this is a great aid in the contemporary world. It helps one to understand why so many people espouse opinions that they don't finally believe in; merely enunciating those opinions--opinions held to be congruous with goodness--makes them feel good.

Fast-forward another 30-some years, we find both individual people and organizations heavily invested in what critics of these trends now call "virtue signaling." Such signaling, it seems, cannot be left to individual initiative; institutions must demonstrate it as well. The University of Michigan, for example, actually monitors students' "cultural sensitivity levels" as part of an $85 million diversity initiative. Using an "Intercultural Development Inventory," the university will henceforth assess students' "ability to shift cultural perspective and appropriately adapt behavior to cultural differences and commonalities" (University of Michigan, 2016). After exposure to individualized learning plans and training opportunities, students will be retested to judge whether they have "improved." Needless to say, these misguided efforts must rest on gross stereotypes accompanied by ideological fervor. They will, predictably enough, produce verbal conformity as students strive to avoid being judged racist and hence inadequate in their "cultural sensitivity levels" (Soave, 2016, October 10).

Such diligence is nothing new. Alan C. Kors wrote about the problem of imposed diversity training – already well established by 2000 – in an essay entitled "Thought Reform 101: The Orwellian Implications of Today's College Orientation" (Kors, 2000). What is perhaps new is the complete normalization of ideological policing at all levels and the explosion of administrators tasked with imposing an unquestioned orthodoxy on all aspects of the university. Kors' warning still rings true today – if it is not already too late:

> Thought reform is making its way inexorably to a college near you. If we let it occur at our universities and accept it passively in our own domains, then a people who defeated totalitarians abroad will surrender their dignity, privacy, and conscience to the totalitarians within.

Overcoming Incompetence

In today's complex world, in which basic human skills appear to be in short supply, it is hardly surprising that even educated adults are thought to need special training in dealing with Others. At the beginning of their book *Building Cultural Competence: Innovative Activities and Models*, editors K. Berardo and D. K. Deardorff (2012) identify themselves as "seasoned intercultural trainers." Arguing that "facilitators and consultants" are required so that "key intercultural skills" become widespread, they laud their book, one of the many in this burgeoning area, as replete with "brand-new exercises, updates on classic models… – and dare we say improvements – of more conventional activities and exercises that can help build the intercultural competence of the people we work with."

There is considerable irony in this situation, for while each individual, separately and presumably through effort, may aspire to acquire cultural competence, the object of that competence by definition is regarded not as an individual but always as a member of a group.

Despite warnings from scholars such as W. O'Donohue and L. Benuto (who write of "the ultimately harmful effects of treating some clients as individuals and some as members of groups (2010, p. 37)), it is now sanctioned practice to subsume the encounter with a unique person into generalized beliefs about a group, all in the name of cultural competence. Unlike terms such as "diversity" or "multiculturalism," however, which purportedly describe states of affairs or attitudes, cultural competence presupposes a subject: someone who *has* it or wishes to *acquire* it, not merely someone who endorses it. And it is to be unleashed upon an Other, for all these terms express a profound conviction of the Otherness of others. Craig Frisby has incisively labeled this practice "Group Identity Doctrine" (2013, p. 555).

Identity, however, is no simple matter. Even at a time when biology is dismissed as a social construct and choosing one's identity is seen by many as a right, not all such choices are considered legitimate and given support by social justice warriors. At the moment, for example, it is something of an orthodoxy (supported by the US government) that individuals, regardless of genetics and genitalia, can select to "identify" as male or female and gain pertinent new rights corresponding to their proclaimed gender. The same generosity is not available to those (such as Rachel Dolezal and Ward Churchill) who take on a racial or ethnic identity that does not correspond to "facts" – those intractable things that nonetheless persist – and who eventually find themselves denounced for perpetrating a deception on the public. Self-definition suddenly ceases to count as accusations of fraud abound.

Recently, the term "cultural competence" has glided seamlessly from professional training manuals into the mouths even of protesting undergraduates. In late 2015, students at Amherst College provided a living example of its current usage. To express their solidarity with oppressed Blacks worldwide, they presented 11 demands to the college. Demand # five (cited by C. Friedersdorf, 2015) was particularly interesting for its adoption of the requisite terminology and its vision of appropriate remedies:

> [Amherst College] President Martin must issue a statement to the Amherst College community at large that states we do not tolerate the actions of student(s) who posted the "All Lives Matter" posters, and the "Free Speech" posters "in memoriam of the true victim of the Missouri Protests: Free Speech." Also let the student body know that it was racially insensitive to the students of color on our college campus and beyond who are victim to racial harassment and death threats; alert them that Student Affairs may require them to go through the Disciplinary Process if a formal complaint is filed, and that they will be required to attend extensive training for racial and cultural competency.

In a lengthy article for *The Atlantic* on this episode, Friedersdorf writes: "Protestors were trying to punish counter-protests with an extensive, compulsory racial-reeducation program." He then quips: "Perhaps the curriculum could be issued in a little red book." He also takes note of the childlike tone of the demands: Protestors insisted on statements of apology from various officials but also that students be excused from classes. Even if "vestiges of institutional racism" do exist on college campuses, he concludes, "pursuing remedies should no more be left to the whims of 18-year-old social-justice ideologues than Wall Street reforms should have been left to Occupy Wall Street."

Not every use of the original slogan "Black Lives Matter" is considered acceptable, nor is everyone entitled to employ it. At Gettysburg College, for example, students protested an anti-abortion poster put up by a conservative group using that very slogan to call attention to the alarming statistics on abortion among Black women – and were censured for making an ideologically incorrect use of the phrase. The college's Chief Diversity Officer explicitly condemned the antiabortion students' tactics. "Posters that were hung last week in numerous locations on campus singled out African-American women in an effort to promote pro-life positions," she wrote. "These posters also made misleading use of 'Black Lives Matter'." She therefore unleashed a long-planned

"bias-response team," which will supposedly organize educational opportunities rather than restrict free speech, we are assured (Wexler, 2016). Nor, of course, is the slogan heard in reference to the disproportionately high rates of murders and rapes of Blacks by other Blacks in the United States.

Popular slogans can thus land people in trouble if used for promoting non-approved views. At DePaul University, a private Catholic school, President Rev. Dennis H. Holtschneider in October 2016 ordered a campus Republican group to redesign its posters containing the apparently unacceptable slogan "Unborn Lives Matter," which he viewed as a provocation (Jaschik, 2016; Volokh, 2016).[4] This came too late, however, to save his position. Student demands for abject capitulation from administrators had already prevailed after an incident in May 2016, when DePaul students disrupted a talk (sponsored by the College Republicans) by the notorious Milo Yiannopoulos. Despite President Holtschneider's expressions of sympathy with the protesters, calls for his resignation quickly multiplied, and, a few weeks later, he did indeed announce his resignation as of the end of the 2016–2017 academic year (Woelfel, 2016). Today he is Executive Vice President and CEO of Ascension, the world's largest Catholic healthcare system.

George Orwell, whose portrait of a totally repressive society in *Nineteen Eighty-Four* was based largely on Soviet Communism, saw that the manipulations of language – whether through the suppression and rewriting of history, the existence of unrelenting surveillance and censorship, or the imposition of Newspeak, a language with a perpetually shrinking vocabulary – were all ultimately intended to control not merely opinion and behavior but the very ability to think for oneself. Though not that long ago it might have seemed implausible even to mention Orwell in the context of American universities, Alan C. Kors and Harvey A. Silverglate extensively documented, in their groundbreaking book *The Shadow University: The Betrayal of Liberty on America's Campuses* (1998), how far we had already traveled down the road of censoring speech and restricting the free exchange of ideas. After *The Shadow University* appeared, the numerous additional cases Kors and Silverglate heard about regarding campus attempts to control speech led them to establish the nonpartisan not-for-profit Foundation for Individual Rights in Education (FIRE) in 1999.

Initially, Kors and Silverglate not only hoped but also believed that FIRE would become obsolete rather quickly. This turned out to be far too optimistic an expectation, as the categories of alleged infractions, the procedures and punishments imposed in shocking absence of due process, and university offices created to deal with the new campus objectives have all steadily grown in the intervening years. Despite FIRE's substantial success in defending free speech, the organization must proceed on a case-by-case basis, preferring suasion rather than legal action. But many universities have demonstrated remarkable recalcitrance in sticking to their supposedly high-minded goals.

In this changed climate, the practice of restricting speech has taken on additional routinized forms. Students, and faculty members as well, successfully force disinvitations or, less frequently, "voluntary" withdrawals of lecturers and even commencement speakers whose ideas are unacceptable on today's diversity-obsessed campuses (see FIRE's *Disinvitation Report 2014: A Disturbing 15-Year Trend*), as has happened to Ayaan Hirsi Ali, Robert J. Birgeneau, Arthur Jensen, Condoleezza Rice, George Will, and many others. In the name of needing safety and protection from disturbing ideas and those who

[4]Unlike public universities (which receive federal funding), the Foundation for Individual Rights in Education reminds us, "private universities are not directly bound by the First Amendment, which limits only government action. However, the vast majority of private universities have traditionally viewed themselves – and sold themselves – as bastions of free thought and expression. Accordingly, private colleges and universities should be held to the standard that they themselves establish. If a private college advertises itself as a place where free speech is esteemed and protected – as most of them do – then it should be held to the same standard as a public institution." See Foundation for Individual Rights in Education, n.d. *Private universities*, emphasis in original.

endorse them, students also regularly shout down speakers with whom they disagree, disrupting and even completely impeding events they don't approve of.

"Inclusion" – in other words – never extends to views unpopular in the modern university. Although it is another ubiquitous demand and goal these days, inclusion is, in fact, rather at odds with diversity and multiculturalism. The former tends to be centripetal and the latter two centrifugal. Consider the fate of Yugoslavia, merely one dramatic case among many, where for decades under Tito's totalitarian rule, inclusion in the nation meant suppression of ethnic and religious differences. Once that regime began to crumble, the social fissures underlying the enforced unity emerged, leading to years of brutal war and the eventual dissolution of the nation into its diverse ethnic and religious groups.

The tribalism of many societies, with their endless strife and violence, evidently offers no lesson, and instead of defending hard-won liberal democratic values such as individual freedom and a secular state not subservient to religion or political ideology, members of the most egalitarian nations in the world seem eager to relinquish those values, oblivious to the predictable results. In this way, the commitment to multiculturalism and cultural competence, purported to contribute to "social justice," instead threatens to drive out critical thinking and common sense as current orthodoxies are enforced.

Kenan Malik (2015) notes a paradox of multiculturalism that also applies to the terms "cultural competence" and "diversity":

> Multicultural policies [and attitudes, he might have added] accept as a given that societies are diverse, yet they implicitly assume that such diversity ends at the edges of minority communities. They seek to institutionalize diversity by putting people into ethnic and cultural boxes…. Such policies, in other words, have helped create the very divisions they were meant to manage.

At a time when most universities have established speech codes, it is worth stressing that one cannot even begin to defend liberal or any other principles without invoking free speech, the key ingredient in being able to argue for anything not already consecrated by prevailing norms. In an environment that curtails speech, whether for the sake of promoting "diversity," "comfort," "safety," "antiracism," or, say, fascism and one-party rule, it is dangerous, often impossible, to express views that challenge official ideas and beliefs, for the consequences of nonconformity can be swift and unrelenting. This is why the First Amendment, which prevents the government from both proscribing and prescribing speech and ideas, is of such crucial significance in the United States.[5] Yet critics of the First Amendment overlook the reality that approved speech needs no defense, since it routinely meets with assent and endorsement. It is precisely the speech judged to be repugnant and offensive that requires protection, and it is naïve to pretend that one can prohibit certain offensive terms while not affecting the expression of unpopular viewpoints and ideas.

Are most students aware of the dangers of curtailing free speech? Apparently not. Vann Newkirk (2016) recently reported on a survey of 3000 students at 240 colleges. He argued that the "hand-wringing" over the decline of free speech is misguided: "According to this survey, the vast majority of college students, even women and black students, believe campuses should not restrict political views as a matter of policy, even if those views are objectionable to some." He then skirted over the more disturbing, but not surprising, survey result: "Students tend to draw the line at slurs and ethnically stereotypical costumes, however, with 69 and 63 percent, respectively, believing campuses should have the ability to restrict those kinds of expressions."

The sight of American students shouting (often using obscenities) for restrictions on others' speech, enabled and protected by administrators no doubt eager to keep their jobs, is not only disturbing in itself but also disturbingly short-sighted. Reigning orthodoxies undergo rapid change, and these censors could suddenly find

[5] On the insistence within academe on ideological conformity to the social justice agenda, which in effect compels speech, in the context of required "diversity" courses, see Patai and Silverglate (2016).

themselves with no grounds on which to defend their own right to free speech and the dissenting views that cannot be expressed without it.[6]

Perhaps because of the obstacles faced by direct restrictions on speech/expression, thanks to First Amendment protections (which courts in the United States have had a way of upholding, even if it means allowing the American flag to be burned or trampled), the major vehicle for controlling unpopular speech has for the past few decades been Title IX of the 1972 Education Amendments, designed to prohibit sexual discrimination in federally funded schools and colleges. Through a series of expansions and directives over subsequent years, Title IX gave rise to speech codes that were often subsumed under harassment policies. In clear violation of the First Amendment, these policies routinely target words as well as actions, using the broad concept of "hostile environment harassment," a convenient catch-all category that serves to allow legally protected speech to be restricted.

Claiming that others' unkind words and unwelcome jokes constitute discrimination has turned out to be a highly effective strategy by which grievances, conflicts, and resentments play out with maximum damage to the accused. The consequences of the endless rules and regulations suppressing speech and managing interactions in the name of the sensitivities of "protected groups" have created a campus climate inimical to a society comprising people capable of thinking for themselves and daring to express their views. To encourage civility is not the same thing as to impose censorship, for the list of terms and ideas (as well as gestures, glances, overheard jokes, and innumerable other potential offenses) is ever-shifting, and in the ideologically charged atmosphere of the academy, everyone is potentially at risk of facing a false or trivial accusation.[7]

An already troubling situation was made considerably worse in April 2011, when, as Robert Shibley, Executive Director of the Foundation for Individual Rights in Education, explains in *Twisting Title IX*, the US Department of Education's Office for Civil Rights "issued a letter unlawfully mandating that the standard of proof in campus sexual misconduct cases be set at the lowest possible level: a 'preponderance of the evidence,' or a mere 50.01 percent likelihood of guilt" (Shibley, 2016, p. 3). This letter, readily accepted as gospel by almost all its recipients, further eroded the due process rights of the accused and the independence of universities (see Admin., 2011). In September 2017, President Trump's Secretary of Education Betsy DeVos rescinded the Obama-era directive and attempted to restore due process. Predictably, this move was attacked by many as an effort to tip the scale in favor of rapists (Berenson, 2017).

What has been the administrative response to infractions of the basic rules of intellectual engagement and academic freedom? Too often, rather than defending free speech and assembly,

[6]Some writers and even administrators openly defend double standards, arguing that only the formerly or presently oppressed and marginalized should have free speech, viewed as a compensatory right, hence not to be enjoyed by all (Patai, 1996). Nat Hentoff's book *Free Speech for Me – But Not for Thee* (1992) captures this paradox quite well. Personal note: I taught English in Brazil in 1968–1969, the year that saw an intensified suppression of civil liberties by the military dictatorship that had taken power in 1964. My classroom was bugged, and my students, university graduates hoping to do graduate work in the United States, did not dare discuss politics. That was also the time when the Congress was shut down, opposition politicians stripped of their mandate and civil rights, and prior censorship imposed on the press, which quickly started censoring itself to stay out of trouble.

[7]For a discussion of sexual harassment law as a tool for the reconstitution of academic life according to feminist priorities, bringing in its wake all manner of new injustices and vigilantism, see Patai (1998). In the fall of 2017, sexual harassment charges in the United States reached a fever pitch with the #MeToo movement, which characteristically failed to distinguish between unpleasant overtures and sexual assault. As more and more allegations sprang up everywhere (starting in Hollywood and then spreading), garnering enormous press attention and support for the accusers, it became ever harder, and apparently irrelevant, to gauge the truth of allegations. Even to raise the issue of due process, of course, is to invite dismissal as a supporter of the oppression of women. For the accused, job loss and ostracism are immediate, and a climate is created in which a mob mentality gains steam as masses of people feel obliged to manifest their solidarity with the accusers. This vigilantism continues into 2018, as I update this essay: evidence and investigation are deemed unnecessary, and the familiar line that women "must be believed" is granted legitimacy.

administrations have capitulated, even endorsed, these assaults. Driven partly by fear of lawsuits and partly by administrators' own ideological zeal, they have embraced speech codes while at times creating tiny "free speech zones" in some part of the campus – implying that the entire rest of the university is a restricted-speech area. Universities also impose ever more sensitivity training and those requisite orientation sessions that often amount to little more than thought reform aimed at incoming and existing students. Faculty and administrators who do not automatically toe the line may find themselves denied tenure, facing job loss, or, as noted above, forced into resigning. And this is happening not just with the acquiescence but, more frightening still, with the active support and insistence of many academics – students, staff, faculty, and administrators themselves – in the name of "social justice."[8]

But it is not only speech and assembly that are under attack. Those who are today called social justice warriors consider statistical disparities of whatever sort between groups to be evidence of injustice and discrimination of one or another type, in need of remediation. In other words, identical outcomes become the only proper measure of a just society. Like all other such charges, the concern with disparate outcomes is applied opportunistically, in accordance with its potential political utility for aggrieved groups.

In his book *The Servile Mind*, Kenneth Minogue (2010) argues that an erosion of individual moral and ethical awareness has occurred as the intelligentsia panders to fantasies of social perfection and expects government and its agents to provide it. This results in the creation of a servile mind, immersed in constant rhetorical posturing about improving the world, while sacrificing individual moral commitments to "politico-moral" grandstanding. Outward manifestations of one's good intentions and proper awareness, including shame over one's own supposed privilege and denunciation of that of others, are routine. Fifteen years earlier, Thomas Sowell (1995) had made similar observations, in his book *The Vision of the Anointed: Self-Congratulation as a Basis for Social Policy*: "People are never more sincere than when they assume their own moral superiority," which lends them "a special state of grace." This allows them to consider those who disagree with them as being not only in error but in sin, a vision that, Sowell argues, has not fundamentally altered in the past 200 years.

Throughout the country, this familiar stance is adopted in the name of promoting social justice. In late 2015, to take just one example from the numerous recent cases, after a professor was (absurdly) accused of racism at the University of Kansas, the provost sent a letter to the campus community previewing an "action plan" to eradicate racism on campus (Vitter, 2015). The plan included the usual "mandatory education, through facilitated sessions, on inclusion and belonging for all students, faculty, staff, and administrators and a plan for accountability." He then reminded the campus of an annual program called the Tunnel of Oppression, which had been set up by the Office of Multicultural Affairs in 2001. Professors were urged to offer students extra credit for visiting the Tunnel of Oppression (2015), described on a special website as "a tour that will engage students in an immersive experience of scenes where participants will experience, firsthand, different forms of oppression through interactive acting, viewing monologues, and multimedia. Participants directly experience the following scenes of oppression: ability, class, body image, immigration, homophobia, genocide, relationship violence, and race." But even this "immersive experience" cannot stand on its own, and the website offers further help: "At the completion of the Tunnel experience participants will go through an active processing session where they will discuss the experience and learn how they can rethink their role in creating positive social change."[9]

[8] Hundreds of cases of all these abuses, big and small, serious, and often farcical, have been documented (see note 1, above). In fact, protection of free speech is now so unusual on campus that when University of Chicago President Robert J. Zimmer wrote an opinion piece in the *Wall Street Journal* entitled "Free Speech Is the Basis of a True Education," this was hailed by many as a courageous stance (Zimmer, 2016).

[9] This and other episodes are discussed in Patai (2015).

Within the classroom itself, another popular response on the part of educators nationwide has for some time involved implementing "anti-oppression pedagogy" – no longer confined merely to a few identity programs or schools of education. Several decades of social justice curricula, diversity, and inclusion have apparently been no more effective than 15 years of Tunnel of Oppression experiences. Equality of opportunity for formerly disadvantaged groups, contrary to what the naïve might imagine, has proven sadly insufficient, which is why "anti-oppression pedagogy," like the Tunnel of Oppression, aims at our very souls: "Anti-Oppression Pedagogy teaches how to structurally analyze systems of oppression, while contemplative practices cultivate an embodied self-awareness. Mindful anti-oppression pedagogy merges the two to cultivate an embodied social justice. This website offers a collection of contemplative practices that have been used in social justice classrooms" (Berila, n.d.).

At the University of Massachusetts Amherst, new "General Education Diversity Requirements" were proposed to the Faculty Senate in 2016 that would impose on students courses having "learning outcomes," such as "diminish the perpetuation of discrimination and oppression," and suggesting that training sessions for teachers may be necessary (Patai & Silverglate, 2016). In the end a somewhat more moderate form of these requirements was quietly adopted, requiring all entering undergraduates to take, in their first year, one newly designed "diversity" course, with another to be taken later. Existing courses that fulfill this new diversity requirement must be revised according to new guidelines and submitted for approval. Among the six "learning outcomes," one focuses on understanding of "diverse social, cultural, and political perspectives," another on "critical awareness of how individual perspectives and biases influence ways of seeing the world," and a third on "knowledge of structural and cultural forces that shape or have shaped discrimination based on factors such as race, ethnicity, language, religion, class, ability, nationality, sexuality, or gender" (University of Massachusetts, 2017).

In keeping with the university's anxiety about these issues, over the past few years, the Chancellor's office has constantly sent out memos about new initiatives and administrative offices devoted to diversity, equity, and inclusion, which, as elsewhere in the nation, consume ever more resources within higher education.[10] In *The Shadow University*, Kors and Silverglate (1998) traced the proliferation of bureaucracy in higher education to the mid-1980s, with the arrival of racial, religious, and sexual minority groups in significant numbers. "Fearful that such diverse students would all but kill one another without the benign supervision of student-life administrators, colleges began to ramp up their staffs. Soon every dean of student life had several deputy deans, and each deputy had assistant deans." This problem was compounded as increasing government regulations were imposed in exchange for infusions of cash into the academy, Silverglate points out (2018). And those infusions were ever more necessary as universities came to be places employing more bureaucrats and their underlings than faculty members. Add the shifting ideological climate, and we arrive at the contemporary university, on the one hand, subject to corporatization and bureaucratic bloat, on the other, in thrall to a predominantly leftist politics that treats the university as a locus for political indoctrination.

No aspect of university life is, these days, immune to this agenda. Getting down to the nitty-gritty, universities may encourage interviewers to interrogate candidates for faculty and staff positions about their attitudes toward the social justice agenda. Drawing on old feminist documents intended to promote women in the academy, the Equal Opportunity and Diversity Office at the University of Massachusetts Amherst, for example, provides search committees with lists of suggested questions designed to ferret out the depth of job applicants' commitment to "diversity." Allowing space in parentheses for filling in the name of the protected group of one's choice, typical questions include: "How

[10]For a typical example, see the list of dozens of "key individuals and councils providing oversight [sic] to campus units" on diversity issues. University of Massachusetts Amherst (2018), "Diversity Matters."

have you demonstrated your commitment to ( ) issues in your current position?" "In your current position, have you ever seen a ( ) treated unfairly? How would/did you handle it?" (Patai, 2016b, May 30).

All these efforts to ensure ideological conformity include nary a hint of concern with intellectual development and education unfettered by political dogma. Instead, what dominates academic rhetoric appears to be the unrelenting desire to set the world aright according to the current lights of campus luminaries obsessed with a single focus. Since administrators use the term social justice (without bothering to define it), they must believe they know not merely what it is and how it can be achieved but also who are the primary victims of our presumptively unjust society and how they can be redeemed.[11] And underneath all these concerns lurks the conviction – whether opportunistic, heartfelt, or both – that group identity is either a privilege or a scourge, a cudgel, or a shield, never just a feature of a complex human reality. The currently popular language of "intersectionality" offers no help, for it merely multiplies categories of oppression and incites competition among the aggrieved.

But all identities do not have equal value, nor is "competence" required to deal with all cultures. While resting on cultural relativism, as does multiculturalism, cultural competence is far from an equal opportunity perspective. It is rarely if ever used to understand (or even imply tolerance of), say, Christian fundamentalists or political conservatives. Only certain identities, apparently, are to be respected and understood (rather than vilified and dismissed), those of "protected groups," those who can claim they suffer or have suffered from discrimination, or those thought to be unsullied by the supposedly sordid history of the west generally and America in particular. We strive to enhance multiculturalism and diversity, and we do so also by acquiring competence in dealing with particular cultures – but not unless they can successfully assert a claim to past or present oppression and marginalization while displaying the requisite politics to undergird their grievances. This is why high-achieving minority groups (such as Asians) cease to count as "minorities" and in fact may find themselves the objects of quota systems intended to counterbalance their accomplishments vis-à-vis other groups.

Thus does the demand for "social justice" undermine merit-based rewards and achievement. This, however, is nothing new. Michael Walzer (1998), in his essay "Multiculturalism and the Politics of Interest," made the same point 20 years ago: "In multicultural politics it is an advantage to be injured. Every injury, every act of discrimination or disrespect, every heedless, invidious, or malicious word is a kind of political entitlement, if not to reparation then at least to recognition. So one has to cultivate, as it were, a thin skin" (p. 89).

While arguing that it is at times "worth taking offense," because a thin skin can act as a kind of early warning system for vulnerable groups, Walzer also observes: "[A] permanent state of suspicion that demeaning and malicious things are about to be said or done is self-defeating. And it is probably also self-defeating to imagine that the long-term goal of recognition and respect is best reached directly, by aiming at and insisting on respect itself" (p. 90).

The demand for multiculturalism and diversity, then, rests on constant claims of wrongs committed

[11] In April of 2016, the University of Massachusetts launched a new version of its strategic diversity plan, entirely focused on "inclusion" of "underrepresented minorities" (now called URMs) and "social justice." Wading through the belabored prose of this 40-some page single-spaced document, one is struck by its unquestioned assumptions: that the causes of poor performance, of underrepresentation, and of feelings of unhappiness are clearly known and have to do with identity issues, and it is the place of the university to address these and set them right. Among the plans for doing so are increased bureaucratization of the university: more counselors devoted to URMs at the health services, more training for all graduate instructors, revising of curricula and syllabi, heightening sensitivity on the part of faculty, and exploring hiring an associate dean for inclusion (the existing dean and many ancillary officers were evidently insufficient). In all these suggestions, one sees not a hint of concern with learning and actual educating. The focus is clearly laid out in an update to the university's Diversity Strategic Plans, a glance at which reveals both the apparent goals of higher education today and the proliferation of administrative positions devoted to "diversity" – from the Chancellor's office on down to deaneries, schools, and departments. See University of Massachusetts (2016b, Oct. 20).

against vulnerable groups, and this in turn both justifies and necessitates policing of others' language and attitudes. More concessions, resources, and attention are required, but not in the context of vigorous and free debate as one might expect at a university. The thin skin useful in detecting potentially dangerous circumstances has been transformed into something quite different, as noted by Claire Fox, founder of the Institute of Ideas, a London think tank. She faults the present generation of thin-skinned young people for displaying a "belligerent sense of entitlement. They assume their emotional suffering takes precedence. Express a view they disagree with and you must immediately recant and apologise" (2016).

The usual administrative capitulation to such demands based on identity politics must be gratifying to those some have called "crybullies" (Kimball, 2015), who use their alleged injuries to rail against and control those around them. Kimball's term is apt also because the supposed spokespeople have rarely been selected by the group they claim to represent. Often, yelling loudly is sufficient to carry the day.

But matters do not end there, for after gaining the necessary legal standing, an institutional presence, and resources, in the real-world minority groups must in the end coexist with other groups: "The others are necessary, obviously, since they must do the recognizing and respecting, and then they will want to be recognized and respected in turn," Walzer writes (1998). This, however, is not the perspective that has prevailed in recent years. Instead, we see identity politics played by insisting on abasement and mea culpas from the supposedly powerful (or merely more successful) groups, which are held responsible for real or imagined inequalities, failures, and hurt feelings proudly claimed by allegedly injured identity groups.

One of the most searing indictments of how identity politics functions was offered over two decades ago by Todd Gitlin. In a section of his 1995 book *The Twilight of Common Dreams* entitled "The Cant of Identity," Gitlin writes:

> The more vociferously a term is trumpeted in public, the more contemptible it is under scrutiny. The automatic recourse to a slogan, as if it were tantamount to a value or an argument, is frequently a measure of the need to suppress a difficulty or vagueness underneath. Cant is the hardening of the aura around a concept. Cant automates thought, substitutes for deeper assessment, creates the illusion of firmness where there are only intricacies, freezes a fluid reality. (2005, p. 400)

Gitlin explains how the cant of identity "underlies identity politics, which proposes to deduce a position, a tradition, a deep truth, or a way of life from a fact of birth, physiognomy, national origin, sex, or physical disability" and laments that "Americans are obsessed today with their racial, ethnic, religious, and sexual identities." Protesting the effect of such fragmentation on left politics, Gitlin objects that "What is supposed to be universal is, above all, difference."

By now such views are normalized throughout academe, mouthed by administrators at all levels, whose jobs are often organized around identity politics. This has led to the paradoxical results Gitlin already noticed: "For identity-based movements, the margin is the place to be." But identity politics never stops, for, "within each margin, there are always more margins to carve out." Furthermore, from the slogan "the personal is political," it was an easy glide to "'only the personal is really political' – that is, only what I and people like me experience ought to be the object of my interest." The result is that universalism is abandoned, even disdained, and we get "cultural separatism, emphasizing difference and distinct needs."

Gitlin suggests that this is one result of the confusion of contemporary life, which has made "firmness of identity" hard to come by. Nor is it only psychological or moral claims that are at stake. "Partly because the state legitimizes labels and allocates resources accordingly, people affirm them." In such a situation, "shape-shifting" becomes normal, and intolerance of "one's own confusion generates a frantic search for hard-and-fast identity labels." But since the market offers a dizzying array of choices, what we get, concludes Gitlin, is "identities lite."

The obsession with identity has only grown worse in the years since Gitlin made these

criticisms. It thrives by ignoring the commonsensical observation of Charles Murray (2005) that "a few minutes of conversation with individuals you meet will tell you much more about them than their group membership does."[12] But Murray took note of an interesting implication of identity discourse: "Talking about group differences obligates all of us to renew our commitment to the ideal of equality that Thomas Jefferson had in mind when he wrote as a self-evident truth that all men are created equal." Murray goes on to quote Steven Pinker's useful formulation of that ideal in *The Blank Slate:* "Equality is not the empirical claim that all groups of humans are interchangeable; it is the moral principle that individuals should not be judged or constrained by the average properties of their group."

Human rights, in other words, reside in all individuals qua individuals, not in groups. That is the important thing that an insistence on multiculturalism and diversity, as these terms are now deployed, threatens. And the threat is intensified when dealing with the "helping" professions, such as psychology, to which clients necessarily appeal as individuals, not as tokens of a group.

But this does not undermine the understanding that, as philosopher Thomas Nagel (1997) argues, reason is universal. Indeed, he points out, subjectivism – the notion that there is nothing beyond whatever is true "for me" – is both self-contradictory (because it, too, rests on a general claim) and an erroneous view.

By contrast, education in cultural competence depends on a radical relativism – the notion that we need special training because human cultures, though all equally valid (a very slippery term), are incommensurate and that differences are far more important than similarities. This is a vastly exaggerated claim, embraced primarily for political advantage. More than 25 years ago, the anthropologist Donald E. Brown developed a list of what he termed "human universals." In more recent writing, he reiterates his basic understanding of the term: "those features of culture, society, language, behavior, and mind that, so far as the record has been examined, are found among all peoples known to ethnography and history" – although, he points out, this does not entail that every individual in a given society manifests all those traits. Anthropologists, however, have been more interested in "differences between societies" than in their commonalities, which have suffered a neglect Brown describes as:

> overt and principled, seeming to follow logically from the view of culture that anthropologists held throughout much of the twentieth century, a view that seemed to be supported by exaggerated (and in some cases false) reports of the extraordinary extent to which cultures both differ from one another and yet decisively shape human behavior, a view that was construed to indicate that there must be few, if any, universal features of the human mind.

Psychologists, Brown argues, have generally been "much more open to the discovery of presumably universal features of the human mind." He goes on to specify: "Examples of universals of psyche or mind that have been identified through broad cross-cultural studies are dichotomization or binary discriminations, emotions, classification, elementary logical concepts, psychological defense mechanisms, ethnocentrism or in-group bias, and reciprocity as a mechanism

[12] See Murray (2005), who argues for recognition of the growing scientific evidence of innate differences among groups, which he believes will, in the next few decades, totally overturn the shibboleths of our time. He adds that acknowledging group differences does not entail any particular political consequences. Among many feminists, however, even acknowledgment of the biological basis of heterosexuality and sexual dimorphism is anathema. As an example, on the Women's Studies E-Mail List, which for more than 25 years has served as a key resource for Women's Studies faculty around the country and beyond, some years ago a biology professor argued, along with me, that sexual dimorphism is the predominant biological reality of the species regardless of a small percentage of anomalies. We were roundly denounced for holding to such retrograde notions. When the biologist offered to explain the biological facts, she was criticized for thinking she had more expertise than others on the list (Patai & Koertge, 2003, p. 313). As numerous Women's Studies program mission statements attest, social constructionism is today posited as a key to understanding both sex and gender, beyond question, despite feminist characterizations of men as inherently harmful. Yet it evaporates when people decide to "identify" as the opposite sex. In those instances, social constructionism vanishes, and we are exhorted to see only genuine and individual self-understanding.

for bonding individuals to one another" (2004, pp. 50–51). Brown ends with the assertion that studying human universals is a crucial component of any effort to understand "human nature."

No one with any experience of the world would deny that there is much to learn about other cultures and their distinctive habits and mores, practices, and preferences. But to recognize this variation is not to reject the existence of universals that allow people to understand each other across cultures. If cultures were indeed incommensurate, there could be no promotion of human rights internationally, nor any appreciation of, say, great works of art produced by cultures other than one's own.

As for relativism, once again it is worth noting that if cultures and groups within them were never to be judged by standards beyond their local and national borders, much social activism would disappear and there would be no grounds for objecting to, say, slavery outside of one's own group. The very notion of fundamental human rights depends on recognition of a commonality shared by all people everywhere.

When the West Is the Least

In her famous and controversial essay "Is Multiculturalism Bad for Women?", the political philosopher Susan Moller Okin (1997) answered the question posed by her title with an unapologetic Yes. Her argument is that multiculturalism promotes tolerance and respect for cultures that are hostile to women, cultures that, for example, encourage forced marriage, female genital mutilation, polygamy, and stunted legal and political rights. This assertion earned her the ire of those (including other feminists) who wanted to celebrate a "politics of difference" and criticized the application of Enlightenment values as ethnocentric.[13] In the nearly two decades since Okin published her essay, the demands for diversity and multiculturalism have multiplied, ironically at the very time that Islamist challenges to basic liberal values of tolerance and equal rights have increased and taken ever more violent turns in western countries as well as in the Muslim world.

While Okin's definition of feminism would be rejected by those feminists who do not seek equality "with," but rather a total transformation "of," the problem she saw in multiculturalism is far more urgent now than it was when she published her essay. Though multiculturalism is hard to pin down, she wrote:

> the particular aspect that concerns me here is the claim, made in the context of basically liberal democracies, that minority cultures or ways of life are not sufficiently protected by ensuring the individual rights of their members and as a consequence should also be protected with special *group* rights or privileges. In the French case, for example, the right to contract polygamous marriages clearly constituted a group right,[14] not available to the rest of the population. In other cases, groups claim rights to govern themselves, have guaranteed political representation, or be exempt from generally applicable law.

Okin is asserting that the defense of "difference" is undesirable if it leads to the acceptance of the oppression of women in the name of a particular culture's values, and she gives as examples the accommodations of European countries to Muslim communities. It is worth adding that it is not only women as a category who suffer in societies in which basic civil liberties do not exist for all individuals. Islam, for example, also targets Christians,

[13] See Walzer (2013, Winter), "Feminism and Me," for an extended appreciation of Okin's work. Throughout his writings, Walzer consistently defends universal principles of justice.

[14] The practice of polygamous marriage is now banned across Europe, but many Muslim polygamous marriages exist "under the public radar," according to the Gatestone Institute, though they are rarely discussed in the media. Some countries, however, such as the United Kingdom, the Netherlands, France, and Sweden, recognize polygamous marriages legally contracted in other countries. There are thought to be around 20,000 such marriages in Britain, and, although the practice became illegal in France in 1993, by 2006 there were an estimated 20,000 polygamous marriages in France. In Germany, a 2012 estimate reported that 30% of all Arab men in Berlin were married to more than one woman. The growing number of Muslim immigrants to Europe suggests that the incidence of polygamous marriages is rising. Such marriages are often also a means of committing welfare fraud (Bergman, 2016).

Jews, apostates, homosexuals, and other Muslims. The evidence has only intensified over the past 20 years, and yet in the face of Islamist terrorism internationally, large swathes of educated westerners are proving themselves unwilling to criticize radical Islam despite its evident destructiveness to those (individuals and entire societies) who do not endorse its beliefs. Home-grown Christian fundamentalists, doing far less damage and engaging in far less violence, are given no such pass, while, for example, misogynist "gangsta rap" is.

Those writers and intellectuals who do not accede to Islamist demands for conformity face threats and violent deaths: Salman Rushdie, his translators, and publishers; filmmaker Theo Van Gogh; the *Charlie Hebdo* staff; Jews and Christians and human rights activists such as Phyllis Chesler and Ayaan Hirsi Ali. These latter find themselves ostracized, disinvited, and dismissed even by many who call themselves feminists and leftists, who have learned the unbalanced lessons of multiculturalism and diversity all too well.

The argument over cultural particularities versus universals, pursued today in an incoherent and opportunistic manner, has a long and interesting history. In the twentieth century, it gained special prominence through the French writer Julien Benda, whose 1927 book *The Treason of the Intellectuals* (2006) was concerned above all with the destructive potential of right-wing nationalisms devoted to cultivating the *Volksgeist*. This development, promoted by the epigones of the late eighteenth-century German philosopher Johann Gottfried von Herder, distorted and blew out of proportion Herder's argument that each national group possesses a unique spirit, rooted in its particular culture.

The epigones severed Herder's philosophical ideas about nationalism from his cosmopolitan and universalist framework, linking them instead with anti-democratic, anti-liberal, and anti-Semitic ideologies (Stern, 1961, p. 278). Today, the selective promotion of ethnic, religious, and sexual identities often sounds like a compulsive repetition of these nationalistic nineteenth-century distortions, resulting in an inversion of any genuine cosmopolitanism for the sake of privileging particular groups in the name of a narrow identity politics.

Benda's critique of French intellectuals for abandoning the Enlightenment commitment to universal values in favor of local (national) identities was driven by an awareness of the dangers of unleashed national pride. Concerned about the potential violence of such sentiments, as evinced in the Dreyfus case of the 1890s, when much of the French population believed that Captain Alfred Dreyfus, a Jew and hence an "outsider," must be guilty of the charges of treason falsely leveled against him, Benda saw the relationship between this insistence on the *Volksgeist* and the potential rise of fascism in Europe.

When comparing past with present identity politics, however, a crucial difference emerges: Herder and other romantic nationalists, in criticizing the universalistic approach of French Enlightenment figures such as Voltaire, were also defending their *own* culture and its values. They endorsed respect for particularity within general and universal principles, as opposed to sacrificing the local for the sake of the universal. By contrast, the current vogue for embracing cultural particularisms has led to quite a different trend among many intellectuals. Today, what accompanies terms such as multiculturalism and diversity in the west is antagonism toward "Eurocentric" culture in particular (especially if it is one's own), typically accompanied by an unwillingness to make criticisms of other (non-western) cultures, however severe their abuses of human rights.

Instead, universal principles are replaced by a *faux* relativism, as is evident in the views prevalent in academic discourse: Yes, all cultures are equal, but western is worse. Yes, women are equal to men, but men are worse. Yes, race is an artificial construct, but whites alone are racist. The same sort of non-thought is everywhere, piling contradiction upon contradiction without embarrassment, always enveloped in the "good" politics presumed to justify any and every inconsistency and paradox.

In a powerful essay introducing a new edition of Benda's work, Roger Kimball (2006) writes:

> The humanizing "reason" that Enlightenment champions is a universal reason, sharable, in principle, by all. Such ideals have not fared well in recent decades: Herder's progeny have labored hard to discredit them. Granted, the belief that

> there is "Jewish thinking" or "Soviet science" or "Aryan art" is no longer as widespread as it once was. But the dispersal of these particular chimeras has provided no inoculation against kindred fabrications: "African knowledge," "female language," "Eurocentric science," "Islamic truth": these are among today's talismanic fetishes.

Benda observed French intellectuals' anxiety that they would descend into "national partiality" if they considered their own country to be in the right. These "strange friends of justice," he wrote, "are not unwilling to say: 'I always maintain my country is in the wrong, even if it is right.'" He concluded that "the frenzy of impartiality, like any other frenzy, leads to injustice." But this is not merely an abstract problem. In writing about the varieties of pacifists, Benda noted the type who asserts, contrary to all evidence, "that the nation is not in the least threatened and that the malevolence of neighbouring nations is a pure invention of people who want war" (2006, pp. 187–89).[15]

Many of today's academics and intellectuals, in thrall to the claims of "social justice" rooted in identity politics, in like fashion are unwilling to recognize threats to their own culture while eagerly defending other cultures even if these are demonstrably worse in terms of those very human rights that the activists proclaim. They are unwilling to criticize nondemocratic, non-western cultures, especially if these are inhabited by nonwhite people. The embrace of cultural relativism is thus revealed as a fraud, lacking the redeeming feature of at least resting on a consistent ethics.

If the much-proclaimed embrace of cultural relativism were authentic, after all, western culture would be valued as much as other cultures, instead of being constantly (mis)represented as inherently and uniquely imperialistic, racist, and violent. True, it makes sense to be more heated about the failings of one's own culture (especially if measured against the bar of perfect justice), but it is quite a different thing to view western culture, American in particular, as far more deficient and always of lesser value than the ones the multiculturalist left extols. Yet that is precisely what famous intellectuals such as Susan Sontag, Michael Foucault, and Noam Chomsky have done, exculpating Communism and Islamism along the way.

Paul Hollander's extensive work on anti-Americanism (1995/2003, 2004) documents this trend, as does Jean-François Revel's later study of French anti-Americanism (2003), which includes a chapter called "The Worst Society That Ever Was." After 150 pages of examples and analyses of his theme, Revel identifies the two "most glaring traits of obsessive anti-Americanism: selectivity with respect to evidence and indictments replete with contradiction" (p. 149). Today, under different names, we observe the same obsessions. The multiculturalist agenda, which leads to a dangerous social fragmentation, presupposes the belief that those who embrace it have indeed chosen the high road and are embarked on the challenging task of creating a better future. In this fantasy, "social justice," freed from the baneful western tradition that in reality gave rise to ideas of universal human rights, will finally flourish unhindered.

None of these concepts, however, stands still; each and all constantly undergo revision and domain expansion. This is why cultural politics as played today is a game in which heads I win, tails you lose (depending on who has, or claims, which identity). To all this is added the further irony that if ignoring or devaluing other cultures is bad, embracing them may be still worse, as is apparent in the current vogue of railing against "cultural appropriation."

Law professor Susan Scafidi (2005), in her book *Who Owns Culture?: Appropriation and Authenticity in American Law*, defines cultural appropriation as "taking intellectual property,

[15] Ninety years after Benda, Victor Davis Hanson, in a column observing the anniversary of D-Day, the 6th of June, considers what has changed in terms of military effectiveness between 1944 and the present. He notes the half-hearted attempts to deal with the threat of Islamic imperialism and terrorism, a reality Barack Obama refused even to name throughout his presidency. Perhaps, Hanson suggests the difference lies in the absence of a sense of purpose, so that, although the United States is far larger, more powerful and affluent than it was in 1944, Americans these days are "more likely to feel that America must be perfect to be good" (Hanson, 2016a).

traditional knowledge, cultural expressions, or artifacts from someone else's culture without permission. This can include unauthorized use of another culture's dance, dress, music, language, folklore, cuisine, traditional medicine, religious symbols, etc." (as cited in Shriver, 2016). Perhaps this helps us understand why even Halloween costumes are now regulated by some schools.

Alain Finkielkraut, the scourge of French intellectual life, has devoted a number of books to protesting the abandonment of Enlightenment values in contemporary France. His book *The Defeat of the Mind*, in dialogue with Benda, criticizes the resurgence of *Volksgeist* particularisms visible in the rise of multiculturalism, pitting ethnic, racial, religious, and national groups against one another (1995). Most recently he has written persistently about French unwillingness to recognize Muslim immigration as the threat it in fact poses to France's secular culture. In an interview with *Der Spiegel* (Von Rohr & Leick, 2013, December 6), shortly after the publication of his book *L'Identité Malheureuse* (2013), Finkielkraut reiterated his argument that "France is in the process of transforming into a post-national and multicultural society. It seems to me that this enormous transformation does not bring anything good."[16] Though presented as a model for the future, multiculturalism, in his view, "does not mean that cultures blend. Mistrust prevails, communitarianism is rampant – parallel societies are forming that continuously distance themselves from each other." More recently still, Finkielkraut has insisted: "Secularism has got to prevail. And we can't compromise on the status of women" (Nossiter, 2016).[17]

A persistent critic of the far right, Finkielkraut (2013, *L'Identité,* p. 86) stresses that the Enlightenment saw all men as equal in the sense that all have the same right to freedom, which means the ability to think, judge, and act on their own as conscious human beings. And by making use of that ability, they form nations. But nations are fragile things, and the identities each depends on, according to Finkielkraut and other contemporary critics, must rely on certain accepted or adopted commonalities. However broad-reaching these may be, once they are gone, a society fractures into particularisms – which is what we are seeing when immigrants arrive who explicitly reject the society they are physically moving into.

This is the situation that makes Finkielkraut speak of France's current *The Unhappy Identity*, the title of his 2013 book. He points out, and the growing problems in European countries confirm, that Muslim immigrants who resist integration do not need to constitute anywhere near a majority in order to have a profound impact on the larger society. This is especially so when that society's very values make it vulnerable to the demands of newcomers who reject its fundamentals, e.g., the equality of women, the predominance of secular values in education and public life, the prevailing legal norms, the acceptance of non-Muslim ways of living and believing, and so on.

Another leading French intellectual, Bernard-Henry Lévy, in his book *Left in Dark Times: A Stand Against the New Barbarism* (2008), makes an important distinction about the significance of "tolerance" as opposed to "secularism." The former leads to an uncritical respect for religion, even if it means abandonment of universal human rights. By contrast, secularism keeps all religious beliefs

> at an equal distance from political power, [and] also has to keep political power equally removed from those beliefs. Tolerance *tolerates* [his emphasis] that one group demands such and such a special right. The secular state does not tolerate or understand that. And that is why, when the political authorities are wrapped up in the wrong done to one community by the representation of its prophet with a bomb on his head instead of a turban, the secular regime answers: "We see that you're upset;

[16] By contrast, in *The Death of French Culture* (2010), D. Morrison argues exactly the opposite: by insisting on its own great, specifically French cultural tradition, France has lost its importance in the world and is killing its culture.

[17] Since 1905, France has had a law of *laïcité* (secularism), establishing strict separation between church and state, which has worked for more than a century. But now, with the largest Muslim population in Europe (about 10%), France sees its traditions and laws openly challenged by Muslims.

> your faith is doubtless seriously wounded by such a representation, but that wound has no place in public debate; the law-maker therefore has nothing to do with it; that's how democracy works." (Lévy, 2008, pp. 179–80)

Writing well before the Islamist terrorist attacks in Paris on *Charlie Hebdo* (January 2015), the Bataclan (November 2015), and in Nice on Bastille Day (July 14, 2016), to mention only the recent episodes of large-scale mass murder in France, Lévy saw clearly the dangers of refusing to recognize Muslim challenges to the French legal establishment in its core principles. When liberal democracies capitulate in this way – whether out of the majority's fear, guilt, or desire to be accommodating to people it sees as disadvantaged – a corrosive instability arises. In such a climate, some do indeed turn to the hard right (as is happening in European countries where Muslim influence is a growing problem), which Lévy, like Finkielkraut, deplores.

The same problems, of course (though thus far on a smaller scale), have arisen in the United States, where in the name of multicultural sensitivities, many have been willing to abdicate First Amendment and other rights. The classical historian Victor Davis Hanson (2016b) does not hesitate to describe the current scene as devolving into "multicultural separatism and ethnic and religious chauvinism." It is by now a routine event to see "diversity" enthusiasts eagerly exculpate Islam. Even after the mass murder at a gay nightclub in Orlando in mid-June, 2016, the same double standards emerged, as Hanson points out: "From Iran to Saudi Arabia, the treatment of gays is reprehensible – but largely exempt from [mainstream] Western censure, on the tired theory that in the confused pantheon of -isms and -ologies, multiculturalism trumps human rights."

Within the academy, antagonism toward the west is both a cause and a consequence of the decline in college courses in western civilization – the very term is unacceptable to some – which has been matched by the ever-expanding college offerings of courses on (certain) "other" cultures. Nor is this a recent development (see Patai, 2016c, September 12). Writing about the failed effort at Stanford to reintroduce courses in western culture decades after they had ceased to be required, Anthony Esolen (2016) bemoans the ignorance of many students, whom he calls "ninnies," lacking in curiosity" about their own culture. "Multiculturalists," he says, are not making serious efforts to learn about other cultures. Rather, they are people "who peddle the tandoori chicken rather than Sanskrit." He adds that "*only* someone who actually has a culture is prepared to learn about another; as a master in the grammar of his native tongue is prepared to learn another. But these days we prefer our education to be like our politics: superficial and silly"[18] (his emphasis). Proving his point, students at Providence College, where Esolen teaches, marched to the president's office in late 2016 demanding that Esolen be fired for criticizing diversity (Dreher, 2016).

Sobbing and outraged students succeed in getting courses and speakers canceled, and free speech and, of course reasoned debate, suppressed (see Davidson, 2018), as only the opinions and preferred rhetoric du jour are acceptable. Literary classics such as *Huckleberry Finn* and *To Kill a Mockingbird*, considered offensive or defective by current standards, are bowdlerized and/or dropped from curricula. This goes hand in hand with identity-driven curricula, which promote the notion that protected groups should study primarily themselves. It is damaging, Yale University students claimed not long ago in demanding curricular change (Flood, 2016), for people of color to study white male poets. Why waste time learning about western culture, except if these courses concentrate on the familiar litany of western deficiencies? And yet the supposedly dominant groups are expected, indeed required, to learn about protected minorities. In both cases, it is mainstream western culture that is to be downgraded, misrepresented, and ignored if not reviled, while identity politics is to be respected by all, and training sessions in diversity and inclusion are promoted and even imposed by colleges nationwide.

[18]Esolen has been writing for some time about the limitations of "diversity" as promulgated in academe. See http://www.crisismagazine.com/2016/the-narcissism-of-campus-diversity-activists

The well-known scholar and former president of the Modern Language Association, Elaine Marks, an instrumental figure in publicizing feminist literary theory, shortly before her death in 2001 turned against the practice of allowing identity politics and the tireless insistence on "differences" to dominate the study of literature. Disillusioned by students who trolled literature and culture for signs of the ubiquitous -isms, Marks published an essay entitled "Feminism's Perverse Effects" (2005), in which she argued that replacing knowledge of western culture with a ceaseless pursuit of signs of its racist and sexist villainy leads students to an incapacity to respond to literature imaginatively. Merely voicing concern over the habit of reading literature for ideological bottom lines stigmatizes a scholar (even one with her track record) as a closet conservative and traitor, she wrote. Since then, higher education has openly pledged itself to an orthodoxy in which courses and programs grounded in identity politics (renamed "diversity") proliferate, preferably taught by professors of the requisite identity. That is, you have to be one to teach it – all in the name of those elusive absolutes: multiculturalism, inclusion, cultural competence, and, ultimately, social justice.[19]

In relation to other arts, not only literature, the same agenda of identity politics prevails, as detailed in Sohrab Ahmari's recent book *The New Philistines: How Identity Politics Disfigure the Arts* (2017). Ahmari was born and raised in Iran, where, after Islamists seized power in 1979, "thousands of ideologically unfit faculty members and students were purged" and holding the wrong opinion or creating the wrong kind of art could mean loss of liberty and life. He has little patience with the art world today, which he finds entirely indifferent to the old standards of truth and beauty, instead embracing identity politics as its alpha and omega. "Identitarians celebrate individual difference, so long as you are different in the same way," he writes. Obsessed with "a set of all-purpose formulas about race, gender, class, and sexuality on the one hand and power and privilege on the other," they deny individuality and agency, treating everyone as "a political type or a stand-in for an ideological cause." Contrary to its exalted claims to transgressiveness, he concludes, identity art becomes drearily conformist.

In the academy, the notion of excellence still puts in a feeble appearance now and then, at least rhetorically. Sleight-of-hand attempts to associate the diversity agenda with excellence now appear at many universities. The president of the University of Michigan, for example, proclaimed in 2016: "We aspire to achieve the highest levels of excellence at the university, and our dedication to academic excellence for the public good is inseparable from our commitment to diversity, equity and inclusion" (Schlissel, 2016, p. 3). The same document ominously warns that "measures of accountability" are a crucial part of the new plan. Similarly, at the University of Massachusetts Amherst, one of the many new administrative positions created to enact the current dispensation is that of Faculty Advisor for Diversity and Excellence. In the documents detailing this position, "inclusive excellence" is mentioned a few times, as if the very word excellence might disguise the real focus, ceaselessly reiterated, which is on the familiar terms inclusion and diversity (University of Massachusetts, 2016a, August 15), mentioned also in the frequent memos celebrating revisions to the university's diversity strategic plan.

To defend perfectly reasonable positions that rest on universal liberal values rather than on identity politics, however, is to be vulnerable to the facile charge of "racism," a charge that makes most people quake in their boots. Equally troubling in the context of the academy, apart from the apparently prevalent belief that First Amendment rights evaporate at the campus gates, is the fear of speaking out that afflicts many of those who do realize something is awry with the relentless accusations of systemic racism, sexism, and the rest of the gang.

With or without apologies, reputations can be ruined and jobs threatened rapidly. Not only is it

[19]At the University of Massachusetts Amherst, for example, Chancellor Kumble Subbaswamy insists on these terms at every possible moment and, as at other universities, has increased the number of bureaucrats at all levels designated to oversee their implementation. See Patai (2016c, September 12).

imperative to refrain from saying anything that might be construed as hurtful, one must also appear never to entertain any thoughts that even skirt around the forbidden terms and ideas. Contagion is a constant danger, requiring permanent vigilance. The stunning silence of many professors and administrators when their colleagues are accused of racism and insensitivity is ample testimony to this reality.[20] An effacement of the distinction between words and deeds is encouraged by harassment policies, formulated to sustain grievances and try to force restrictions on free speech.[21] False and trivial accusations are neither discouraged nor punished. Implanting correct attitudes seems to have become the central mission of higher education these days.

One of the most obvious examples that bears witness to this new reality is the spread of terms such as "microaggression," originally coined by Chester M. Pierce in 1970, perhaps necessary in recent years because macroaggressions are scarce in academe. The inevitable result is a rush to proclaim a fragile and marginalized identity, followed by deployment of those effective old-fashioned weapons of shame, blame, and blackmail to extract concessions.

In a fascinating reversal, then, claiming powerlessness these days bestows power. And the claim can be justified only by discounting or simply denying the actual enormous progress toward equal opportunity that has occurred over generations. Women are the majority of university students, graduating at higher rates and entering various postgraduate programs in higher numbers than men. Yet this does not keep feminists from still charging that the academy is a male-dominated institution inimical to the interests of women, a terrain of constant sexual violence, like American society as a whole, they allege. Universities avidly compete for minority students and faculty, yet charges of racism increase rather than decrease. In order to keep identity battles at a fever pitch, real distinctions and reliable data are ignored or, more ingeniously still, are redefined as manifestations of "systemic" racism and ethnocentricity. But it is "racist" to comment on, say, honor killings among Muslims, even on a feminist academic listserv (see Patai, 2008a).

Of course, apostasy does occur from time to time, both in and out of the academy. Christopher Hitchens, who revised his earlier leftist views after 9/11, having recognized that Islamic terrorism was a real danger, argues in a tone reminiscent of Julien Benda that the first step we must take "is the acquisition of enough self-respect and self-confidence to say that we have met an enemy and that he is not us, but someone else. Someone with whom coexistence is, fortunately I think, not possible. (I say 'fortunately' because I am also convinced that such coexistence is not desirable)" (2004, p. 418). Hitchens has no patience with "moral equivalence" arguments nor with the conventional view that we must respect all religions. Perhaps, given his renowned atheism, he meant that we should respect none, but an equally pertinent observation is that not all religions have the same drive to suppress others, or, in the modern world, try to achieve their aims via brutality and terrorism, as radical Islam does quite openly.

Why, indeed, respect all religion any more than all politics? Is fascism to be respected, just

[20] See Friedersdorf (2016), regarding the Yale University case of Erika and Nicholas Christakis, who were the targets of vociferous protests over "insensitive" or "culturally unaware" Halloween costumes. Erika Christakis's sin was to write an email urging the university to employ tolerance and not set forth guidelines policing students' choices of Halloween costumes, but the reaction was swift and drastic as she and her husband, a Yale professor, came under sustained attack. Friedersdorf found students and faculty members afraid to state their views of the case openly "due to a campus climate where anyone could conceivably be the next object of ire and public shaming." As if it were news, he notes: "Insufficient tolerance for disagreement is undermining campus discourse." In fact, it was the enraged and censorious student activists who, as usual, got their way. For Erika Christakis's account 1 year later, see https://www.washingtonpost.com/opinions/my-halloween-email-led-to-a-campus-firestorm--and-a-troubling-lesson-about-self-censorship/2016/10/28/70e55732-9b97-11e6-a0ed-ab0774c1eaa5_story.html?utm_term=.5c3a387809dc

[21] See MacKinnon (1993), who explicitly denies the distinction between words and deeds, so that a written depiction of rape and the act of rape are conflated. With a similar blindness to crucial distinctions, she sees rape as indistinguishable from heterosexual intercourse. For a detailed discussion of MacKinnon's threatened lawsuit against my writing about her views, see Patai, *What Price Utopia?* (2008b), Chapter 17, "MacKinnon as Bully."

as anti-fascism is? It seems unlikely that most people extolling diversity and multiculturalism, and readily applying labels such as "fascist" to those who contest their views, would assent. But to acknowledge this reality requires something other than adherence to mythemes of inclusion and cultural competence.

Even leaving aside the pertinent questions Okin and others have raised, of whether all cultures (and subcultures) deserve equal respect and on what grounds it might be advisable to distinguish between them, the particular dismissal and rejection of western culture in today's academy lead to a paradoxical situation: Many campus social justice warriors display profound ignorance of their own culture's traditions, to which one may add that it is easier for students to protest against hurtful speech and stay on permanent alert for microaggressions than to actually learn something about the world; it's more fun, more dramatic, and more gratifying to one's sense of moral superiority, and, not least, it takes far less time. Genuine cultural competence, by contrast, might require both recognition of what is real and laborious study.

Yet, as Kenneth Minogue (2010, p. 206) ironically observes, academic critics "are in no way more dramatically Western than in their hatred of their own heritage. It is an entrenched European tradition, though previously found largely in a religious idiom." Advocates of multiculturalism also constantly display their dependence on that heritage in other ways. Their very demands cannot but rely for their fulfillment on the existence of the western tradition of universal rights and principles of justice. How else could minority groups expect their hegemonic oppressors not only to endlessly apologize but actually to set aside their own group interests and work instead to promote those of an identity group they purportedly oppress?

This state of affairs rests upon the paradox Minogue highlights. If there were no universal principles, no rights inhering in human beings as individuals (rather than as members of one or another group), if people were indeed irretrievably separated, mired in the interests of their own group and unable to see beyond it, minorities could never succeed in the shame-and-blame game now routinely played. It works because many members of the groups being attacked, despite being presumptively guilty of oppressive and unjust behavior (even if only many generations ago), can be and are actually expected to act on behalf of other groups. Without such a conviction, no minority group – say those claiming "Blacks Lives Matter" and insisting that to say "All Lives Matter" is somehow to be racist and insensitive – could expect a modicum of success, let alone actually manage to extract resources, apologies, curricular reform, and even resignations from the programs and administrators they attack.

Is there a relationship between the pursuit of multiculturalism and the rest of the social justice agenda in higher education and the distressingly low level of actual academic achievements of American students vis-à-vis those of many other nations?[22] International surveys (see DeSilver, 2015; OECD, 2012), indicating the unimpressive performance of American students in many areas (especially troubling in view of the much higher per capita spending on education in the United States), seem to suggest that cultural competence should, but evidently does not, begin at home.

The Utopian Dilemma

There is a curse besetting utopianism, J. L. Talmon wrote in an essay on utopianism and politics (1959). "While it has its birth in the noblest impulses of man, [utopianism] is doomed to be perverted into an instrument of tyranny and hypocrisy. For those two deep-seated urges of man, the love of freedom and the yearning for salvation, cannot be fulfilled both at the same

[22] The problem has long existed in secondary education as well. A particularly revealing example is the College Board's 2015 prescription for the new Advanced Placement European History (APEH) examination, which, like its controversial earlier revisions of AP United States History, rewrites history according to its particular leftist agenda, suppressing certain key themes and figures while highlighting others considered more politically useful. See Randall (2016).

time." Nonetheless, he warns against a sneering and dismissive disdain for human beings and their struggles: "Such an attitude of pessimism is unwarranted, and lacks generosity and foresight. We must try to do good – but with a full and mature knowledge of the limitations of politics."

The political scientist George Kateb expresses a similar view in his classic work *Utopia and Its Enemies*. He argues that the imposition of a utopian society would indeed require suppressing various sorts of "excellence" – that is the word he uses (1963). Like Talmon, Kateb neither renounces utopianism nor embraces this loss but rather suggests that the appropriate response is sad recognition of the limits and costs of manipulating human beings. As we shall see further on, many writers of speculative fiction attempt to delineate what those costs are, and satirical dystopias are one of their preferred means for doing so.

Today, however, judging by the demands of campus protestors, there exists a widespread belief in the west that, as Minogue put it, "inequality is itself the same as oppression," a belief that in turn rests on the view that "perfection would be an order in which everyone equally shared in the goods of this world" (2010, pp. 202–03). This perhaps helps explain the difficulty many on the left have had in recognizing, or admitting, the actual conditions of life under communist regimes. The sheer destructiveness of these societies has tended to be excused as at least having been motivated by high ideals. By contrast, the new multiculturalists' disinclination to criticize radical Islam, to take one of the most troubling examples of our time, is surely not motivated by genuine belief that Sharia law will usher in a better world.

Such silence on the part of those who do enjoy free speech, a free press, and freedom of association is (apart from legitimate fear in some cases) in large part rooted in the desire to avoid suggesting or even implying that, by contrast, western liberal values are actually better. As Andrew Anthony wrote about Ayaan Hirsi Ali, "she is loathed not just by Islamic fundamentalists but by many western liberals, who find her rejection of Islam almost as objectionable as her embrace of western liberalism" (2015).

Still, it is easy to understand the dilemma faced by true believers in abdicating their former convictions. These are hard to give up, as Paul Hollander has carefully documented in his work on communism worldwide, for apostasy requires abandonment of deeply held beliefs and past affirmations and affiliations. An extreme but hardly unique example is provided by the famed British Marxist historian Eric Hobsbawm (1917–2012) who, in his late 70s, still refused to renege on his life-long commitment to communism, instead affirming that, even had he known in 1934 of the deaths of millions of people in the "Soviet experiment," he would nonetheless have supported it because "the chance of a new world being born in real suffering would still have been worth backing" (cited in Hollander, 2006, p. 289). Hobsbawm continued to defend Marxism until the end of his life (Kettle & Wedderburn, 2012). Perhaps that is the sign of a true ideologue: new information need not unsettle one's core beliefs.

There is considerable congruence between the reality of communist societies as observed throughout the twentieth century and the utopian fiction that for centuries has envisioned regimentation of one sort or another as necessary if the "good society" is to be achieved. Thomas More's *Utopia* (1516), which gave its name to the literary genre, already fully develops this theme. Choosing the name Utopia because it can be understood as *eu*topia (good place) or *ou*topia (no place), More's little book contrasts the imaginary island of Utopia, situated somewhere in the new world, with the corruption and degradation of old Europe.

Leaving aside the numerous dystopian institutions and characteristics in More's work (such as enslavement of conquered peoples, subordination of women to men, and so on), whose meaning can be debated endlessly, Utopia's key structural feature is that it is a radically egalitarian and uniform communistic society, with no private property whatsoever nor attachment to material goods, inhabited by peaceful citizens living according to strict and clearly laid out rules under the ever watchful eyes of their neighbors. Though controversy persists about More's intentions, no contemporaneous evidence suggests

that he was offering this vision as satire, and, indeed, it has remained the *locus classicus* of utopian literature for centuries.

The most famous nineteenth-century American utopian novel, Edward Bellamy's best-selling *Looking Backward* (1888), also was based on complete economic equality attaching to each individual from birth. Bellamy's model of social organization is the military, with the workforce forming what he calls "the industrial army." Nonetheless, Bellamy recognized that people crave "distinctions," and, while not sacrificing economic equality, he envisions symbolic rewards in the form of medals and other visible tokens, awarded to exceptional men, who are thus better able to attract women, he explains.

In the English-language tradition, many reactions to such notions of equality have appeared, especially after the mid-nineteenth-century rise of Marxist ideology. Thus, even before Bellamy's book was published (and led to the formation of "Bellamy Clubs" worldwide, in support of his brand of socialism), the American writer Bertha Thomas in 1873 published a satirical short story, "A Vision of Communism: A Grotesque," which takes equality and personal comfort to a new high (or low) by imposing correctives to the "Iniquitous Original Division of Personal Stock," i.e., those talents and characteristics that, despite the existence of complete economic equality, provide unfair advantages to some and, if left uncorrected, cause envy, resentment, and inequality.

In a similar vein, the British humorist Jerome K. Jerome, in his 1891 story *The New Utopia*, envisions complete harmony and equality resulting not only from prohibitions of "wrong" and "silly" behavior but also through surgery to reduce brains to average capacity, to lop off limbs of the physically exceptional, and so on. A better-known modern version of the theme appears in Kurt Vonnegut's famous story *Harrison Bergeron* (1970), in which a "Handicapper General" and her team impose disabilities and impediments on gifted individuals (without, however, mutilating them), so as to promote something resembling equality in all spheres.

Perhaps the most detailed, if lesser known, such dystopia is the novel *Facial Justice*, by the British writer L. P. Hartley (1960), which takes as its epigraph "The spirit that dwelleth in us lusteth to envy" (St. James). Following a nuclear war and years during which the surviving world population had to live underground, a new society is formed in Britain, once again above ground. Wracked by a sense of collective guilt over the war, this society, run by a never-seen dictator, imposes absolute equality: everyone wears sackcloth, all houses are alike (and the property of the state), and any kind of pairing off is discouraged. To avoid awareness of distinctions of any type, people are inculcated in "the Horizontal View of Life" – they may look neither up nor down (noticing height differences, whether in people or ruined buildings), but only straight ahead. Not surprisingly, the ruins of an old tower are considered a "phallic emblem from the bad old days."[23] The word "mine" is hardly used, and "yours" means "everyone's." A popular new phrase is "voluntary-compulsory."

The novel's protagonist, named Jael 97, is "facially over privileged" and hence must report to the Ministry of Facial Justice to be fitted with a synthetic face, guaranteeing conformity to the acceptable norm. Because diversity of ideas is dangerous, leading to murder and war, in Hartley's future England it is better to have only one idea. Making it still harder to rebel is a new edict declaring that all are now living in the Fun Age. Merit is discouraged, for it requires effort, "and we aren't supposed to make an effort. Let the worst man win." The Constitution is "based on equality of the most deep-seated and all-embracing order." The idea of perfection itself is seen as "antisocial," the worst possible crime. However, since grievances are common, safety valves are provided: A "discontentometer" exists, and each person is allowed seven complaints a week.

Hartley takes his fictional society's directives to their logical conclusion: *The Daily Leveller* newspaper publishes an article suggesting that correcting grammar and spelling errors should be

[23]Readers who think this a dystopian absurdity should consider that a residence hall director at the University of Michigan reported a "phallic snow object" as a bias incident (see Snyder & Khalid, 2016).

banned since it can lead to envy and bitterness. The article also protests against the tyranny of the objective case – e.g., who vs. whom – because "it wasn't fair for a word to be governed by a verb, or even a preposition. Words can only be free if they're equal, and how can they be equal if they're governed by other words?"[24] Anthony Burgess, author of *A Clockwork Orange* (1971), one of the most famous of the twentieth-century dystopias, praised *Facial Justice* as "A brilliant projection of tendencies apparent in the post-war British welfare state" (1984).

While Hartley's and similar works are obviously *reductiones ad absurdum*, current campus demands for comfort, safe spaces, and protection from microaggressions and hurt feelings suggest these dystopian speculations are no longer as far-fetched as perhaps they once seemed to be. After all, not merely economic disparities but any competitive advantages are likely to cause discomfort to those who lack them – for who can deny that beauty, intelligence, artistic and other talents, health, strength, industriousness, wit, and energy, not to mention great hair, along with much else, are, alas, not equally distributed in life? But this should not diminish our perception that, as is often observed these days, reality is making satire ever more difficult.

Fixing all such problems requires ever greater state involvement. A scathing and humorous attack on the actual scene in England today is Josie Appleton's recent book *Officious: Rise of the Busybody State* (2016), which she sees as predicated on the sole belief "in the inherent virtues of regulation." While pretending that "procedures" are in themselves capable of "warding off evil," she writes, the real function of the new officiousness is to transform "unregulated life into regulated life" (pp. 9-10), demanding public submission.

In the United States, with the growing number of "Bias Response Teams" (BRTs) – which thoughtful universities encourage anyone and everyone to contact if they ever experience, witness, or merely overhear (in the real world or online) something they don't like – the busybody state is hard at work. These BRTs, intended as support systems for fragile students, are "rapidly becoming part of the institutional machinery of higher education" (Snyder & Khalid, 2016). Examples of complaints around the country involve intentional or unintentional words or acts:

> Definitions of bias incidents vary by campus but have the following key features: They encompass "any behavior or action directed towards an individual or group based upon actual or perceived identity characteristics." These characteristics include "race, color, ethnicity, social class, national origin, religion, sexual orientation, gender identity and/or sexed equation, age, marital status, veteran status, and physical and mental health" – sometimes even "height" and "weight."[25]

A relatively recent development, BRTs have been around for about a decade and typically function behind the scenes, lacking transparency but possessing the ability to embroil alleged culprits in administrative punishments and retraining, all in the name of making students feel entirely comfortable and safe (Snyder & Khalid, 2016). It is also noteworthy that even a school such as the University of Chicago, which in August 2016 vigorously defended First Amendment rights against "safe spaces" and the like (Creeley, 2016), nonetheless has Bias Response Teams, on call 24/7, as at other universities.

Far from celebrating multiculturalism and diversity, such new policies highlight the prescience of dystopian visions in their understand-

[24] Once again, fiction prefigures reality. Alan Sokal and Jean Bricmont, in their book *Fashionable Nonsense* (1998), expose the often comical abuses of science by contemporary theorists; they devote one chapter to French feminist writer Luce Irigaray who criticized "masculine" physics and famously suggested that $E = mc^2$ is a "sexed equation," because it "privileges the speed of light."

[25] Snyder and Khalid (2016), professors at Carleton College who describe themselves as committed to "rigorous studies in the liberal arts disciplines," give numerous examples of what are considered "bias incidents" in schools around the country. At the University of Massachusetts Amherst (n.d.), an "Online CARE Report" offers any member of the university or local community the option to fill in an "Anonymous Witness Form" rather than the standard one requesting the "reporter's" name and contact information.

ing that a serious demand for social harmony must involve the enforced suppression of individual identity and free expression – for the sake of (a usually illusory) social cohesion. Dystopian satires, furthermore, come to mind when one considers current claims that "disparate outcomes," as noted above, necessarily indicate prejudice and injustice and must therefore be corrected, all in the name of "social justice."

It is certainly true that the existence of excellence, just plain talent, or any other advantage however acquired can cause those who lack it to feel resentful and uncomfortable. But more unacceptable to many people today is any discussion of genetically driven disparities among human populations, which suggests that the dystopian satires mentioned above were onto something fundamental. Nicholas Wade's controversial book *A Troublesome Inheritance: Genes, Race and Human History* (2014) argues – delicately and with constant disclaimers, given the problematic history of "eugenics" – that natural selection has produced distinct social behaviors that play a significant role in racial and cultural variations worldwide. Earlier research about racial disparities in intelligence, such as R. J. Herrnstein and C. Murray's *The Bell Curve: Intelligence and Class Structure in American Life* (1994), which Wade conspicuously does not mention, also aroused heated denunciation. Evidently arguments that challenge the view that race is (merely) a social construct or rhetorical trope are frowned upon these days, regardless of the evidence – unless, that is, embracing them is politically useful.

Beyond sheer denial of race as a biological reality, however, various ways exist for dealing with the problems of disparity between groups (as between individuals). It can be addressed by siphoning off the talented into a separate class; by medical, genetic, and/or behavioral engineering designed to produce conformity and remove grounds for tension; or by sheer authority and terror imposing uniformity on all people – except, of course, the leaders. All of these and other methods have been explored both in existing societies and in speculative fiction, with troubling if not downright nightmarish results. The predictable consequences, apart from a stultifying sameness, are the disappearance of creativity and initiative, which can only lead to stagnation and decline.

A further characteristic of many dystopias is the suppression and distortion of history. Such a practice is necessary – as we see today all around us – if people are to absorb an ideology that knowledge of the past could challenge. Orwell's *Nineteen Eighty-Four* offers probably the best known treatment of this theme, but many details and elements of his novel suggest he was familiar with another dystopia published more than 10 years earlier in England. The British feminist writer Katharine Burdekin (1896–1963), using the pseudonym Murray Constantine, in 1937 published a powerful and prescient anti-fascist novel. *Swastika Night*, written in 1936, is set in the seventh century of the Hitlerian millennium, when militarist German and Japanese empires divide the world between them. A cult of masculinity is enforced; Jews have ceased to exist, and Christians are the lowest of the low – except for women, who are reduced to the level of ugly animals used merely for procreation. All books and actual knowledge of the past are suppressed, as are certain words and concepts. The notion of women as desirable and independent individuals has long since vanished.

In another of her speculative fictions, composed in 1935 but published only decades after her death, Burdekin (1989) had explored the same themes of censorship, rewriting of the past, and the oppression of one sex by the other. Entitled *The End of This Day's Business*, it is an intriguing example of the fictional sex-role reversal, of which there are many in the dystopian and eutopian tradition. The novel is set 4000 years in the future, at a time in which women rule the world. Though in many ways depicting a eutopia, the novel also has a fundamental dystopian dimension: for the sake of maintaining their power and a peaceful society, women have reduced men to ignorant playthings, allowed competitive sports, games, and sexual access, but living in their separate sphere, ignorant of who their children and fathers are. The men are treated with kindness and condescension but denied literacy and all accurate knowledge of his-

tory. Their past achievements are hidden from them, and their material culture has long since been destroyed, so that no sources of pride in their sex remain. Only women, in this future, have actual knowledge of the past, ritually provided in order to instill in them the conviction of the need to maintain their own power.

The novel's protagonist, in keeping with Burdekin's deep suspicion of mere "reversals of privilege," finally rebels against this order of things and informs her son of the truth. Like Socrates, she is put to death for this transgression (see Patai, 2002).

We live in an age where the goals of many social justice warriors seem to resemble these dystopian scenarios. In the name of presumptively desirable if elusive social goals (justice, equality, inclusion), restrictions on personal interactions and free expression have greatly increased. Attacks on and defenses of free speech on college campuses are anything but "content neutral," despite well-known Supreme Court decisions regarding the First Amendment. While religious fundamentalists and creationists in some states have tried to impede the teaching of evolution, they and other right-wing groups are a small minority compared to the uniformity of thought that has dominated education for the past few decades.

Equally alarming, current orthodoxies have been allowed to define not only institutional and public policy but also scholarly research, which means that certain questions are not even to be raised, let alone seriously explored. The ensuing policing actions are often undertaken by other scholars, whose political commitments override professional obligations and sound investigation, with the result that certain topics are boycotted and prohibited, and their proponents vilified.

One of the most interesting recent books on the negative effects of such politics on scholarship is Alice Dreger's *Galileo's Middle Finger: Heretics, Activists, and the Search for Justice in Science* (2015), which chronicles hair-raising stories of group bullying of scholars whose research did not serve the political agendas of one or another popular cause. Such episodes have multiplied in recent years, as the blatant politicization of education and research has been deemed by many academics as not only acceptable but desirable. At the macrolevel, entire fields come to be dominated by ideology, not the pursuit of knowledge. At the microlevel, surveillance of speech and attitudes has grown so intense that even the most august reputation can be readily sullied by a politically injudicious joke or passing comment, as happened to Sir Tim Hunt, the Nobel Prize-winning British biologist (see Young, 2015).

Today, as Dreger demonstrates, important and complex research areas are discouraged if not outrightly prohibited, particularly in relation to sex and race differences, the formation of sexual identity, law enforcement, family life, and so on. Entire programs in academe are built around ideological assertions that are not to be questioned, as is readily apparent in, for example, Women's Studies programs – in recent years renamed Women, Gender, and Sexuality Studies, perhaps to clarify that their focus now is primarily on dismantling "heteronormativity."

As noted above, it is common in dystopian scenarios for individual freedom to be set in opposition to the common good. Benefitting from and cultivating one's own qualities and abilities are seen as invariably leading to resentment and conflict, even if economic equality (at the low level that suppression of talent and initiative will allow) is guaranteed. The intractable problems of difference and sameness – the very thing that has entangled the many feminists who readily switch from one to the other as needed in their arguments about gender equality and women's roles – have a long and contentious history. The underlying issue, however, is how one understands human nature and the relationship between nature and nurture, for these will determine beliefs about the extent to which individuals can be shaped, molded, or constrained for the sake of the group. While all societies depend upon some such shaping, and individual consciousness is always accompanied by group ties as well, the disagreement over ends and means resides in the details.[26]

[26] For a more detailed discussion of these and other dystopian works and the issues they raise, as well as a description of the development of speech codes designed to prevent hurt feelings on the part of protected identity groups at the University of Massachusetts Amherst, see

Notions of civil liberties and rights attaching to all individuals qua individuals, rather than as members of groups, have taken a long time to develop and be implemented, and it is therefore worth remarking that it requires far less time for them to be destroyed – or, for that matter, voluntarily abandoned. When group pride must be maintained at all cost, individual moral awareness and autonomy disappear, replaced by hypervigilance of social life and suppression of individual initiative. The result is what Minogue (2010) refers to as "sentimental moralism," bound to produce a servile mind.

A pertinent example is offered in Ayn Rand's short dystopian novel *Anthem* (1937), interesting because, apart from her attack on collectivism, well before Orwell, she envisioned the effects of collectivism even on language. Though ostensibly a first-person narrative, the novel contains no singular pronouns, only plural forms: "We" but never "I" and "our" but never "my."[27] Any invention or contribution not coming from the collective is suppressed, and the predictable consequences are a primitive way of life in which even the knowledge of how to produce electricity has been lost. Extreme regulation is a necessity if people are truly to be protected from invidious comparisons and competitiveness – in other words, from human emotions.

In the pronoun policing currently demanded by and on behalf of transgender activists, we see an extension of these older patterns, once again dressed up as efforts to prevent discrimination. Perhaps the linguistic totalitarianism masterfully satirized in Lou Tafler's inventive novel *Fair New World* (1994) will soon become a model. Tafler takes the battle of the sexes to what once seemed to be absurd new heights. He imagines three separate societies. Two are dystopias: Bruteland inhabited only by men and Feminania by women. The third is a eutopian alternative called Melior, governed by a philosopher king who did everything he could to not be elected.

In Feminania, the Femininnies have created a language called Fairspeak, in which the letter combinations *man* and *men* have been replaced by *womb*, *womban*, and *womben*, producing words such as *wombdate*, *wombanacle*, and *dewomband*. Naturally words such as *woman* and *female* are unacceptable and have become *womban* and *fembale*. Etymology counts for nothing, as in the real-world preference for *herstory*, promoted by feminists decades ago, which Tafler perhaps took as his inspiration, and even gender-neutral endings are revised. Thus *er* and *or* are replaced by *her*, and *son* by *daughther*, producing words such as *acther*, *disasther*, *daughtherg*, *pherdaughther*, *pridaughther*, and *readaughther. Gent* has become *lady* (as in *intellilady*, *dililady*, and *ladylewombanly*), and scores of terms such as *wombanufacture*, *docuwombentary*, *wombagewombent*, and *comwombencewombent* abound. In all sections of the book dealing with Feminania, then, the reader must slog through a soup of zany, often multisyllabic words. The author, however, has thoughtfully provided a glossary.[28]

In dystopian (and often eutopian as well) scenarios, the great social conundrum of how to reconcile individual and group needs emerges most intensely in the arena of love and personal relations. These, if they mean anything at all, involve selection and the "sin of preference," as Rand names it in *Anthem*. Many famous dystopias try to deal with the messiness of personal attachments by suppressing them altogether, whether by prohibiting sex, regimenting it, or facilitating unfettered sexual access but outlawing love and

Patai (1996).

[27] In feminist circles, for example, the line between individual achievement and group cohesion has long had to be carefully negotiated, given that disciplinary expertise, competence, and knowledge often incite envy and unhappiness. One feminist expressed resentment at Susan Brownmiller for the fame she achieved with her book *Against Our Will* (1975): "Do you have to put your name on your book?…Rape doesn't belong to you, it belongs to the movement" (cited by Patai & Koertge, 2003, p. 230). Phyllis Chesler discusses this problem at great length in her book *Woman's Inhumanity to Woman* (2001).

[28] For the twentieth anniversary edition of *Fair New World*, Professor Hardy Orbs (2014) has contributed a foreword that, among other things, clearly explains the basic rules of Fairspeak.

dismantling family attachments. Lobotomies, drugs, constant surveillance and indoctrination, imposed uniformity, ceaseless group manifestations of fealty, orgies of hatred and/or sexual license, and the abolition of art not devoted to celebrating the state are all staples of these works.

Once again today, life imitates art, and social activists seek to introduce repressive practices in schools, where they can more easily be imposed on a captive audience. A recent much-discussed article by psychologist Barbara Greenberg (2018), who describes herself as "a huge fan of social inclusion," argues that schools should ban the habit of forming "best friends." Why? Because these practices lead to emotional distress among children and teenagers. Greenberg writes: "The word 'best' encourages judgment and promotes exclusion." She advises parents to prod their children, instead, to have a small group of close friends. Or, one might add, they could just send their kids to convents, which have a long history of attempting to suppress what they called "particular friendships."

But it is not only personal relations that a well-regulated society attempts to control. Art, too, with its appeal to imagination, is a constant irritant and offender. More than 60 years ago, Ray Bradbury's *Fahrenheit 451* (1991) devoted considerable attention to the problem of the role of the individual in a society aiming at social harmony. Writing in the early days of television, Bradbury envisioned a future America in which the preeminent value is general contentment, fed by drugs, physical comfort, surveillance, and a constant stream of anodyne pseudo-interactive television programs broadcast on multiple huge screens affixed to living room walls. Firemen no longer put out fires; instead they burn books, as the fire captain, Beatty, explains to the rebellious fireman Montag (who has begun to wonder about the content of the books he's burning). Books convey the "texture," the "pores" of life – and for that reason awaken dangerous feelings best left undisturbed. This practice was not imposed by the government but selected by the people, including professors who did not defend their turf. Captain Beatty lays out the rationale:

> "You must understand that our civilization is so vast that we can't have our minorities upset and stirred. Ask yourself, What do we want in this country, above all? People want to be happy, isn't that right? Haven't you heard it all your life? I want to be happy, people say. Well, aren't they? Don't we keep them moving, don't we give them fun? That's all we live for, isn't it?…."

Beatty provides examples of what this means in practice:

> "Coloured people don't like *Little Black Sambo*. Burn it. White people don't feel good about *Uncle Tom's Cabin*. Burn it. Someone's written a book on tobacco and cancer of the lungs? The cigarette people are weeping? Burn the book. Serenity, Montag. Peace, Montag." (Bradbury, p. 59)

This is not, however, merely a modern theme. Kierkegaard, in his 1844 work *The Concept of Anxiety*, famously suggested that "anxiety is the dizziness of freedom." Some decades later, in *The Brothers Karamazov* (1879–1880), Dostoyevsky presents a similar argument through the monologue of the Grand Inquisitor, who explains that human beings consider their birthright of freedom insupportable and therefore perpetually seek some authority or leader to relieve them of it – in exchange for security. Only in this way can they achieve happiness.

Such ideas have profoundly influenced dystopian fiction, which routinely includes a scene involving an authoritative figure like Captain Beatty who explains to the (usually rebellious) protagonist why the masses not only must but actually wish to be spared the burden of freedom. But whereas Dostoyevsky's parable sets forth a criticism of the power and authority of the Roman Catholic Church, in more recent renditions (in fiction, film, and reality), the same rationale is offered for secular state regulation of daily life.

Demands for thought reform, too, are inevitably a staple of the dystopian literary tradition, in which individual autonomy is understood to be a potential threat to state stability. It is inconvenient to have people thinking for themselves, since this entails questioning rules and regulations, contesting others' views, and stirring up conflict. It makes sense for those in authority to

claim all this must be suppressed for the greater good.[29]

Those who dismiss these speculative works as mere fantasy need only recall the numerous totalitarian regimes that, throughout the twentieth century (and into the twenty-first century), have tried to obliterate the Enlightenment values of individual autonomy, responsibility, and civil liberties through combinations of propaganda, censorship, imprisonment, torture, and death. This assault continues into the present day in regimes such as those of North Korea and Cuba.[30] It is also found in nations and communities governed by rigid Sharia law, which subordinates individuals to the dictates of a religio-political ideology.

In his 1932 novel *Brave New World*, Aldous Huxley has one of the World Controllers say "There isn't any need for a civilized man to bear anything that's seriously unpleasant" (1969, p. 243). Reality has finally caught up with fantasy, rendering satire obsolete. At the University of Portland, Oregon, in early 2016, a webpage called "Speak Up" was launched, urging students to contact the Public Safety Department to report any "instances of discomfort" that they may have experienced or witnessed (Aguilar, 2016). The precipitating incident was the claim that students of color feel isolated due to the prevalence of "microaggressions" on campus. They can also now receive training in how to spot the subtleties of "microaggressions." And more recently, some schools are insisting that facial expressions may also be construed as microaggressions, along with conventional terms such as "you guys," which excludes women.

The kind of hypersensitivity that used to be promoted primarily in a few identity-based programs such as Women's Studies or African-American Studies, with their emphasis on the ceaseless victimization of their specific identity groups, accompanied by the invariable assignment of guilt to other groups, has now morphed into an endless litany of potential offenses, in need of correction by "cultural competence" and its fellow terms. It has become so routine that monitoring by an ever-expanding cadre of administrators and staff is now required (Patai, 2016a, February 7).

And why not? When something has achieved the status of a major social problem, around which moralizing and posturing can coalesce, most everyone wants to be in on the action. Each new suspected affront then becomes, as Joel Best explained in his book *Threatened Children* (1990), "just another instance of X," the intractable problem, useful for mobilizing grievances and demands. Key aspects of this process, according to Best, include expanding definitions of the problem, along with escalating statistics, rhetoric, and, of course, media attention.

A current instance of this process has been unfolding before our very eyes in the #MeToo movement that began in 2017 and is still gaining steam nationally and internationally (see note 7). It has intensified (but by no means originated) the atmosphere of moral panic that has been festering for the past few decades. Nearly 25 years ago, the cultural theorist John Fekete analyzed this phenomenon in his powerful and controversial book *Moral Panic: Biopolitics Rising* (1994), more relevant today than ever. "Biopolitics," writes Fekete, is a "new primitivism which promotes self-identification through groups defined by categories like race and sex." Such an atmosphere, affecting virtually all aspects of life in North America (and spreading from there), as we see on a daily basis today, characteristically refuses to distinguish trivial from serious charges – so that rape and a vulgar pass are

[29] For present purposes, I am here referring to those dystopias that (whatever the ironic intents of the authors) present themselves as *eu*topias, good places, and thereby justify the suppression of individuality and civil liberties, purportedly for the benefit of the population. Such works include E. M. Forster's short story *The Machine Stops*, Yvgeny Zamyatin's *We*, Aldous Huxley's *Brave New World*, Ayn Rand's *Anthem*, Ray Bradbury's *Fahrenheit 451*, and numerous other novels and stories. This would exclude works such as Orwell's *Nineteen Eighty-Four* in which the goal of the leaders is to cause suffering and induce submission, so that they may better experience the thrill of power – dystopias, in other words, in which there is not even a pretense that government control is exercised for the sake of the well-being of the populace.

[30] See the Constitution of the Republic of Cuba (1992). Chapter V, Article 39 (d) states: "there is freedom of artistic creation as long as its content is not contrary to the Revolution."

treated as equally serious; is uninterested in the accuracy of allegations, and cultivates a crude identity politics that promotes vilification of entire groups and celebration of others. Furthermore, it encourages dangerous "panic remedies," as Fekete points out. By capitulating to such a climate, democratic and formerly liberal societies start to unravel, adopting practices that closely resemble those found in authoritarian dystopias, whether satirical or actual.

It is illuminating that while "moral panic" spreads, alarm over actual political threats diminishes (unless those threats come from conservative politicians in the west). In the past 15 years, however, as the problems associated with massive Muslim immigration to Europe have intensified, a new kind of dystopian fiction has emerged, warning of Islamist takeovers of western countries and often resting on knowledge of the history of Muslim imperialism, adapted to modern times.

The most famous of these is no doubt Michel Houellebecq's 2015 novel *Submission* (the literal meaning of the word Islam), a best seller in his native France, which envisions the peaceful ascension in the near future of an Islamic political party through democratic means, thanks to an alliance between socialist and Islamic politicians. In conjunction with home-grown attacks on western values, it is becoming clear that violence is not necessary to overthrow a society: a clever utilization of liberal values, propaganda, media support, and current multicultural dogma could bring about the same result.

As it happens, Houellebecq's novel was published on January 7, 2015 – the very day Islamist terrorists murdered 12 staff members at the offices of the Parisian satirical weekly *Charlie Hebdo*, in the name of avenging affronts to their prophet Mohammed. The ensuing discussion in many western democracies about when free speech goes "too far" should be instructive as a sign both of the rapidly changing climate in the west, and in particular of the habit of capitulation to Islamist extremism. Houellebecq, of whom a caricature appeared on *Charlie Hebdo*'s cover that week, has predictably and repeatedly been accused of "Islamophobia." Yet his fame, or notoriety, in France, persists, whereas no work such as his has attained much popularity in the United States.

By contrast, Margaret Atwood's 1986 dystopia *The Handmaid's Tale*, envisioning a fundamentalist Christian takeover of the United States resulting in a nightmarish and misogynistic totalitarian society, was and continues to be an immensely popular and widely used text. No attacks on the author for her supposed abuse of free speech to vilify a particular religious group were launched. Most intriguing is that Atwood's novel was an extrapolation, an extremist fantasy, whereas Houellebecq's, like other such anti-Islamist speculative fiction in recent years, utilizes widely known and verifiable proclamations and practices based in Sharia law, which numerous surveys indicate a significant numbers of Muslims in western countries (to restrict the discussion only to them) would indeed welcome.

Conclusion

The paradox of the ideological cluster that includes defending the language of multiculturalism, cultural competence, and diversity – all resting on identity politics – is, as noted above, that it invariably relies on ideas of basic human rights and freedoms that were first defined, embraced, and widely implemented in the west. It is considered unforgivably ethnocentric, however, to say this today. Nonetheless, the real costs of abjuring such values are readily apparent: one has only to look at past and present examples from the USSR to China, North Korea, Rwanda, Libya, Syria, and numerous other places.

In his essay *On Liberty* (1859), John Stuart Mill writes against paternalism and for individual autonomy. His liberalism, endorsing restrictions on government power, is the opposite of what today goes by the name of liberalism, with its ceaseless demands for codes and regulations imposed by the state and its institutions. Mill ended his work with this warning:

> …a State which dwarfs its men, in order that they may be more docile instruments in its hands even for beneficial purposes, will find that with small men no great thing can really be accomplished;

> and that the perfection of machinery to which it has sacrificed everything, will in the end avail it nothing, for want of the vital power which, in order that the machine might work more smoothly, it has preferred to banish.

If taken seriously, the supposedly laudable goals of equity, inclusion, diversity, and the general pursuit of "social justice" are ultimately achievable only by rigorous micromanagement of speech and everyday interactions. Many people (mostly living in relatively free societies) seem inclined to consider this a small price to pay if hurt feelings and discomfort are to be averted, and their naïve ideas of how to create a better world are implemented. And this is precisely what we are seeing at those highly privileged places, universities – from which the same goals and practices spread to lower levels of education and to the society at large.

Extremes have a way of meeting. The celebration of ever cruder speech and gestures that followed the Free Speech Movement of the mid-1960s has by now morphed into a very different demand. Though vulgarity and sexuality pervade the mass media, in the academic world and beyond, the desire for individual freedom of speech and association has turned into cries for protection from others' potentially offensive speech, gestures, glances, jokes, touches, invitations, innuendos, questions, facial expressions, and much else. Nothing is new here, perhaps: all things can turn into their opposite if one waits long enough.

Hubris, or political passions, should not lead us to think that if we can just regulate the content of education thoroughly, we will bring about social justice. In fact, we hardly know what "social justice" is, let alone how it may best be attained. Therefore, while we still enjoy the freedom to learn, explore, and debate and while we still have full access to information and the means of analyzing it, it behooves us to notice how easily the new insistence on cultural competence and all its kindred terms can slide into ideological policing and cultural incompetence, rooted in generalities that may not be far removed from the stereotypes they originally aspired to replace.

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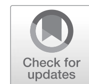

18 Psychometric Foundations of Psychological Assessment with Diverse Cultures: What Are the Concepts, Methods, and Evidence?

Stephen N. Haynes, Joseph Keawe'aimoku Kaholokula, and Junko Tanaka-Matsumi

Measurement is the foundation of science. In the social and behavioral sciences, it involves the assignment of numbers to represent a person's or group's behaviors, emotions, thoughts, cognitive processes, values, physiology, environments, and social interactions (Pedhazur & Pedhazur-Schmelkin, 1991). *Psychological assessment* is the process of acquiring and integrating both quantitative and qualitative information about a person or group and deriving judgments based on that information. Measurement is an essential element of that process (see multiple definitions of "psychological assessment" in Geisinger, 2013).

A scientific approach to psychological assessment involves several interrelated considerations:

(a) Are appropriate methods being used to acquire information about a person, given the characteristics and contexts of that person and the purpose of the assessment?
(b) How well does the quantitative and qualitative information derived from the assessment of a person accurately reflect the targeted behaviors, attributes, and events?
(c) Are the behaviors and events targeted in the assessment relevant to that person and to that assessment context?
(d) To what degree are the judgments and decisions based on the assessment information appropriate for that person?

The scientific study of measurement in the social and behavioral sciences is called *psychometrics* (see Haynes, O'Brien, & Kaholokula, 2011; Haynes, Smith, & Hunsley, 2011; Hogan, 2015; and Nunnally & Bernstein, 1994, for discussions of psychometric principles and methods). For example, the psychometric evaluation of a measurement instrument (more precisely, of the measures derived from that instrument[1]) might consider its *internal consistency* – the

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[1] Many assessment instruments provide multiple measures that differ in their psychometric characteristics. Consequently, psychometric evidence pertains to assessment *measures* rather than assessment *instruments.*

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degree of consistency or strength of interrelations of the elements within an assessment instrument when they are used to form a composite measure. An example is the degree to which data from multiple items in a questionnaire, or multiple codes in a behavior observation instrument, that are intended to measure "mood" covary or are statistically interrelated. Alternatively, do some items in the instrument correlate poorly with others and possibly measure constructs other than mood, such as anxiety?

A psychometric evaluation of a measure could also consider its *convergent validity* – the degree to which the data from an assessment instrument are related to other measures of the same construct and to other theoretically associated measures. An example is the degree to which a parental measure of adolescents' mood agrees with adolescents' self-reported measures of mood.

Especially relevant for this chapter on psychometric foundations of psychological assessment with diverse cultures is the evaluation of a measure's *content validity* and *consequential validity*. Content validity refers to the degree to which elements (e.g., items on a questionnaire, behavior codes in an observation system, stimuli presented during ecological momentary assessment) in the instruments are relevant to and representative of the targeted construct. An example is the degree to which the items in a self-report questionnaire measure of social anxiety are relevant to that construct and cover the range of symptoms and contexts associated with social anxiety. Consequential validity refers to the degree to which judgments and decisions based on a measure are relevant and appropriate for a person. For example, to what degree are data from an assessment instrument appropriate for making treatment decisions for a person experiencing trauma-related symptoms or for the educational placement for a person with developmental disabilities?

Many aspects of an assessment instrument and its associated measures affect content and consequential validity (see overview in Haynes et al., 2011, pg. 68). In this chapter, we emphasize the influential role of diversity, culture, and individual differences. An assessor and persons making decisions based on assessment data must consider the degree to which an instrument and its measures are appropriate in the context of the person's disability status, ethnic background, age, sex, cognitive abilities, social and economic contexts, sexual orientation, or other dimensions of individual differences. Judgments and decisions are more likely to be appropriate and beneficial for a person to the degree that they are based on culturally appropriate assessment instruments, methods, and measures.

A major tenet of this chapter is that the *psychometric evidence* about a psychological assessment measure can, but cannot be assumed to, generalize across dimensions of diversity and individual differences. Consistent with the focus on diversity, we stress the *conditional* nature of psychometric evidence. That is, the psychometric characteristics of measures can vary across dimensions of individual differences as well as across assessment contexts and specific psychometric dimensions.[2] We also note that constructs and their measures can differ in the degree to which they are sensitive to dimensions of individual differences. For example, a self-report measure of couple interaction and satisfaction might evidence greater variability in content and convergent validity across ethnic groups when compared to a computerized measure of working memory capacity or visual-spatial abilities.

In this chapter, we outline science-based psychometric principles in the development and evaluation of psychological assessment instruments and measures that are culturally appropriate and sensitive to diversity. We define *diversity* (similar to Gross et al., 2014; Herdman & McMillan-Capehart, 2010) as "differences between individuals on attributes, or dimension of individual differences, that are potentially relevant to a variable of interest." Within the context of this definition, age and economic status might

[2] As demonstrated in all of the chapters in Hunsley and Mash (2008, 2018), an assessment instrument can provide measures that differ across psychometric dimensions such as internal consistency, convergent validity, and discriminant validity. Further, the psychometric attributes of a measure can also differ across applications, such as brief screening versus treatment outcome evaluation.

be considered relevant attributes, but eye color and height might be considered irrelevant attributes, associated with the causes and characteristics of excessive use of alcohol. For example, social factors such as peer approval and bonding are often more important influences for alcohol use among adolescents than among persons in later adulthood.

We adopt the definition of *culture* as "the shared patterns of behaviors and interactions, cognitive constructs, and affects that are learned through a process of socialization and that distinguish members of a group from members of another group.[3]" Thus, *culture* can be associated with dimensions of diversity such as age or generational status, gender, sexual orientation, ethnicity, race, religious affiliation, geographic location, disability status (e.g., deafness), physical characteristics (e.g., dwarfism), and income level.

Consistent with the arguments by O'Donohue and Benuto (2010), and relevant for identifying the best measurement strategies for a person, we also stress the non-categorical, continuous, multidimensional, and interactive nature of culture. Aspects of diversity are considered to be continuous unipolar or bipolar dimensions. For example, first-generation Americans of Japanese heritage can differ in the degrees to which they are acculturated (i.e., to the degree to which the individual adapts to the norms of the dominant culture in the USA) and enculturated (i.e., to the degree to which the individual maintains the norms of their Japanese culture). A person can be high or low in both dimensions or high on one and low on another. Further, these differences could be moderated by age, sex, and income level. As another example, persons of a Buddhist faith can differ in the degree to which they adhere to the tenets and practices of Buddhism (Kim, Ahn, & Lam, 2009). The point is that the identification of significant differences between cultural groups can lead to overgeneralized inferences when important differences among people within those groups are not examined (e.g., Wilson, 2009).

Below, we also discuss the potential differential applicability of *measurement strategies* (the manner in which information is obtained) and the potential differential validity of constructs that the strategies are intended to measure, as a function of the unique aspects of the person being assessed. For example, is an intake interview by a male nurse in a primary care setting the best way of identifying behavior problems with recent older female Asian immigrants? Is this assessment strategy more likely than the administration of a self-report questionnaire to identify problems?

In discussing cultural considerations in psychological assessment, and relevant to considerations of content validity discussed above, we also consider the degree to which the attributes and events that are targeted in a measurement instrument are appropriate for the individual being assessed. To what degree are the constructs, latent variables, behaviors, and events measured relevant and appropriate, given the person's culture? Should the assessment instrument include other, or additional, constructs, latent variables, behaviors, and events? If the attributes and events in the measurement instrument are relevant and representative, are they measured in a culturally appropriate manner? Integrating these questions, we must consider the degree to which the derived measures from an instrument are valid for that person. Further, if there are concerns about the validity of a measure for a person, what are the implications for the judgments that are influenced by the measure?

As we discussed above and consider further below, it can be difficult to estimate the appropriateness of measures and measurement strategies because each person exists within multiple cultural dimensions (e.g., gender, age, ethnicity, disability status) and persons can vary along important dimensions within a traditional cultural category. For example, consider the significant differences in enculturation and acculturation, age, English language abilities, and income level among "Asian-Americans" (Suinn, 2009) and how these differences make it difficult to estimate

[3]The University of Minnesota Center for Advanced Research on Language Acquisition (http://www.carla.umn.edu/culture/definitions.html) lists 10 definitions of "culture" with citations.

the cultural appropriateness of a measure of social anxiety for "Asian-Americans."

Attention to cultural dimensions encourages careful thinking about the potential differential validity and generalizability across and within cultures of the measures obtained and of the judgments influenced by those measures. Assuming that the constructs targeted by an instrument are relevant to the person being assessed, to what degree are the measures of those constructs and the judgments from those measures valid given the individual's status on multiple dimensions of individual differences?

Diversity is an important consideration in clinical assessment and research because assessment-based judgments have important consequences for the person being assessed, for the outcome of psychopathology and treatment research, and for the advancement of the science of psychology. The results of psychological assessment can influence a person's categorization and psychiatric diagnosis (learning disabled, autism spectrum), a judge's estimate of a child's safety and security in a home placement, and a counselor's recommendation for placement of a person in a restrictive or educational setting. Data from psychological assessments can also influence judgments about a client's apparent strengths and deficits, a jury's judgment about a person's responsibility and punishment for criminal acts, and a clinician's pretreatment clinical case formulation. Decisions about the best medication or psychological intervention, the goals for that intervention, and judgments about the outcome and process of clinical intervention are also influenced by the outcomes of psychological assessment (Geisinger, 2013). In sum, psychological assessors, and those rendering decisions about a person based on assessment data, must consider the degree to which it is fair to use a particular measure to influence important decisions about that person, given the context of the person's culture. Below, we discuss the psychometric criteria that are useful in judging the cultural fairness and validity of measures and strategies for constructing a culturally fair assessment instrument.

To illustrate the challenges in judging the cultural fairness of psychological assessment, hundreds of articles, chapters, and books have discussed the international and cross-cultural application of questionnaires developed in the USA, such as the Minnesota Multiphasic Personality Inventory (MMPI) and others that measure the "Big-Five" personality traits (e.g., Butcher, 2009; Geisinger, 2013). These sources evaluate whether measures of personality traits, such as "neuroticism" or "extraversion," originally defined and measured with multiple self-report instruments about 70 years ago by academic researchers in the United States (US) Midwest, are valid and useful when applied to persons living in Africa, Europe, South America, and Asia and valid and useful across ethnic groups or geographical regions within the USA. These sources most often examine the across-ethnic-group generalizability of psychometric evidence, such as factor structure or test-retest reliability (e.g., Chen, 2008; Gross et al., 2006). Suzuki and Ponterotto (2008), Suzuki, Onoue, and Hill (2013) discussed several studies that found statistically significant racial and ethnic differences in MMPI scale scores and the meaning (i.e., consequential validity and utility) of those differences.

Recall that the ultimate considerations in the cross-cultural applicability and sensitivity of psychological assessment measures pertain to their *consequential validity* (Messick, 1995; Widaman & Reise, 1997). That is, will a measure used with persons who differ from those who participated in the original instrument development and psychometric evaluation facilitate appropriate decisions about those persons? Will judgments about sources of distress in their interpersonal relationships, educational attainment, problem-solving abilities, criminal responsibility, and parenting skills be valid and fair when based on the adopted measure?

Many clinical scientists have discussed the validity and fairness of tests developed within a Euro-centered cultural framework when applied with persons who operate within other cultural frameworks. For a directionally reversed anal-

ogy, consider the validity and utility for persons from the US Midwest in regard to a measure of the five-factor personality constructs (wood, earth, fire, metal, water) from Chinese medicine (e.g., http://longevity-center.com/five-element-personality-questionnaire/; https://essentialhealing.wordpress.com/2009/02/19/the-five-elements-which-one-are-you/). A standard psychometric evaluation of the appropriateness of this instrument for this new population might examine the degree to which measures from this questionnaire demonstrate internal consistency, test-retest reliability, and factor stability with a Midwest sample of mostly Americans of European descent. If these initial evaluations are supportive, the psychometric evaluation might then consider if measures from this instrument correlate highly with other measures of these constructs. Assuming support for the internal consistency, test-retest stability, factor structure, and convergent validity, can we be confident (more precisely, how confident can we be) that these measures of wood, earth, fire, metal, and water are useful and valid for persons from the US Midwest?

Although the initial data were supportive, we would need additional and more precise psychometric evaluations to answer that question. For example, we could examine the degree to which the psychometric evidence for these measures differed across dimensions of diversity within our Midwestern sample such as ethnicity (e.g., Hispanic-Americans vs. European Americans), older vs. younger, males vs. females, and income levels. Perhaps more conceptually and methodologically challenging would be evaluations of content validity. Are the items in the "metal" scale relevant and representative of that construct for this population and do measures of "metal" lead to appropriate and useful judgments and decisions when applied to a young, college-educated, gay, African-American woman in Wisconsin?

As noted above, the evaluation of the cultural appropriateness of judgments from adopted measures must also consider the context of the assessment (Hunsley & Mash, 2008, 2018). Are the measures valid and useful as an initial screen for behavior problems? For arriving at a psychiatric diagnosis? To assist in the construction of a clinical case formulation? To estimate the effects of an intervention?

This chapter reexamines the multiple dimensions of culture and highlights their importance in psychological assessment. Given the multiple contexts and applications of psychological assessment (e.g., clinical, forensic, organizational/industrial, epidemiological, and educational), the chapter focuses on the psychometric principles applicable to cultural appropriateness in clinical assessment; yet, the principles and strategies described here are applicable across contexts and applications. Three edited books published by the American Psychological Association (Geisinger, 2013) cover psychological assessment across multiple settings, methods, conceptual bases, and goals.

We presume that the reader has a basic understanding of clinical assessment methods, such as self-report and behavioral observation. We also presume that the reader is familiar with fundamental psychometric concepts, such as convergent and discriminant validity, internal consistency, temporal stability, and factor structure. Many undergraduate and graduate textbooks (e.g., Haynes, O'Brien, et al., 2011; Haynes, Smith, et al., 2011; Hogan, 2015; Urbina, 2014) provide extensive coverage of these topics. This chapter also does not cover the research designs and results of cross-cultural research, a topic that has been addressed in numerous books, chapters, and journal articles (e.g., Chen, 2008; Chin & Kameoka, 2006; Suzuki & Ponterotto, 2008; van de Vijver & Tanaka-Matsumi, 2008).

After we review the concepts and document the importance of dimensions of individual differences, diversity, and culture in psychological assessment, we review culture-relevant principles and methods in the scientific development and evaluation of measures. One particularly relevant psychometric concept is the *equivalence* or *invariance* of measures: To what degree are the psychometric characteristics and meanings of measures equivalent or invariant across cultures?

To what degree does psychometric evidence for an instrument *generalize* across dimensions of individual difference? Equivalence and invariance of measures across groups and persons pertain to their content validity, item-level performance, internal consistency and structure, and convergent, discriminant, and construct validity.

Equivalence and invariance also pertain to the consequential validity, or fairness, of judgments based on a measure. For example, is it fair to use a particular measure to make decisions about a person's psychiatric diagnosis, educational placement, or responsibility for criminal acts, given a person's culture and the characteristics of the population used to originally establish the psychometric evidence for the measure?

In this chapter, *fairness* of a measure refers to the degree to which it or judgments based on it are equivalent across reference groups or the degree to which a particular person or group is advantaged or disadvantaged on the basis of a measure. Consider the fairness (i.e., *consequential validity* or degree of *bias*) of judgments about the intellectual abilities of a deaf person based on the results of an unadapted intelligence test. As Chen (2008) noted, when diverse groups are compared, or persons from diverse groups are compared, on the basis of measures with non-equivalent psychometric properties, differences may erroneously be inferred, and true differences may be masked. Consequently, a child could be referred to a suboptimal education program, a person could be precluded from a potentially beneficial treatment program, a parent could erroneously be judged as competent or incompetent to raise a child, or important sources of distress for a client could be missed or misattributed. The American Psychological Association (http://www.apa.org/science/programs/testing/fair-code.aspx) identified four aspects of "fairness" in testing/assessment: (a) developing and selecting tests, (b) administering and scoring tests, (c) reporting and interpreting test results, and (d) informing test takers.

This chapter considers psychometric principles applicable to cultural considerations across methods of assessment (e.g., self-report, behavioral observation) and for both idiographic (individualized) and nomothetic (group-based) measurement strategies (e.g., Haynes, Mumma, & Pinson, 2009). This chapter also presents the principles and methods for the development and initial evaluation (i.e., *content validation*) of culturally appropriate assessment instruments. We also review potential sources of error in culturally sensitive clinical assessment. We conclude the chapter with specific recommendations for the development and evaluation of culturally appropriate measures.

Multiple Dimensions of Culture and Diversity

As we noted in the previous section, there are many dimensions of culture and diversity, such as ethnicity, age, sex, religion, sexual orientation, and income level (see extended discussion of multiple definitions of culture and cultural competence in Frisby, 2009). These dimensions can intersect in many ways. Consider the differences between an older Navajo woman who is a Mormon living in an urban area and a younger Navajo man practicing his traditional religion and living on a reservation.[4] These two Navajo persons may share many ethnic similarities but can differ greatly in their beliefs, values, social networks, communication styles, and other cultural domains. They are probably different in many aspects of their culture when compared to a person of northern European American descent who, aside being from another ethnic group, lives in a suburb and practices a different religion. It is important to understand that the validity of measures of a construct can vary along different permutations of these dimensions of culture.

Persons who differ across dimensions of culture and diversity can differ in the experience or

[4]We provide a specific example of an ethnic group, Navajo, often associated with the broader ethnic category of American Indian or Native American rather than assuming all American Indian persons share the exact same attitudes, values, behaviors, and life experiences. Broad ethnic or other broad characterizations (e.g., middle class) should be used cautiously because of large within-group variations.

expression of a given construct, such as how they express symptoms of depression and anxiety. In describing the depressive symptoms, a person of Asian descent might express more somatic complaints (e.g., chest pain, stomach aches, and fatigue) versus affective (e.g., sadness) or interpersonal complaints (e.g., loss of a relationships) than a person of European descent (Dere et al., 2013; Kirmayer, 2001). A female diagnosed with obsessive-compulsive disorder (OCD) might have contamination and cleaning obsessions, whereas a male diagnosed with OCD might have religious and sexual obsessions (Labad et al., 2008). Age of onset for a behavioral problem can also influence symptom expression, such as when OCD developed in a young person is associated with more obsessions with symmetry/ordering and religion/sex than when developed in an older person (Labad et al., 2008).

Posner, Stewart, Marín, and Pérez-Stable (2001) exemplify how multiple dimensions of culture can impact the validity of measures from psychological assessment within the same ethnic group. They examined the factor structure of the 20-item Spanish-translated version of the Center for Epidemiologic Studies Depression Scale (CES-D), an instrument commonly used to measure depression symptoms in diverse populations, in Latinos. They found large configural variance (differences in the factor structure) between men and women. Based on goodness-of-fit indices, the data for Latino men indicated a poor fit (χ^2 = 809.69, degrees of freedom [df] = 185, Akaike's information criterion [AIC] = 439.69), but the data for Latino women were an adequate fit (χ^2 = 276.70, df = 185, AIC = −93.30). That is, within this ethnic group, the items in the CES-D did not show similar between-sex relationships with the latent variables of the depression construct they purported to measure. The original four-factor structure (i.e., depressive affect, well-being, somatic complaints, and interpersonal) of the CES-D was an adequate fit for only Latino women. When the researchers accounted for age and acculturation level, the goodness-of-fit indices improved for women (χ^2 = 241.25, df = 183, AIC = −124.75) but not for the men (χ^2 = 726.69, df = 183, AIC = 360.69). Although *factorial (*i.e., *structural) equivalence* alone is insufficient to assume that the CES-D provides valid measures of depressive symptoms for Latino females, the large difference between males and females in the factor structure of the CES-D illustrates how the markers of a construct and the correlations among the markers can vary across cultural dimensions, even with persons who share a commonality on one of these dimensions. As we discuss more below, this is further evidence for the importance of considering the *multidimensional cultural contexts* of each person in psychological assessment.

It will be evident that in many cases, there will be insufficient psychometric evidence on the cultural equivalence of a measure that is appropriate for the specific cultural or diversity intersects of a person. For example, there are many measures of the characteristics of anxiety symptoms but an insufficient amount of evidence of the psychometric qualities of a measure for an older, gay, divorced, high SES, Latino man. What is required in these assessment situations is a conservative approach to clinical decision-making. Decisions should be made cautiously, tentatively, and based on multiple methods, using the best science-based strategies available.

Differences in ethnically based cultural beliefs, values, and expectations can affect the kinds of information that are most salient to a person. A person from East Asia might attend more to contextual factors in explaining his or her behavior than would a person from the USA of European descent, who might attend more to intrapersonal factors (Lieberman, Jarcho, & Obayashi, 2005). There are differences in the saliency of negative versus positive emotions between European American and Japanese persons (Matsumoto, 1989). Persons of Australian Aboriginal and European descent more accurately recall an event that involved people (e.g., healers) and activities (e.g., traditional versus Western healing) specific to their culture than events and activities of the other culture because of familiarity (Steffensen & Calker, 1982). These differences can affect the kinds of information and environmental cues people of diverse cultures attend to or are willing to report in explaining a behavior or event during psychological assessment.

There are also cultural differences in the rating of a behavior or event. For example, the ratings of a person's emotional expression (i.e., anger and disgust) vary considerably between Americans of African, Asian, and European decent (Matsumoto, 1993). Ethnic groups, especially those from different nations, differ in their response sets. A more recent study by Sneddon, McKeown, McRorie, and Vukicevic (2011) indicate a concordance across cultures (e.g., Northern Ireland, Serbia, Guatemala, and Peru) in persons' ratings of the valence and patterns of natural emotional states but cultural variations in the ratings of their intensity. A person from the USA might be more likely to use the extreme ends of a Likert-type response scale (e.g., "never" or "always") compared to a person from Asian countries who might be more likely to use middle points (e.g., "sometimes" or "neutral"; Chen, 2008). These differences may be due to difference in social norms or values or in the frame of reference in making judgments.

The cross-cultural differences in rating of a particular behavior or event are important because they can lead to erroneous conclusions about what a rating means. As we noted in the previous section, cross-cultural differences in the meaning of a measure (i.e., *scalar equivalence*) can also affect clinical decisions about a person, such as when the frequency and intensity of anxiety symptoms are over- or underestimated on a screening instrument that then leads to under- or over-referral for further evaluation – that is, reduces the *consequential validity* of a measure. The study by Peng and colleagues (1997) illustrates our point here. In relation to the reporting of values (e.g., guiding principles in a person's life), they examined four different survey methods (i.e., ranking, rating, attitude scale, behavioral case scenarios) across Chinese and Americans and against the criterion of cultural experts' independent judgments and found low convergence for ranking and rating methods. Their findings provide evidence that the rating or ranking of subjective cognitive processes differ across dimensions of culture and that the measures derived from these methods can differ from established criteria. Criteria are often used in clinical decision-making, such as comparing a person's rating of his or her anxiety symptoms' severity, intensity, and duration against the criteria for diagnosing anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

A person's causal attributions for behavior problems and treatment expectancies can also differ across dimensions of culture. Jacob and colleagues (2008) found that European American parents were more likely to believe that biological or physical factors played a greater role in the etiology of their child's depressive symptoms versus African-American parents who were more likely to attribute her child's depressive symptoms to nonphysical factors. They also found that African-American parents are more likely than European American parents to choose behavioral over psychopharmacological interventions for their child. Consider how their expectations of treatment effectiveness can be differentially influenced by their attributions about the causes of depressive symptoms. Consider how children may be less different than their parents, across ethnic groups, in their causal attributions and treatment expectancies, which suggests generational or age-group differences in these beliefs (Jacobs et al., 2008).

The validity of measures from an assessment instrument can differ across persons of different age groups (e.g., adolescents, middle-aged, or older-aged) because of differences in cognitive abilities and other developmental-related aspects (e.g., changes in the rates of aggressive or hyperactive behavior or in cognitive and physical functioning). Consider how the items of an assessment instrument designed to measure the presence of psychological stressors in adults (e.g., divorce, financial, or sexual difficulties) might be less relevant to adolescents. Also consider how the items in an instrument that relies on retrospective recall of events might yield more reliable responses from young adults than from elderly persons due to an age-associated increased likelihood of memory problems.

As suggested above, the prominent symptoms or makers of a behavior problem can differ based on stage-of-life associated with age, such as

when older persons with depressive symptoms report more problems with appetite and sexual relations than younger and middle-aged adults with depressive symptoms (Hybels, Landerman, & Blazer, 2012). Marital satisfaction is more strongly related to parenting and sexual variables in younger couples but more strongly to health and financial variables in older couples (Haynes et al., 1982). The variables that affect marital satisfaction also vary in their strength of effect across males and females, socioeconomic levels, and sexual orientations (Brezsnyak & Whisman, 2004; Gorchoff, John, & Helson, 2008; Twenge, Campbell, & Foster, 2003).

Other important dimensions of culture, diversity, and individual differences include SES, religious beliefs, and sexual orientation. For example, differences in the use of religious coping strategies and help-seeking behaviors and attitudes (e.g., preference for health professionals from same ethno-religious background) across persons of different ethno-religious affiliations (e.g., White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jewish, and Afro-Caribbean Christian) have been found in response to symptoms of depression and schizophrenia (Cinnirella & Loewenthal, 1999). The experience of discrimination also strongly affects the attitudes, perceptions, and social support system of persons from a lower SES, persons from certain religious faiths, or lesbian, gay, bisexual, and transgender (LGBT) persons (Burgess, Tran, Lee, & van Ryn 2007). A person's perceptions of discrimination and the resulting emotional response to the perception affect his or her willingness to disclose information, such as that related to sexual, child rearing, or religious activities, or inhibit the person from seeking mental health services due to fear of persecution or embarrassment. The important point here is that a person's SES, religious affiliation, or sexual orientation is likely to be associated with unique perspectives, attitudes, practices, and resources not captured by assessment instruments whose development and validity were established with predominately middle-class, heterosexual Protestants.

As is evident from the previous presentation, many questions arise when determining the cross-cultural validity of a measure: How well does a measure of depressive symptoms, whose validity indices were established with a primarily European American, male, Protestant, or middle-class persons, capture depressive symptoms in persons of Chinese descent, females, Jewish persons, or persons from a lower SES? Is there conceptual or operational equivalence (discussed in the next section) in the construct of "depression" across these dimensions of individual differences? Does the same score derived from a marital satisfaction scale mean the same thing across couples of different age groups or for LGBT couples? Are there differences in the relevant markers of anxiety across ethnic or age groups, sexes, or SES, and how well do they combine to measure the construct of anxiety? How do the kinds of information people recall or attend to affect their response to items on an assessment instrument? How does a person's response style affect the validity of the scores derived from that instrument, and do response styles systematically vary with culture? What impact does a person's culturally influenced causal attributions or treatment expectations have on the rating of his or another person's behavior?

In summary, the many dimensions of culture underscore the importance of an *individualized approach to clinical assessment*: It is important in clinical assessment to treat each person as an individual who is affected by multiple dimensions of culture. Each individual is unique in life experiences, beliefs, attitudes, values, practices, social relations, and environmental contexts that have been shaped by their ethnic heritage, sex, stage of life and life experiences, religion, SES, and sexual orientation. However, the individualized multidimensional nature of persons is often insufficiently recognized when assessment measures are developed, validated, or considered for use with a particular person. The most common, but often inaccurate, assumption is that all persons who share one dimension of culture (e.g., ethnicity) also strongly share similar life experiences, behaviors, and attitudes that could impact a particular behavior problem. Thus, it is important to keep in mind that the meaning and markers of a construct and their saliency and ratings,

the causal attribution of a behavior problem or event, the kinds of information attended to and recalled, and social relations can differ as much within persons of the same culture as across persons of diverse cultures.

The dimensions of culture, diversity, and individual differences reviewed, and others not reviewed here (e.g., differences between geographical or regional location within a country or between civilians and military personnel), can affect the validity and utility of a psychological assessment measure. Thus, culturally appropriate content validity and indices of psychometric equivalence should be carefully considered when selecting an assessment instrument, interpreting its results, and making decisions about a client. The multiple dimensions of culture affecting a person's behavior also emphasize the importance of using multiple assessment methods and strategies when measuring a construct in order to increase the likelihood of capturing important aspects of that construct.

Realistically, it is difficult for any single assessment instrument to be equally valid or psychometrically equivalent across all clinically meaningful dimensions of culture, diversity, or individual differences. No assessment instrument can have the same indices of psychometric equivalence across all the possible permutations involving the intersection of ethnicity, age, religion, gender, SES, and sexual orientation. We recognize that this level of equivalence would be close to impossible. However, our point is that the validity and utility of any given assessment instrument must be assumed to be conditional – it is possibly limited to the conditions (e.g., characteristics of the study participants) under which it was developed and initially tested. For these reasons, we emphasize the use of multiple methods and strategies of psychological assessment (e.g., Haynes, Smith, et al., 2011). For example, a Native Hawaiian adolescent might be asked to complete a depression questionnaire validated in an American Indian adolescent sample in the absence of any such instrument having been validated in a Native Hawaiian adolescent sample. The assumption here is that two dimensions of culture and diversity are a better match (i.e., native status and age) than using a depression questionnaire that has only been validated in a predominately European American adult sample. The information obtained from this depression questionnaire should be supplemented with information gathered from a semi-structured interview of the Native Hawaiian adolescent as well as information from his or her parents or teachers to get a better picture of his depression. Later in this chapter, we discuss how to develop a culturally appropriate assessment instrument.

Examples of the Importance of Diversity in Assessment: A Focus on Diagnosis

The assessment of diversity dimensions is of increased importance in contemporary diversified societies. To what extent do cultural factors predict within- and between-group variations in clinically relevant indicators of mental health and illness? How do we select those individuals who meet the screening criteria, and, of particular relevance for this chapter, how do we evaluate the adequacy of a particular method of selection and of the measures and judgments derived from the resulting measures? Content validation is particularly important in the diagnostic assessment of various psychological disorders. For example, Kleinman (1982) reported that Chinese patients diagnosed with neurasthenia spontaneously expressed somatic symptoms such as headache, muscle pain, fatigue, and sleep disturbance. However, the same Chinese patients, if probed in interviews, would admit to dysphoric mood and other psychological symptoms of depression. Kleinman (1982) reported that most of these Chinese patients met the standard Western diagnostic criteria for depression. These observations have been supported by more recent empirical research on symptom-level variation in Han Chinese and Euro-Canadian depressed outpatients (Dere et al., 2013). In this case, content validation of the standard Western diagnostic instruments and criteria, such as DSM-5, should accommodate somatic symptoms as one mode of expressing depression.

In this section, we direct attention to the importance of culture in clinician-rated assessment, focusing on editions of the DSM and the clinicians who use the DSM. Mental health professionals are trained observers with their own diversity backgrounds. They interact with patients and clients within the dynamic clinical context relying, sometimes automatically, on nonverbal thin-slice (i.e., narrow range of experience) judgments (Slepian, Bogart, & Ambady, 2014). Cultural competence concerns the clinician's accurate assessment of clients' orientation, symptoms, judgment, and other mental functions. In diagnostic interview situations, the clinician engages in the assessment and interpretations of the client's verbal and nonverbal behaviors to develop case formulation (Zayas, Torres, & Cabassa, 2009).

Training in cultural competence in diagnostic assessment requires knowledge of the client's culture including the language, cultural modes of expressing distress, and meanings of subjective experiences (Tanaka-Matsumi, Seiden, & Lam, 1996). If the clinician is not adept in the client's culture, then diagnostic accuracy and reliability (as well as the validity of other judgments) would be reduced when compared with those of the culturally competent clinicians (Malgady & Costantino, 1998; Zayas et al., 2009).

In clinical interviews and diagnosis, the assessment instrument is the clinician. In this next section, we emphasize the importance of the interviewer's culture and the importance of psychometric principles applied to interview-derived data and the judgments, such as a diagnosis, based on those data.

Psychiatric diagnosis has occupied a central place in mental health research and services. Successive editions of the DSM developed by the American Psychiatric Association (APA) and the International Classification of Diseases (ICD) developed by the World Health Organization (WHO) have been renewed and revised in the past 60 years. The two systems aim for compatibility and consistency in psychiatric diagnoses. ICD is used in epidemiology and health management and for clinical assessment purposes, particularly in countries other than the USA. DSM is also used in clinical management and research. Both systems are available in multiple language translations and have been applied across diverse cultural groups and nations. Various interview protocols based on various editions of the DSM have been developed in order to diagnose individuals with mental disorders. For example, the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) are both semi-structured interview guides that are designed to enable clinicians make informed DSM-IV Axis I and Axis II diagnoses (First & Gibbon, 2004). Further, the SCID-5-CV (Clinician Version) was released in late 2015 (https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5) for making DSM-5 (American Psychiatric Association, 2013) diagnoses.

In reality, the base rate of the diagnoses in a specific population affects diagnostic reliability (i.e., between-diagnostician agreement), and reliability can be a particular problem with infrequently reported behavior problems. This applies to subgroups defined by diversity factors, such as ethnicity. To what extent does culture matter in this diagnostic system? Recall that DSM-IV developed an Outline for Cultural Formulation (OCF) for the evaluation of the individual's cultural background that contained five steps of information gathering. The five steps included (a) cultural identity and cultural reference group(s) of the individual, (b) cultural explanation of illness, (c) cultural factors related to psychosocial environment and level of functioning, (d) cultural elements of the therapeutic relationship, and (e) overall cultural assessment for diagnosis. The DSM-5 introduced the Cultural Formulation Interview (CFI) by operationalizing the process of data collection for the OCF. There are 16 standardized questions to be asked during the interview (Lewis-Fernández et al., 2014). Questions we have posed for measurement invariance also apply to DSM as it has been used in clinical assessment research across numerous dimensions of culture.

Psychiatric diagnosis has occupied a central place in mental health research and services.

Historically, the German psychiatrist, Emil Kraepelin (1899), proposed a dual classification of "dementia praecox" (later termed as "schizophrenia" by Bleuler) and "manic-depressive psychosis". Kraepelin's seminal account of psychopathology was based on careful, repeated observational accounts of patients through clinical and experimental work in psychology, pharmacology, and natural sciences. When Kraepelin traveled to Bogor in Jakarta, he devoted his time to observation of indigenous people with "mental illness" to determine the sociocultural and ethnic factors that influenced the types, prevalence, and expression of mental illness. Kraepelin compared 100 European patients, 100 indigenous patients, and 25 patients of Chinese decent at the Buitenzorg mental hospital through interviews using two interpreters of Javanese to Dutch and then to German (Pols, 2011). Kraepelin's empirical approach to the classification of mental illness contributed to the development of the multi-axial DSM-III and subsequent editions.

The dual classification into schizophrenia and manic-depressive psychosis was, however, qualified by the cross-cultural contextual approach of the US-UK Diagnostic Project (Cooper et al., 1972; Kendell et al., 1971). This innovative international collaborative project investigated sources of differences in diagnostic rates of first admission psychiatric patients in local mental hospitals in London and New York City. The project also contributed to the subsequent development of standardized assessment methods to compare maladaptive behavior patterns across cultures. It should be noted that this research did not look into specific ethnic differences of the patients or the patient-diagnostic matching in terms of ethnicity. The project had three parts each with specific results with implications for diversity outcome.

First, the US-UK Diagnostic Project (Cooper et al., 1972) reported cross-cultural differences in diagnostic practices of American and British mental health professionals. Specifically, British psychiatrists in London had a broader concept of affective disorders, while American psychiatrists in New York City had a broader concept of schizophrenia. This was considered as one of the reasons for differences in hospital admission rates of these two psychiatric disorders between the two countries. There were far more patients with the initial diagnosis of "schizophrenia" in the New York sample and more patients with the initial diagnosis of "depressive psychoses" in the London sample.

Second, when the project psychiatrists were trained in the use of the WHO's standardized diagnostic system (ICD-8), these differences in diagnoses were greatly reduced. The cross-national agreement was high for prototypical cases with salient symptoms. However, disparities emerged when the project psychiatrists evaluated mixed cases. For these cases, American psychiatrists had a broader concept of schizophrenia, and British psychiatrists had a broader concept of manic-depressive illness. Both groups of trained psychiatrists indicated that they were confident in diagnosing both the prototypical and mixed cases. Third, American and British psychiatrists were found to apply different diagnostic criteria to videotaped interviews of psychiatric patients of American and British background (Kendell et al., 1971).

The US-UK Project revealed that sources of cross-cultural diagnostic differences included not just the patient but also the mental health professional and the diagnostic measurement system. The important point here is that empirical research on cross-cultural psychopathology must consider the triple interactive factors of the patient, observer, and assessment context such as specific assessment situations (e.g., teaching hospital or community mental health practice) as being relevant to the process and outcome of clinical diagnosis (Draguns & Tanaka-Matsumi, 2003; de Haan, Boon, Vermeiren, & de Jong, 2014; Tanaka-Matsumi, 1999; Zayas et al., 2009). These three factors can contribute to "errors" in clinical decisions that affect reliability and validity of measures from assessment instruments that involve clinical decision-making (for reviews see Haynes, Smith, et al., 2011).

Measurement questions raised by the US-UK Diagnostic Project led to the adoption of field testing for DSM-III. DSM-III-R (1987) incorporated an emphasis on convergent and discriminant

validity of the diagnoses involved. DSM-IV (1994) was reportedly based on more scientific foundations with exhaustive literature reviews, creation of prototypical cases for independent evaluation by trained diagnosticians, and field testing to increase reliability (Widiger, Frances, Pincus, Davis, & First, 1991), although only a limited number of diagnoses were examined. Following DSM-IV-TR (2000), DSM-5 was published in 2013 with some major changes in the system including, for example, part-dimensional approach instead of all-categorical approach.

Will DSM-5 survive tests of fundamental measurement principles and criteria? Such work is already under way as shown in a major review titled "The cycle of classification: DSM-I through DSM-5" by Blashfield, Keeley, Flanagan, and Miles (2014). Figure 18.1 updates the data presented earlier by Follete and Houts (1996) on the increase in the number of diagnoses and pages of the editions of the DSM. How do we conduct reliability and validity checks on those 541 diagnoses according to DSM-5? Follete and Houts (1996) indicated the role of theory in taxonomy development reviewing the DSM as a case study. From a measurement perspective, observed variations between assessors or across cultures or time are difficult to explain if the diagnostic system was not founded on theoretically derived nomological networks of diagnostic indicators. Both content validity and consequential validity need empirical evaluation across diversity dimensions.

Blashfield et al. (2014) classified DSM-relevant research intro three domains: measurement, research on clinicians, and taxonomic issues. One of the consistent findings from research on DSM-I through DSM-5 is that clinicians have their own models of mental illness that do not necessarily correspond to the diagnostic criteria and steps prescribed in the DSM system, a finding of tremendous importance for cultural psychopathologists and for understanding the impact of culture on measures based on diagnosticians' judgments (Kleinman, 1977, 1988; Lopez & Guarnaccia, 2000). Blashfield et al. (2014) appropriately stated: "Because it is too soon to tell whether research will support its structure, validity, and reliability, we comment on the goals of the DSM-5 as specified by the APA prior to its publications" (p. 41). Our current chapter, "Conceptual and Psychometric Foundations of Psychological Assessment with Diverse Cultures, What Are the Concepts, Methods, and Evidence?" has much to do with scientific evaluation of DSM-5 and related clinical assessment methods across diverse cultural contexts involving the person assessed, the observer using the system, and the assessment method itself. These issues pertain to the multiple

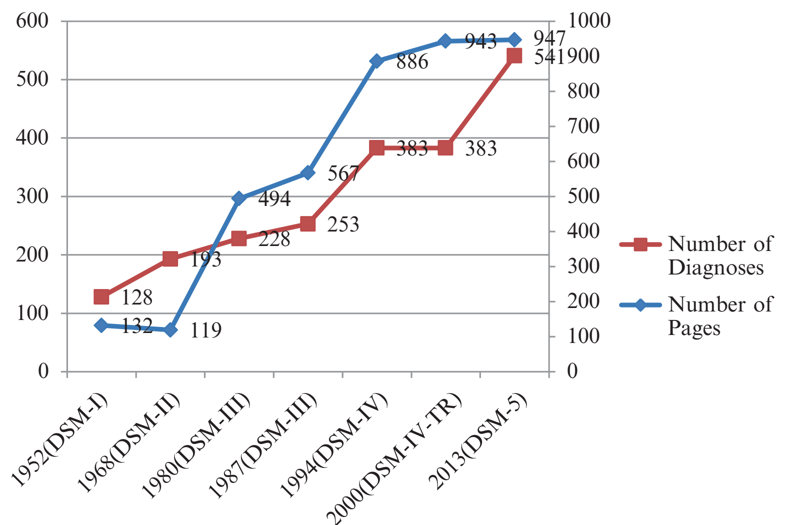

Fig. 18.1 Changes in the number of diagnoses and pages of successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) versions I through 5

dimensions of *equivalence*, discussed in greater detail in the next section.

In conclusion, from psychometric perspectives, there is no proof that the DSM functions equivalently across multiple dimensions of culture. Ethnic and language backgrounds of both the clinician and the patient affect diagnostic judgments using the DSM (Malgady & Costantino, 1998). Although cultural case formulation interview has been developed, it is not an inherent part of the diagnostic method (Lewis-Fernández et al., 2014). Despite the widespread use of the DSM, its content and consequential validity remain to be tested across multiple dimensions of culture (de Haan et al., 2014).

Measurement Equivalence and Invariance in Multicultural Assessment

Earlier in this chapter, we emphasized that several sources of evidence contribute to the psychometric evaluation of psychological assessment measures and the clinical judgments they influence. Recall also that the psychometric attributes of a measure, such as its internal consistency and convergent, content, and consequential validity, can vary across assessment goals and contexts. Low indices of reliability or validity suggest that the measures and judgments based on them partially reflect important sources of error variance.

Psychometric evidence is relevant to all measures and assessment contexts, but the relevance of specific types of evidence depends on the goals and methods of the assessment. For example, when categorization or diagnosis is the goal of assessment, evidence about a measure's *positive and negative predictive value*, *sensitivity*, and *specificity* is particularly important. In direct behavioral observations of persons' actions, evidence about internal consistency and temporal stability are less important indices of a measure's validity when behavior is expected to vary across time and settings. For descriptive self-report measures of personality, *item-level performance* and *factor structure* are important sources of psychometric evidence because they indicate the degree to which items capture a latent variable. These types of evidence about psychological assessment instruments and measures can be pursued through classical or item response analysis strategies. The sum of evidence from multiple sources leads to inferences about the *construct validity* of a measure (see AERA and APA, 2014; Haynes, Smith, et al., 2011; Hogan, 2015).

In the application of psychological assessment instruments with diverse cultures, we are first interested in all of the above sources of evidence. Measures without strong indices of reliability and validity must be avoided because they can adversely affect decisions about persons from whom they are obtained. With our emphasis on the conditional nature of psychometric evidence, we are especially attentive to the *cross-cultural equivalence or invariance* of measures and their targeted constructs: T*he degree to which a measure derived and validated with one cultural group shares a common validity, meaning, and relevance when used with a culturally different group* (Chin & Kameoka, 2006). For example, does a same score on a measure of social anxiety mean the same thing for persons from Tokyo, Istanbul, and Chicago or for persons who live in the USA with Japanese, Native Hawaiian, and Northern European ancestry and/or ethnicity? Does an item on a social anxiety questionnaire "Feel nervous with strangers" have the same meaning to persons from these diverse cultures? Can a similar cut score for diagnosing "social anxiety" be used across cultures? When administered to culturally diverse groups, do measures on a social anxiety questionnaire show similar patterns of intercorrelations, temporal stability, factor structures, or associations with external measures? Is convergent, discriminant, and consequential validity evidence similar across cultures? Do persons from different cultural groups respond differently to an item depending on whether it is administered in an interview, on paper, or on a computer screen? Does use of 4-pt, 5-pt or T-F response format differentially influence responses of persons across different cultural groups?

These questions address the *cultural equivalence* (the terms *equivalence* and *invariance* are

often used interchangeably) of measures, measurement instruments, assessment strategies, and assessment-influenced judgments. Cultural equivalence is important because, as we have emphasized throughout this chapter, important decisions about persons are often influenced by the outcome of psychological assessment. Decisions and judgments about a person are more likely to be erroneous if they are based on culturally nonequivalent measures.

Cultural equivalence of measures is also important because the science-based understanding of psychopathology and fundamental cognitive, social, developmental, and biological process within and across diverse cultures is influenced by the veracity of the measures used in the research (see discussion of *etic and emic research strategies* and the use of imported vs. indigenous instruments in Hwang, Myers, Abe-Kim, & Ting, 2008; Solarsh & Alant, 2006).

As we noted in the previous example of the CES-D and MMPI, and in many chapters in Geisinger (2013), the equivalence of measures across cultures is most often examined through between-group comparisons of their *factorial (*i.e.*, structural or configural) invariance*. In these studies, a self- or other-report questionnaire is translated and back translated and the factor structure examined, in a sample from a culture different from that of the original questionnaire development sample. A failure to confirm a factor structure across culturally different samples, usually indicated by unsatisfactory fit indices in confirmatory factor analyses, suggests possible *operational nonequivalence* – that the indicators for the measured latent variables differ across cultures, that the indicators are incorrectly measured, or that the factors or constructs originally identified are less applicable in the diverse culture.[5]

One important source of operational nonequivalence is a failure to engage in recommended (e.g., Haynes, Smith, et al., 2011; Selbo-Bruns, 2015; Sireci & Faulkner-Bond, 2014) instrument development and *content validation* strategies prior to administering a psychological assessment instrument to persons from a culture that differs from the original development culture. Appropriate development and content evaluation strategies for a new assessment instrument involve gathering data from target populations and experts with that population on the meaning of the measured constructs and their relevant indicators (see the last section of this chapter for recommended strategies for instrument development). For example, in adapting, evaluating, or developing an instrument to measure couple satisfaction, an interviewer might query a sample of couples from the target culture by asking, "What are you doing, feeling, thinking, and experiencing when you feel happy (or angry, unhappy, satisfied) in your relationship?" Or, "how do you express your feelings to you partner when you are feeling happy?" This type of query with persons in the target population is designed to identify culturally relevant indicators of the target construct, in this case, markers of "couple satisfaction" (Snyder, Heyman, & Haynes, 2008; Snyder, Heyman, Haynes, & Balderrama-Durbin, 2016). A measure of "couple satisfaction" should include culturally appropriate markers of important variables and constructs, and this strategy would help detect differences in these markers and variables when adopting an instrument for use in a new culture.

Following initial content development and validation strategies, the next step is to obtain expert and population review and ratings of the *relevance* and *representativeness* of items, factors, response formats, instructions, and subscales. This step is necessary to confirm or refine the cultural appropriateness of elements of the assessment instrument. Failure to engage in a science-based development and content validation processes is based on the frequently invalidated assumption (e.g., Chin & Kameoka, 2006) that markers and meanings of constructs are invariant across cultures.

Haynes et al. (1992) illustrate test construction and content validation procedures with a culturally different sample – in this case, the

[5]Differences between culture groups in total or scale scores could, but not necessarily, mean that the measures are culturally nonequivalent. As noted by Suzuki et al. (2013) between-group score differences could be a function of measurement error or true differences between the groups on the measured constructs.

development of a self-report measure of couple satisfaction that is applicable with older couples. Most measures of marital satisfaction (see reviews in Snyder et al., 2008, 2016) were developed with samples composed mostly of younger adults. Haynes et al. (1992) interviewed several groups of married persons over the age of 60 about aspects of their marital relationships that were associated with and affected their marital satisfaction. The authors also received additional feedback from professionals experienced in working with older couples. Subsequent test-development strategies were aimed at refining the original item pool and other elements (e.g., a larger font size increased the user-friendliness of the questionnaire) and examining the instrument's internal structure, reliability, and convergent validity.[6] This questionnaire (*Marital Satisfaction Questionnaire for Older Persons*) identified several variables that were similar to those included in instruments developed with younger couples (e.g., agreement about philosophy of life, how affection is demonstrated). Relevant to our emphasis on the conditional nature of psychometric evidence, elements in the new questionnaire also reflected the increased importance among older couples of other variables, such as the respondent's personal health, the health of the spouse, and the expression of physical intimacy (not confined to "sex"). The content validation process also identified the decreased influence on couple satisfaction for this group of variables such as finances, relationships with in-laws, and raising children.

Returning to the multidimensional and conditional nature of psychometric evidence, consider how the administration of a questionnaire of couple satisfaction developed with young couples could result in supportive psychometric evidence when administered to older couples. That is, satisfactory indices of the factor structure, test-retest reliability, and convergent validity could be found, even though the scores would partially reflect error variance associated with inclusion of unimportant variables and the omission of important variables. In the absence of appropriate content development and evaluation, the overall outcome would suggest satisfactory cross-cultural equivalence and the generalizability of psychometric evidence across age groups.[7]

Consider also how common test scoring algorithms could also contribute to erroneous scores and judgments if an older couple skipped the "how satisfied are you with your relationship with your in-laws" item (because the in-laws had died). Many test scoring protocols would use an algorithm (e.g., using the mean of all items in a subscale) to substitute a score for the irrelevant item.

Would the differences between measures of couple satisfaction developed with younger vs. older couples be important if the measures were highly correlated? Would it matter in terms of judgments about a person? Assume that the correlation between measures from the two instruments was 0.8 when administered to a sample of older couples. In this case, could valid judgments about an older couple be based on measures from a questionnaire developed with younger couples? Recalling the conditional nature of psychometric evidence, the answer would be "yes" or "no" depending on the purpose of the assessment: for initial screening at a community mental health center, probably "yes," and to identify important aspects of a relationship for a pretreatment clinical case formulation or to track specific areas of couple adjustment during treatment, probably "no."

In sum, because of insufficient content development and validation, the previously developed instruments could fail to provide optimally valid measures of satisfaction for older couples in some assessment contexts. In this context consider how a clinical case formulation, decision about treatment foci and outcome, and research

[6]The Haynes et al. (1992) study also included the adoption of several items from existing questionnaires and psychometric evaluations of item performance, internal consistency, test-retest reliability, factor structure, convergent validity, and discriminant validity.

[7]Nonequivalence on some dimensions of psychometric evidence could also be found, given that lower expected indices of covariation would be expected between total or scale scores of couple satisfaction and measures of specific items such as raising children. As indicated in the study by Gross et al. (2006), differential item functioning may also point to some content validity problems.

on the variables that influence relationship satisfaction might be impaired for older couples. Without appropriate content development and validation strategies, the degree to which an instrument captures elements of the targeted construct in a new culture cannot be determined. No subsequent evaluation of reliability or validity of the measure can substitute for insufficient content development procedures.

Suzuki et al. (2013) also discussed the "does it matter" aspect of cross-cultural equivalence in terms of consequential validity. For example, many articles have noted statistically significant personality and intellectual assessment scale score differences between African-Americans, European Americans, Asian-Americans, and Native Americans (see data beginning on page 222 of Suzuki et al., 2013). Are the amplitudes of differences in personality and intelligence scale scores often noted across diverse groups important and meaningful? Are these differences large enough to be associated with differences in meaningful external criteria such as daily functioning, psychopathology, quality of life, or other outcomes? Suzuki et al. stressed that the consequences of nonequivalence have not been sufficiently studied and the need for caution in ascribing clinical or social significance to statistical indications of cross-cultural nonequivalence. Consistent with our previous comments on the multidimensional nature of diversity, Suzuki et al. and others have also emphasized the importance of moderator variables, such as a person's acculturation and enculturation, in understanding between- and within-group differences on measures.

In another example of the complexity of cultural equivalence studies, Gross et al. (2006) examined scalar and other forms of equivalence of the CBCL $1_{1/2}$–5 across racial/ethnic (Latino, African-American, White) and income groups in the Chicago area. Differences in CBCL scores across racial/ethnic and income groups had been reported in several studies (e.g., Keiley, Bates, Dodge, & Pettit, 2000), but the source of those differences had not been investigated. Gross and colleagues examined the associations between parent race/ethnicity, income, and language version with internalizing and externalizing behavior problem ratings in young children. The authors administered the CBCL to 682 parents in the Chicago area and examined scale means, distributions, score reliabilities, the proportions of children with scores falling into the borderline, and clinical ranges. The authors conducted item analyses and confirmatory factor analysis (CFA) to examine equivalence across race/ethnicity, language version, and income groups. The authors found that the CBCL internalizing and externalizing scales were "largely equivalent" across groups. Differential item performances were noted for three of the internalizing and one externalizing scale items. Interestingly, the authors found a biasing effect associated with the item "whining," with significantly lower scores and covariances for Latino parents. The authors hypothesized that "it is possible that whining is a behavior that does not hold the same meaning across ethnicities."

The authors' attention to moderating relations helped explain some previous results. They found (a) that parent reports of behavior problem scores significantly differed (eta squared 0.007–0.029) across income, gender, and parent race/ethnicity groups, (b) that higher rates of externalizing behavior problem were more strongly associated with family economics than with race/ethnicity, and (c) significant race/ethnicity and income group differences for internalizing scores. Relevant to our earlier discussion of content validity, the authors hypothesized that "culture and differences in linguistic meaning may also have contributed to the higher internalizing scale ratings."

The application of an assessment instrument in a culture diverse from the culture in which it was developed must also be based on evidence that the original development and evaluation of the instrument reflected the best science-based strategies. First, elements in the instrument, such as items on a questionnaire and behavior codes, must have been precisely defined and selected. Second, the intended use of measures from the instrument, such as diagnosis or screening, must be specified and consistent with its intended use in the diverse culture. Third, the psychometric

evidence for the original instrument must be strong and relevant to its intended use in the diverse culture.

As we emphasized earlier, evidence of factorial equivalence and reliability of an appropriately translated instrument with persons from a diverse culture is necessary but insufficient to assume that the instrument provides valid measures of the targeted construct (Bingenheimer, Raudenbush, Leventhal, & Brooks-Gunn, 2005; van de Vijver & Tanaka-Masumi, 2008). More import, evidence of internal structure and temporal consistency when an instrument is applied in a diverse culture are less convincing without evidence that the measures from the instrument are associated with external, *culturally relevant criteria*.

Consider the previously discussed administration of the Chinese medicine five-factor questionnaire on wood, earth, fire, metal, and water personality traits to Midwestern university students. Administration of the carefully translated instrument confirmed the original five-factor structure and test-retest stability derived from an original sample of Mandarin-speaking persons from Mainland China. Without validation of the factor/scale scores using external criteria that are culturally appropriate for the new sample, the validity, meaning, and utility of scores from the instrument are unknown.

As Suzuki et al. (2013) noted, many studies have investigated cross-cultural equivalence by examining correlations between a measure and external measures that were derived from the original cultural group. Thus validation of measures from the Chinese medicine five-factor questionnaire with Midwestern university students must include measures validated with this group rather than with a different measure developed and validated in Mainland China.

Chen (2008) discussed the importance of, and strategies for, examining cross-cultural measurement equivalence. Chen reviewed and conducted simulation studies on 127 studies published in peer-reviewed journals that examined cross-cultural (mostly cross-national) measurement invariance, with a focus on configural invariance, of measures on life satisfaction, self-esteem, self-concept, affect, and other constructs. Chen suggested that when these scale scores are used as predictors, the predictive relations are likely to be underestimated in the original group (e.g., studies with North Americans) but overestimated in the diverse group (e.g., studies with mainland Chinese). When these scale scores are used as outcome measures, relations are likely to be overestimated in the original group but underestimated in the diverse group. To illustrate issues associated with conceptual and operational equivalence, Chen discussed the impact of conceptual differences and the cultural value of “modesty” on measures of self-concept and other constructs across different cultures.

In summary, the application of an instrument across diverse cultures requires evidence about its content validity and other dimensions of equivalence. Clinical scientists must examine the *conceptual* or *functional equivalence* of an instrument: To what degree are the meanings and markers of a construct similar across the cultures, and how well does an assessment instrument capture the meanings and markers for a particular culture? The meaning of “depression” and the way people think and behave when “depressed” could differ in important ways across cultures. *Operational equivalence* refers to the degree to which these indicators combine as measures of a construct for persons from different cultures. *Scalar equivalence* refers to the degree to which the same scores/measures from an assessment instrument mean the same thing across diverse cultures. *Item performance equivalence*, measured with item response theory-based strategies, refers to the degree to which item responses are related to levels of the measured construct across diverse cultures (Gorin & Embretson, 2008).

Culturally Related Sources of Error in Psychological Assessment

The precision, meaning, and clinical utility of all psychological assessment measures can be affected by multiple sources of error. For example, an interview or self-report questionnaire of depressive symptoms might provide insufficient

or excessive coverage of the different aspects of depressive symptoms. Their outcome might also be affected by the inclusion of irrelevant items, terms that exceed the cognitive abilities of the respondent, memory errors, state of the client (e.g., medication effects or fatigue associated with an excessively long assessment time), dissimulation, and response bias. Errors can also be associated with the interviewer, such as failure to establish rapport with the client or poorly phrased queries or, as noted earlier, with the interviewer's preconceived notions. The setting (classroom vs. clinic), timing (e.g., following a stressful vs. nonstressful day), or assessment condition (e.g., court-mandated vs. self-referred) in which a questionnaire is administered, an interview takes place, or a behavioral observation occurs can affect a person's responses and behaviors (i.e., produce *reactive effects*) and thereby introduce measurement and inferential error.

Especially relevant to this chapter are sources of measurement and inferential errors associated with insufficient cultural appropriateness or sensitivity of an assessment instrument (see Frisby, 2009; Reynolds & Suzuki, 2012 for discussions of cultural competence). These sources of error are often associated with the content validity of an assessment instrument, the validity of normative data used for classification and diagnoses, biases introduced by an interviewer or rater, and cultural differences in the self-report of behaviors or events.

Deficiencies in the content validity of an assessment instrument, discussed in previous sections of this chapter, can be a major source of error. Recall that there can be differences in the precision with which an assessment instrument captures a construct for a particular cultural group. Posner et al.'s (2001) study of differences between Latino men and women on CES-D measures suggests between-gender differences in the content validity of the CES-D, perhaps due to insufficient coverage by the CES-D of aspects of depressive symptoms for Latino men compared to Latino women. These results suggest that using the CES-D to measure the depressive symptoms of Latino men can diminish the validity of subsequent clinical judgments, such as misidentifying a man as meeting or not meeting criteria for depression.

The Johnson et al. (2007) study also illustrates the issue of possible content validity deficiencies in their comparison of the Brief Panic Disorder Screen (BPDS) between African- and European Americans who were patients of a primary care clinic. They found that the BPDS had lower levels of internal consistency and specificity for panic disorder (PD), based on comparisons to a diagnostic structured interview, for African- compared to European Americans, across different cut scores. That is, the BPDS was significantly better at correctly identifying European Americans than African-Americans who did not have PD, regardless of the cut score used. Relevant to our prior discussion of equivalence, the original sample used to validate the BPDS consisted of mostly European Americans from an outpatient clinic specializing in anxiety treatment (Apfeldorf, Shear, Leon, & Portera, 1994). The lower negative predictive power of the BPDS for African-Americans suggests that the meaning and markers of the construct of PD, and the meaning of the derived scores from the BPDS, differ from those of European Americans.

The study by Johnson et al. also illustrates the potential errors associated with the use of culturally inappropriate normative data for classification. As we reviewed in the preceding section, important decisions, such as a diagnosis or whether or not to refer a person for further psychological evaluation or for immediate treatment, are often based on a person's score on a particular assessment instrument, in comparison to the normative sample. The degree to which cut scores derived from normative data are valid for a person depends on the score's precision in capturing the targeted construct for that person given his or her cultural context. In Johnson et al.'s study, a cut score of 11 on the BPDS accurately classified (true positives and true negatives) 78% of European Americans but only 59% of African-Americans. Thus, to reduce the chance of harmful errors in judgments based on psychological assessment measures, it is important to use data normed on a population similar on dimensions of culture to those of the person for which it is being

applied. In the absence of appropriate normative data, the meaning of a cut score, or whether it is validly capturing the construct of interest, is highly suspect.

We also noted in the previous section how interviewer, rater, and observer biases could introduce culture-related measurement error (Davis, Couper, Janz, Caldwell, & Resnicow, 2010). For example, an interviewer or rater can exhibit *confirmatory bias* or the tendency to seek out or pay greater attention to information or behavior that supports his or her preconceived notions about the interviewee or person whose behavior is being rated or observed.[8] Biases are particularly concerning when they are attached to racial, gender, age, SES, religious, sexual orientation, and other dimensions of diversity. Holding such biases, whether they are explicit or implicit, can lead to inappropriate (e.g., seeking confirmation of bias), irrelevant (e.g., focusing on stereotypical behaviors), or narrowly focused (e.g., excessive coverage of one element of a behavior problem) questioning by an interviewer. Similarly, a rater observing a person's behavior in a clinic or natural setting might be more attentive to those behaviors that match the cultural stereotypes held by the rater (e.g., expecting more aggressive behaviors by African-American boys). Both the interviewer and rater might interpret the same behavior differently across persons as a function of some difference between them on a dimension of culture. Consider how a biased interviewer might be more likely to make dispositional attributions (e.g., he has anger management deficiencies) regarding an anger outburst of a young Pacific Islander male but make situational attributions (e.g., he was being discriminated against) when the same behavior in a similar context is expressed by a young Japanese-American male. Biases that affect the type of behaviors queried or observed and inferences about their causal factors can lead to invalid measures and, ultimately, invalid clinical decisions about a person.

[8]See lists of biases on pages 26–27 in Haynes, Smith, et al. (2011).

Differences across persons from diverse cultures in how behaviors are self-reported can also introduce measurement and clinical judgment errors. As we reviewed earlier, there can be differences across persons from diverse cultures in the kinds of information they are willing to or can share (e.g., sexual behaviors; Weinhardt, Forsyth, Carey, Jaworski, & Durant, 1998), in what kinds of information or events they may be more likely to attend to (Lieberman et al., 2005), in how they rate their own and others' behaviors (Chen, 2008; Matsumoto, 1993), in the method of assessment (e.g., in-person interview vs. questionnaire) in which they are most likely to report symptoms, how they attribute the cause of a behavior, and what they expect of treatment (Jacobs et al., 2008). These differences can introduce *recall biases*, such as incomplete or inaccurate recollection of events (Steffensen & Calker, 1982), and *reporting biases*, such as dissimulation or the tendency to make socially desirable responses.

The interviewer, test administrator, observer, or purpose of interview or method of administration could influence a respondent's self-reports if he or she perceives bias on the part of these individuals or assessment contexts. Consider how a LGBT person's self-report of certain sexual or social behaviors could be affected if that person perceives that an interviewer holds stereotypical heterosexist attitudes about these topics. Also, consider how differences between the respondent and interviewer in ethnicity or other dimension of diversity (e.g., consider a young Hispanic female being interviewed by an older European American male or vice versa) could lead to discomfort or hesitation in disclosing important personal information. The fear of confirming negative stereotypes can adversely influence the performance of many minority groups on psychological assessments, especially those assessing intelligence or cognitive abilities (Steele & Aronson, 1995; Wicherts, Dolan, & Hessen, 2005).

We realize that there are many sources of error that can affect the validity of psychological assessment, beyond culturally related biases (explicit or implicit), insensitivity, or ignorance of the assessor, and psychometric variance of an

assessment instrument. We provided many examples of how assessment instruments can be culturally biased. Many studies, especially in the medical field, have found an association between implicit racial bias and clinical decision-making (for a review, see van Ryn et al., 2011). Other types of biases in clinical decision-making have been reviewed elsewhere (see Lilienfeld & Lynn, 2015). We recognize there are many other reasons for introducing errors into assessment, such as insufficient training of assessor on general interviewing skills or on psychometric principles in instrument development. However, even well-trained and seasoned assessors succumb to errors (e.g., use of heuristics) and biases (e.g., confirmation and hindsight bias) that affect psychological assessment. Many strategies can be applied to help reduce these errors and biases, such as consciously considering the "alternative perspective" or "view point" or taking an "outsider perspective." Our point is that the recognition and understanding of these potential sources of error in psychological assessment can reduce their occurrence and adverse impact on clinical decision-making.

In summary, measurement errors associated with the cultural appropriateness and sensitivity of assessment instruments, measures, contexts, and goals can lead to misinterpretation of their derived scores. As we outline in more specific detail in the last section, to minimize culture-related assessment errors:

1. The assessment instruments used should have supportive psychometric evidence appropriate for the person or group being evaluated.
2. If cut scores based on normative data are used, they should have been developed with groups appropriate for the person or group being evaluated.
3. Steps should be taken to minimize biases introduced by the interviewer or rater who is evaluating the behavior of someone from another cultural background; these steps could include seeking advice from a colleague who shares the same cultural background as the respondent, receiving cultural competency training, and developing rapport with the respondent before starting assessment.
4. Aspects of the assessment instrument, including response options, instructions, and manner of data collection, should be appropriate for the person or group being evaluated.

In light of our above recommendations, we reiterate that it is difficult for any single assessment instrument to be equally valid or psychometrically equivalent across all clinically meaningful dimensions of culture, diversity, or individual differences. When psychometric equivalence studies are conducted, they tend to focus on cross-national (e.g., Chinese versus US) or cross-ethnic (e.g., Latino versus non-Hispanic Whites) comparisons or, in some cases, across-sex, and rarely do they consider the modifying effects of age, generational or acculturation status, SES, or religious beliefs. There are also very few studies that evaluate the cross-cultural validity of cut scores to provide appropriate normative data. We realize this makes it difficult to select the most appropriate assessment instrument for assessing a particular psychological construct in a person or across persons with a diverse cultural background. In the next section, we describe the steps involved in both developing a culturally sensitive assessment instrument and in evaluating the cultural appropriateness of an existing instrument.

Developing Culturally Appropriate Assessment Instruments

Developing a culturally appropriate assessment instrument involves an iterative, multi-method, qualitative, and quantitative process to eventually result in a valid measure of a target construct (e.g., social phobia) for a particular population (e.g., an ethnic, age, or SES group or a clinical population) and for a particular application (e.g., screening, diagnosis, or research; Selbo-Bruns, Floyd, & Haynes, 2015). The process of instrument development involves item generation, refinement, and content validation. A similar process of content validation is involved when evaluating the cultural appropriateness of an existing

assessment instrument that has been validated with a different target population and application (Huang & Wong, 2014). Recall that the validity and reliability of all measures are conditional and vary across dimensions of individual differences and assessment contexts.[9]

Developing a culturally appropriate assessment instrument, or evaluating the cultural appropriateness of an existing instrument, is more challenging for cross-cultural application because of multiple dimensions of individual differences. There can be differences across diverse cultures in the meaning and markers of a construct (i.e., their *conceptual* or *functional equivalence*), in how these indicators combine as measures of a construct (i.e., their *operational equivalence*), in the meaning of measures from an assessment instrument (i.e., their *scalar equivalence*), and in how responses to items relate to levels of a construct (i.e., *performance equivalence*).

For cross-cultural applications, the measures derived from an assessment instrument should yield comparable validity indices across the diverse cultures. An example of this can be found in our previous discussion of Posner et al. (2001) study. Recall how the original four-factor structure of the CES-D was a better fit for Latino women versus Latino men. Without such data, the degree to which measures from the instrument capture the targeted constructs across persons of diverse cultures is questionable and can lead to erroneous inferences about cross-cultural similarities or differences or erroneous assumptions of homogeneity within a cultural group. The construct of social anxiety illustrates this challenge in cross-cultural application of an assessment instrument designed to measure this construct whose validity indices have been established with samples from only one culture group. There can be meaningful differences in social behavior and the level and manifestations of social anxiety between persons from collectivistic (e.g., emphasis on social responsibility and cohesion) and individualistic (e.g., emphasis on independence and self-reliance) cultures. Differences in social norms and expectations between these cultures can affect the nature, form, and indicators of social anxiety and the degree to which it is problematic (Kleinknecht, Dinnel, & Hiruma, & Harada, 1997; Schreier et al., 2010).

Of course, some instruments can provide culturally equivalent measures that fairly influence judgments and decisions. The assessor must consider the degree to which data from an instrument are appropriate for use in the assessment of a particular person and assessment occasion. The assessor must consider if the person being assessed differs in important ways from the samples used to develop and validate the instrument and its measures.

In the process of developing and evaluating an assessment instrument, several elements undergo content validation to ensure its cultural relevance and comprehensiveness. These include the item content and wording, response format, the scoring scheme, the instructions, and the appropriateness of the instrument and its derived measures for their intended application (Selbo-Bruns et al., 2015). Content validation also involves specifying the nature and scope of the targeted construct and its facets. In developing a measure of social anxiety, for example, the construct can be defined as a specific anxiety disorder or problem with behavioral (e.g., withdrawal from anxiety-provoking situations), cognitive (e.g., fear of negative evaluation), affective (e.g., negative mood), physiological (e.g., nausea and palpitations), interpersonal (e.g., inability to make friends) facets (DSM-5, American Psychiatric Association, 2013) and contexts (e.g., familiarity with other persons, group size). A global measure (i.e., combination of all facets) of social anxiety can be obtained as well as separate measures for each facet, and these measures can all differ in their content validity and clinical utility. The important point here is that the content validity of all elements of an assessment instrument can differ across cultures. Appropriate development and content validation of an

[9]This and the following section focus on the development of self- and other-report assessment instruments. The principles are the same, but the strategy is different in the development of behavioral observation systems. These are discussed in Bakeman and Haynes (2015).

instrument for one culture do not insure that the instrument is content valid for another.

In this and the following sections, we outline the steps involved in either developing a new culturally appropriate assessment instrument or in evaluating the cultural appropriateness of an existing one when applied with persons from a different culture. The steps we outline are (1) defining the construct of interest, (2) item generation or evaluation, (3) determining or evaluating the response format, (4) expert and stakeholder review of items and instrument elements, and (5) refining or modifying of items and elements. For more detailed information on assessment instrument development, refer to Clark and Watson (1995) and Haynes, Smith, et al. (2011), Haynes, Richard, and Kubany (1995), Selbo-Bruns et al. (2015), and Matsumoto (2003) for cross-cultural validation of assessment instruments.

Step 1: Defining the Construct of Interest

The first step is to define the target construct as precisely and comprehensively as possible. This will serve to guide the focus and construction of items (Step 2) and can be paraphrased in the instruction of the instrument to help respondents focus on the construct of interest. The extant theoretical and empirical literature should be reviewed to help define the construct, followed with its evaluation by culturally appropriate experts in the field, such as researchers and clinicians familiar with both the culture and target construct.[10] The experts assist in deriving a precise specification of the construct to include its behavioral, affective, cognitive, physiological, and interpersonal facets and relevant events associated with these facets (Messick, 1995). This process should consider the intended application of the instrument (e.g., screening versus diagnosing; clinical versus research) and the target population (e.g., persons with social anxiety within a particular culture).

For cross-cultural application, the multiple dimensions of culture need to be carefully considered. Are the construct and its facets similar across persons of different ethnicities or age groups, for example? These considerations help to address the conceptual or functional equivalence of a measure: the degree to which the derived measures accurately capture the construct of interest will depend on the degree to which the facets and their markers and meanings are the same across multiple dimensions of individual differences. This process is involved in both the development of new instruments and in the evaluation of the cultural appropriateness of existing instruments. Recall from Posner et al.'s (2001) study how the facets (or factor structure) measured by the CES-D differed between sexes of the same ethnicity, illustrating the challenge of measures from an instrument having similar validity indices across multiple interacting dimensions of individual differences.

Step 2: Generating and Evaluating Items

After the construct and its facets have been defined, the next step is to generate as many culturally appropriate items as possible that represent all facets of the targeted construct through a process of data elicitation. Initial item content can be generated based on a review of the relevant literature and other instruments with similar foci and on rational deduction based on the construct definition from Step 1 (e.g., see footnote 6). For new instruments and for evaluating the content validity of existing instruments for understudied populations, elicitation interviews, either individually or in groups, with persons from the target population and with experts (i.e., persons familiar with that construct for a particular

[10]It can be challenging to determine who might be an "expert" in the cultural dimension of interest in relation to a particular psychological construct. Ideally, it would be a person who shares the same cultural dimension of interest and who has clinical and/or research experience specific to the psychological construct as it operates in other persons who share the same cultural dimension of interest. When this is not possible, an expert should be a person with clinical and/or research experience specific to the psychological construct and the cultural dimension of interest.

culture) should be conducted (Rowan & Wulff, 2007). Item generation can also begin in conjunction with the process of defining the construct in Step 1.

Content analysis is done to reduce, synthesize, and specify the information obtained to this point. The purpose of content analysis is to identify the important themes and facets of the targeted construct and to use this information to generate a large pool of items (i.e., the entire universe of items that could represent the construct of interest) in order to organize subsets of items for each identified facet. At least two persons involved in the instrument's development should review the information and generate the pool of potential items for later quantitative analysis. Items are retained based on their relevance – the extent to which each item is appropriate to the construct and its facets. Items of questionable relevance can be retained for further examination. The iterative process of data elicitation and construct analysis occurs until *saturation* is reached; that is, no new themes, facets, or items are collected from additional reviews and/or interviews.

Items are then categorized based on the construct definition and facets identified and subjected again to expert review to ensure the representativeness of the item pool or the degree to which they capture the facets of interest. Particular attention is paid to how items are constructed. They should be unambiguously worded, grammatically correct, and consistent across items, and each should reflect a single idea. Semantically overlapping items could be developed and reduced based on subsequent psychometric evaluation.[11]

To evaluate the content validity of an existing instrument, a similar process of content validation occurs. In addition to the item-generation process described above, the items from the existing instrument should be examined for their meaning and relevance to the construct and its facets as specified for the cultural dimension of interest. The facets and their items should be evaluated by persons from the target cultural group and from culturally appropriate experts in the field. Items could be reworded, replaced, or removed if necessary. The modified assessment instrument should also be subjected to subsequent psychometric evaluation as discussed in Step 5 below.

For cross-cultural application, the items should be comparable in meaning and relevance to the construct. For example, the item "Do you feel blue?" is a common question to assess the affective facet of depressive symptoms in the USA. However, the concept of "feeling blue" as an expression of a person's mood is a culturally specific idiom of distress that has a different meaning or no meaning in other cultures. This example illustrates the psychometric concept of *idiomatic nonequivalence*, that is, an item that reflects a culturally specific expression that either has no meaning or a different meaning to persons from a different cultural group. Items that reflect culture-specific idioms may be necessary for an assessment instrument designed to be used for a specific cultural group but should be avoided for instruments used cross-culturally. The items should evidence idiomatic equivalence when used for cross-cultural applications, or items should be reconstructed so that their meaning and relevance to the construct are equivalent across the diverse cultures of interest.[12]

Step 3: Determining and Evaluating Response Format

Next to consider is the response format to be used, such as whether to use a Likert scale,

[11]A useful process for initial qualitative item evaluation is to project each item separately on a screen in front of the test developers, or on test developers' computer screen. Each item can then be discussed and modified, categorized, or deleted in real time.

[12]Not reviewed here, but important to adapting an existing assessment instrument to another linguistically diverse cultural group, is the issue of translating items into a different language (Cha, Kim, & Erlen, 2007). A forward-backward translation method or a dual-panel approach can be used in translating the elements of an instrument into another language (Acquadro et al., 2008). The translated elements should undergo the same content validation steps outlined here.

multiple choices, true-false, or an open-ended format. The best response format depends on the items generated, the nature of the construct being measured, and the type of data to be collected (e.g., quantitative indices of severity vs. identification of specific behaviors) and its intended application. For behavioral checklists or coding of observations, a true-false or yes-no format might be adequate to assess the presence or occurrence of a behavior, such as in responding to the item, "Do you become angry when your teacher corrects you in front of other students?" For assessing the frequency, intensity, or duration of a behavior or event, a Likert scale or multiple-choice format would be necessary. For Likert-scaled items, whether to have an even number or odd number of response choices would depend on whether there is a true midpoint or neutral response (odd number of choices) in measures of a construct.

The best response format can differ across cultures. As discussed earlier, respondents from different cultures may differ in their tendency to choose extreme ends or middle points on Likert scales (Chen, 2008). In cross-cultural application, the response format, if affected by these response tendencies, could lead to scalar or performance nonequivalence of measures from an assessment instrument. If cultural group A has a tendency to rate items using the extreme ends while cultural group B has a tendency to group ratings around the midpoint, cultural group A's within-group variance in scores would be relatively inflated, while cultural group B's within-group score variance would be relatively decreased. Increasing the anchor points on a Likert scale from 5 points to 10 points, for example, can help to address an extreme-end response style (Hui & Triandis, 1989). Response categories should also have naturally opposing and mutually exclusive anchors. To address midpoint response tendencies, an even number of response categories might be used where there is no explicit midpoint (Si & Cullen, 1998).

Determining the best response format can be challenging. Reviewing the relevant literature can help in this determination, if previous research on the cultural dimension of interest in regard to response styles has been done. In most cases, the experts used from the previous steps can provide input into this matter. Ultimately, the response format selected should be subjected to expert and stakeholder scrutiny as we discuss in the next section. In cases where meaningful input cannot be provided or consensus cannot be achieved, a pilot study in a sample of people might be needed to determine the best response format.

Step 4: Reviewing of Items and Other Elements by Experts and Stakeholders

In this next step, experts from the field, such as researchers and clinicians, and stakeholders, such as members of the target cultural population who exhibit the construct of interest (e.g., persons from a specific ethnic or age group who have been diagnosed as having social anxiety),[13] are asked to quantitatively evaluate the relevance and representativeness of each item and the structural features of the items and assessment instrument (Haynes, Richard, & Kubany, 1995). They may reword items or offer new items. A minimum of five experts should review and score the relevance of each item and the representativeness of each item set. A "table of specifications" can be created for the judges to use. It is a table with a domain and facet grid depicting the items generated to cover all aspects of the targeted construct and used to help determine the distribution and representativeness of items across its different facets (Suen, 1990). The expert judges are also asked to evaluate the appropriateness of the response format and the clarity, consistency, and

[13] Being from a particular cultural group does not necessarily make you a cultural expert or expert in all aspects of that culture. It is important to identify stakeholders who share the specific cultural and psychological dimensions of interest for the assessment instrument being developed. They are more likely to provide relevant feedback based on their experience and/or expression of the psychological construct, such as specific idioms of distress for social anxiety. It is also important to solicit the perspectives of several stakeholders to compare and contrast responses.

specificity of how the items and the instrument instructions are worded.

To summarize the information collected from the expert judges for decision-making, averages for each item or the *content validity index* (CVI) can be calculated (Lynn, 1986). The CVI is a ratio score between 0 and 1.0, and it is the number of judges who rated the item above a criterion (e.g., "relevant") divided by the total number of raters. For example, if 4 out of the 5 judges rated an item as "relevant" (vs. "not relevant"), the CVI score would be 0.8. The average rating of each item and its CVI score can be used together to make a decision to either retain or remove from the pool based on an a priori-determined cutoff mean and/or CVI score. Another round of expert review is needed if significant item edits or additions occur in the first round. The result should be a group of highly relevant, clearly worded, and well-structured items that cover all aspects of each facet of the target construct.

Cognitive interview methods are often used with stakeholders to evaluate the elements of an assessment instrument (Rosal, Carbone, & Goins, 2003; Willis, 2005). Cognitive interviews can be used to assess how respondents interpret items and their relevance and importance to the target construct, their ease of understanding the items and directions, and their perspectives of the relevant response categories. A rating scale of "0" to "10" can be used to help respondents rate the relevance and importance of items in which a "0" might indicate "no relevance at all" or "not important at all" while "10" might indicate "extremely relevant" or "extremely important." A similar rating system can be used for the response format categories. High scoring items may be retained while lower scoring items may be discarded. Items deemed difficult to understand or confusing may be revised, or new ones may be generated to ensure cultural relevance. The instrument's directions/instructions and response format categories may also be revised with input from the stakeholder respondents.

This process of using expert judges and stakeholders to evaluate the items, facets, and other elements of an assessment instrument can also be used to evaluate the cultural appropriateness of items in an existing assessment instrument for a specific cultural group or their cross-cultural relevance and representativeness. Are the items relevant and item sets representative of the construct and its facets for the targeted cultural dimension of interest? How do their relevance and representativeness compare across diverse cultures? For example, how relevant would the item "Do you feel blue?" be to measuring the concept of depressive symptoms in Chinese persons living in China? Also consider how any single item or item set might be meaningful or relevant to measuring depressive symptoms in China, given that there are over 55 distinct ethnic groups in China with large differences in language dialects.

Step 5: Refining and Evaluating Items and Other Elements of the Initial Version of an Assessment Instrument

The final step of initial instrument development is psychometric evaluation to reduce the number of items to an optimal level and to ensure they, and the subscales they represent, perform satisfactorily. In this step the instrument is administered to a large number of persons from the target population (e.g., persons with social phobia and who belong to a particular cultural group) to make further decisions about which items to retain or remove. The goal is to retain an optimum number of well-performing items to facilitate good reliability and validity of the derived total and subscale scores.

The optimal number of items to retain will vary, depending on the proposed use of the instrument. A screening instrument might have few items, while an instrument used for comprehensively assessing a construct might have more items. For example, a screening instrument to measure social anxiety might only include a few highly performing items that capture the behavioral (e.g., "I avoid social situations in which people might judge me") and physiological (e.g., "I experience a pounding heart") facets. In addition to well-performing items, a more comprehensive measure might also include cognitive (e.g., "I believe people will negatively evaluate me"), affective (e.g., "I become very fearful when

in public settings"), and interpersonal (e.g., "I am unable to spend time with friends and family") facets.

Refining the pool of items can begin by examining the frequency of endorsement for binary response formats (e.g., symptom checklists) or the response range for rating-type formats of these persons from the target population. The goal is to remove items that are answered similarly across all, or a vast majority, of the persons because they would fail to discriminate among persons or to capture individual differences in regard to the target construct. Infrequently endorsed items might be retained if they are highly relevant for the assessment purpose, such as in the case of low-base-rate behaviors (e.g., violent or high-risk behaviors).

The item sets are further refined to optimize the internal consistency of the scale or subscale. Cronbach's alpha is the index of internal consistency most often used for unidimensional and presumably homogeneous scales, and coefficient omega (hierarchical) is the index recommended for multidimensional scales. The latter is an indicator of the proportion of scale variance attributable to a general factor (Zinbarg, Revelle, Yovel, & Li, 2005). Items with a low item-total score correlation (e.g., <0.70) from these analyses can be removed to further refine the instrument.

For a new instrument, exploratory factor analysis can be used to confirm the anticipated structural relationships among items and factors and to identify the weakest and strongest items for measuring the construct and its facets. Factors not identified in pervious steps could emerge. Items that do not load significantly on the expected or newly identified factors, and those that load significantly on multiple factors but should be independent, can be eliminated.[14]

[14]For some assessment contexts, low-endorsement items can be retained. Consider the importance of an item such as "My boyfriend/girlfriend has threatened me with a gun or knife" in an assessment instrument designed to identify problems in an adolescent dating relationship. A very low endorsement rate diminishes the chance of satisfactory indices of factor loadings and inter-item correlations, but it would be important to identify adolescents who are at risk for violence.

For evaluating an existing instrument, confirmatory factor analysis can be used to examine how the factor structure in a sample of persons who share the cultural dimension of interest compares to the factor structure found in the original sample of persons who may be dissimilar on that cultural dimension. Posner et al.'s (2001) study reviewed earlier illustrates the use of confirmatory factor analysis to examine the psychometric properties of an assessment instrument originally examined with persons of a different culture. Recall the large difference they found in the factor structure between women and men of Latino heritage; how the original four-factor structure, based on a sample of mostly European Americans (Radloff, 1977), was a good fit for the women only; and how inferential errors could result from interpreting factor/scale scores from Latino men.

Confirming the same factor structure is not sufficient to estimate the appropriateness of an assessment instrument and the validity of its measures across cultures because a confirmed structure is not necessarily the best structure. Exploratory factor analysis should also be done to determine the best factor structure of an existing instrument for application in a new cultural group. In either case, the previous steps outlined here should be taken to specify the target construct and its facets in the target cultural group and to ensure that the items and the facets measured by the assessment instrument are relevant and representative of that construct for that population. Some items may be irrelevant or inappropriately worded and, if included, could lead to scalar nonequivalence (i.e., differences in the meaning of a score derived from that instrument) even in the context of satisfactory indices of fit in confirmatory factor analysis. The aspects of the target construct and their item sets may combine differently across different cultural groups leading to operational nonequivalence.

Finally, item response theory (IRT) analysis can be used to examine how the items and their ratings provide unique or redundant information in distinguishing between low and high scorers (Edelen, & Reeve, 2007). Items that fail to distinguish between scorers, and redundant items, are removed. IRT analysis can also be used to

examine differential item performance across subgroups that differ on dimensions of individual differences (e.g., ethnicity, gender, age, and SES).

In summary, developing a culturally appropriate assessment instrument or evaluating the cultural appropriateness of an existing one involves a similar process of content validation. The instrument development and content validation process involves an iterative, multi-method, and multi-step process to derive a measure of a target construct that is valid for a particular population and for a particular application. These steps involve:

1. Defining the construct of interest, and its facts, as precisely and comprehensively as possible.
2. Generating a large pool of items that are relevant and representative of the construct.
3. Determining the most appropriate response format based on the construct specified and intended application.
4. Reviewing of items and instrument elements by expert reviewers to ensure relevance and representativeness as well as wording structure and understandability.
5. Refining or modifying of items and elements through psychometric evaluation.

For cross-cultural applications, an assessment instrument and measures derived from it should be examined for conceptual, operational, scalar, and performance equivalence.

We outlined the important steps and strategies that should be taken in developing a culturally appropriate assessment instrument or in evaluating the cultural appropriateness of an existing instrument. It is important to note that not all existing assessment instruments with published psychometric evidence have been developed in accordance with the steps and strategies we outlined. There is no common accepted standard of, or approach to, assessment instrument development that is required to establish content validity. Most often psychometric evidence of validity is based only on indices of factor structure and internal and test-retest reliability estimates. As we noted earlier, no subsequent evaluation of reliability or validity of the measure can substitute for insufficient content development procedures. Thus, the steps to content validation we outlined here provide a rigorous, science-based approach to assessment instrument development that will increase the confidence that can be placed in the psychometric evidence established through subsequent analysis of internal structure, internal consistency, test-retest reliability, and convergent and discriminant validity.

In Summary: The Best Strategy for Developing a Culturally Sensitive Psychological Assessment Instrument that Is Based on One Developed with a Different Culture

1. Select an assessment instrument only if it has been developed and content validated consistent with best practice and has been strongly supported by subsequent psychometric evidence.
2. Carefully translate/back translate all aspects of the instrument (i.e., title, instructions, and items).
3. Gather quantitative evidence from culturally appropriate[15] experts of the relevance and clarity of each facet, item, and other elements of the instrument for the culture with which it will be applied.
4. Gather quantitative evidence from culturally appropriate experts of the representativeness of the facets for the targeted construct and of the items for the facets: the degree to which they cover the domain of their intended target for the culture with which it will be applied.
5. Concurrent with "3 and 4," solicit suggestions for refinement of existing items and facets and the inclusion of new items and facets.

[15] A "culturally appropriate" expert refers to a professional (e.g., psychologists, teachers) who is knowledgeable about the targeted construct and the culture with which the new instrument will be applied. A "culturally appropriate" sample refers to persons who are members of the culture with which the new instrument will be applied.

6. Concurrent with or prior to "3–5," conduct structured interviews with a culturally appropriate sample of the intended population and culturally appropriate experts to generate additional items and facets and to refine the constructs under investigation.
7. Based on data from "3 to 6," develop a grammatically consistent, clear, precise, and parsimonious set of instructions, response format, and user interface that are consistent with the intended use of the instrument.
8. Based on data from "3 to 6," develop a grammatically consistent, clear, precise, and parsimonious set of items that cover the domain of each facet and the facets that cover the domain of the targeted construct that are consistent with the intended use of the instrument.
9. Consistent with "3–5," gather quantitative information from independent culturally appropriate samples and experts about the relevance, representativeness, and clarity of the initial version of the instrument.
10. Concurrent with "9," solicit suggestions for refinement of existing items and facets and the inclusion of new items and facets.
11. Based on data from "9 to 10," develop a refined version of the instrument.
12. Examine the item-level performance of the refined instrument through standard iterative procedures that include item response analyses and factor analysis applied with a large sample from the target population.
13. Based on data from "12," develop a final form of the instrument.
14. Examine the psychometric performance of the final form of the instrument through EFA, internal consistency, test-retest reliability, and convergent and discriminant validation.
15. Depending on its intended application, examine the sensitivity, specificity, positive and negative predictive power, treatment utility, and predictive validity of the refined instrument (based on findings from "14").
16. For cross-cultural applications with the original culture with which the instrument was developed, CFA and other measures of cross-cultural equivalence should be examined.

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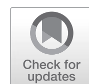

19 Identifying Cultural Effects in Psychological Treatments Using Aptitude-Treatment Interactions

A. Alexander Beaujean

The purpose of this chapter is to pose, then address, a basic research question that describes the general basis for examining one aspect of treatment effectiveness: does a treatment work differently across population subgroups? This chapter covers different aspects of the study design and highlights the aptitude-treatment interaction (ATI) approach as one method for analyzing this type of data. This chapter covers the development and interpretation of the basic ATI model, criteria for determining if an ATI exists, and some criticisms of the framework. In addition, this chapter discusses some extensions of the basic model that may be necessary for some common clinical situations. The chapter concludes with a didactic example of how to analyze and interpret data to determine if an ATI is present.

Scientifically Determining if Treatments Work

Generally speaking, science is premised on the perspective that objective reality exists and can be meaningfully apprehended through the physical senses, although various control conditions need to be included in experiments in order to determine whether valid inferences are possible. This assumption becomes a bit more tenuous with respect to human behavior, because human behavior is never predictable with 100% accuracy (Gage, 1996). Moreover, when providing treatments, it is not just the treatment techniques that influence outcomes but also the client-clinician relationship (Norcross & Wampold, 2011).[1] Thus, human variability can influence both treatment delivery (by the clinician) and reception (by the client).

This is why a scientific approach to determining treatment efficacy is paramount. First, the scientific process has a built-in self-correcting mechanism, whereby hypotheses are systematically evaluated through research that is open to scrutiny first by peer review and then by the general public. Second, although absolute certainty is not attainable, confidence in a treatment's effect grows in accordance with the quantity and quality of research supporting it.

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[1] Throughout this chapter, the term *treatment* refers to a psychological treatment. A psychological treatment is (a) specifically tailored to the problematic processes that cause impairment and distress; (b) emerges from cognitive, behavioral, or educational science; and (c) emanates from diverse theoretical approaches (Barlow, 2004). Such treatments can be implemented in a variety of settings (e.g., clinic, hospital, school) and by different professionals (e.g., psychologist, clinical social worker, teacher).

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Thus, by evaluating evidence through multiple -high-quality studies, the scientific process can identify and help disregard treatments that do not work or are harmful when compared to other approaches (Cook, Smith, & Tankersley, 2012). Third, while not perfect, the scientific method guards against reliance on personal biases or pseudoscientific evidence to determine whether or not a treatment works (Lilienfeld, Lynn, & Lohr, 2015; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014).

The search for treatments that work has been underway for decades, and it is well known that certain treatments are most effective for certain problems (e.g., Weisz & Kazdin, 2010). For example, Nathan and Gorman (2015) wrote there is strong evidence that cognitive-behavioral therapy can eliminate the core features of bulimia nervosa; parent management training and multisystemic therapy can help troubled families with children who have conduct disorder; a combination of relaxation exercises with cognitive therapy can reduce worrying in generalized anxiety disorder; cognitive-behavioral therapy that involves exposure and ritual prevention can reduce or eliminate the obsessions and behavioral and mental rituals of obsessive compulsive disorder; and exposure-based procedures can reduce or eliminate the symptoms of social phobia.

Because of the human element involved, caution is advised in order to avoid over-generalized claims that any treatment will work for every individual (Cook, Tankersley, & Harjusola-Webb, 2008). Instead, results from behavioral science research are best used to identify the practices that are *most likely* to bring about the desired outcomes for any given situations. Moreover, finding such treatments does not obviate the important role of clinicians' professional expertise in delivering the treatment or discovering new aspects of treatment delivery that should be explored (Norcross & Wampold, 2011). Instead, behavioral science is at its best when it informs and optimizes practitioners' clinical wisdom, and practitioners' perspectives and experiences are then used to improve clinical research (Bernal & Scharró-del-Río, 2001).

Criteria for Determining if Treatments Work

An *evidence-based treatment* (EBT) is a treatment that is clearly specified and is supported by empirical findings in quality research with a delineated population (Chambless & Hollon, 1998; Cook et al., 2012). Central to this definition is the idea that there are objective criteria for determining whether or not a treatment works. Different groups (e.g., the American Psychological Association, Campbell Collaboration, US Department of Education) have developed different sets of such criteria (e.g., Chambless & Ollendick, 2001; Confrey, 2006; Slavin, 2008). Typically, the criteria require evaluating two dimensions of the treatment to determine if it works: efficacy and effectiveness. While these two aspects are discussed as if they are independent of each other, the distinction between them is not always very clear, and studies can examine both aspects concurrently (Nathan, Stuart, & Dolan, 2000). The general idea, however, is that for clinicians to adopt a treatment for a given problem, there should be multiple lines of evidence supporting the treatment's use (American Psychological Association [APA], 2002; Chambless & Hollon, 1998).

Treatment Efficacy *Efficacy* is the technical term for evidence showing that a treatment works when compared to an alternative (e.g., different treatment, placebo) in a controlled clinical environment (APA, 2002; Chambless & Hollon, 1998). The fundamental question in evaluating efficacy is simply whether it is possible to demonstrate scientifically that a treatment is beneficial for a specific problem with any client in any situation (i.e., internal validity). Thus, efficacy evidence evaluates the strength of evidence in establishing causal relationships between treatments and the issue being treated.

Determining causal relationships is a difficult task (Antonakis, Bendahan, Jacquart, & Lalive, 2010; Imbens & Rubin, 2015). To at least some extent, making this determination depends on the causal theory used, which in turn influences the

type of evidence gathered (Shadish & Sullivan, 2012). For example, Donald Campbell's thinking about causality (e.g., Campbell & Stanley, 1966)—a typical framework presented in psychology and education graduate programs—largely focuses on minimizing the number of plausible rival hypotheses (i.e., threats to validity) that could account why variables are related. Consequently, randomized experiments are the "gold standard" to use in collecting data because they eliminate the most validity threats and, thus, allow for the strongest causal inference. In contrast, Donald Rubin's (2004) approach to causality—which is typically presented in economics and health graduate programs—is focused more on the analysis required to make causal inferences for a given study design. Thus, his approach focuses more on specifying an appropriate model for the data that is mathematically sufficient to estimate the causal effect. While Rubin favored randomized experiments because of the simplicity in the required analysis, he has applied his causal approach to other designs as well—including observational studies. (For an in-depth discussion of these two perspectives, see West & Thoemmes, 2010.)

It is not surprising, then, that there are different efficacy criteria to determine if a treatment works (e.g., APA, 2002; Institute of Education Sciences [IES], 2013; National Research Council [NRC], 2002; Substance Abuse and Mental Health Services Administration, 2015). The differences in criteria can be thought of as existing on a continuum.

On one end of the continuum is the perspective that the criteria for determining an EBT should be comprehensive, operationalized in great detail, and invariable across problems and outcomes (e.g., IES, 2013). Having such criteria can aid in both having consistency in judgments across treatments and reviewers; in addition, it allows consumers to trust the process of determining what works. On the other end of the continuum is the perspective that designing, evaluating, and synthesizing behavioral research are too complex to be accomplished by rigidly using a checklist of static criteria (e.g., NRC, 2002). This idea here is that determining if a treatment works needs to take into account the individual characteristics of the treatment (e.g., content, implementation, outcomes). Thus, each study of a treatment is critiqued differently and the determination of what works is done by the scientific community developing a consensus on the evidence. While this approach allows for a wider variety of studies to provide evidence about whether a treatment works, it has the potential to find that different treatments work because of using different evaluation criteria.

The location of given set of criteria on the continuum can make a difference in determining whether a treatment is classified as an EBT. For example, Briggs (2008) compared the syntheses of elementary and middle school mathematics curricular programs using the What Works Clearinghouse criteria and the Best Evidence Encyclopedia criteria. He found that the correlation between the two sets of ratings was 0.57, and in only 18% of the cases was a program given the same rating using the different criteria sets.

Despite the differences in criteria, there are some general commonalities among them. First, there needs to be a strong theoretical foundation for the treatment in the relevant peer-reviewed literature. Second, the outcomes that should occur if the treatment is successful should logically come from the theoretical foundation and be explicitly and adequately measured as part of the treatment research program. Third, most—if not all— of the evidence supporting efficacy should come from empirical studies. The nature of the studies, however, is where many of the efficacy criteria differ. For example, the What Works Clearinghouse bases its effectiveness ratings on studies from randomized experiments (or certain types of quasi-experiments), while the Best Evidence Encyclopedia bases its ratings on quantitative syntheses (e.g., meta-analysis) of studies that use "consistent, scientific standards." The overall gist, however, is that for a study to demonstrate that a treatment works, it needs to minimize the influence of any nuisance variables (e.g., different implementations of the treatment) on the outcomes of interest. Thus, efficacy designs often employ methods to ensure the treatment is similar across clinicians and clients

(e.g., treatment manuals), are done in tightly controlled environments (e.g., hospitals, university clinics), and involve some type of experimental control over treatment allocation.

Treatment Effectiveness Showing that a treatment is efficacious is necessary, but it usually is not sufficient evidence to be classified as an EBT. The reason is that most efficacy studies do not capture the variability involved in using the treatments in the "real world" (i.e., external validity; Bardo & Pentz, 2012). Thus, treatment *effectiveness* evaluates whether a treatment works in typical clinical practice.

Effectiveness studies usually examine at least one of three different aspects of treatment: feasibility, cost utility, and generalizability (APA, 2002). *Feasibility* refers to the likelihood that an efficacious treatment can be delivered to the clients for whom it was designed (Bowen et al., 2009). *Cost utility* refers to both the monetary and time costs, both immediate and long term (Yates, 1997). *Generalizability* refers to the extent to which a treatment's effects will be replicated across settings or populations. The rest of this chapter focuses on this generalizability criterion, because it is the most common aspect of effectiveness investigated when examining cultural influence (National Institutes of Health, 2001; Smith, Rodríguez, & Bernal, 2011). Nonetheless, it is important to realize that feasibility, cost utility, and generalizability are not independent of each other. If a treatment requires biweekly meetings with the clinician for a year, its effects might be generalizable but have little feasibility.

Culture One important component to consider in studying a treatment's effectiveness is *culture* (Smith et al., 2011). There is not a single definition of culture (Cohen, 2009), but across definitions, there is some agreement that (a) it emerges from environmental interactions, (b) it consists of shared elements (e.g., values, history, rituals), and (c) it is transmitted across time (cf. APA Presidential Task Force on Evidence-Based Practice, 2006). While race, ethnicity, sex, gender, and socioeconomic status may be components of culture, these terms are not synonymous with culture. Other examples of variables that are implicit in conceptualizing cultural differences are geographic region, religion, occupation, worldview, and individualism/collectivism—and there are many others.

When treatment studies purport to examine the influence of culture, usually the researchers are trying to answer questions concerning the applicability or generalizability of a treatment to a population subgroup (usually defined by one or more cultural variables). Burlew et al. (2011) gave some examples of why examining such questions can be important when studying a treatment's effectiveness. In one treatment study, investigators examined if a group intervention for males could reduce their HIV risk through lowering their risky sexual behaviors. The intervention group, as a whole, showed a greater reduction in risky sexual behaviors than the control group; upon further analyses, however, the investigators found that the intervention was not as effective for the Black participants as it was for the other ethnicities. Conversely, Burlew et al. described two other treatment studies (one for pregnant substance users and the other for smokers with attention deficit hyperactivity disorder) where the intervention and control groups did not show any aggregate differences but the "racial/ethnic minority" subgroups showed positive outcomes for the intervention.

Of course, just because differences in treatment outcomes exist does not mean that they are due to differences associated with race, ethnicity, language, or culture. Often there is more variability within population subgroups than between them (Cohen, 2009; Lubinski, 2000). Likewise, individuals may be members of different cultural groups yet not exhibit any meaningful differences on treatment outcome variables. Thus, determining if differences in treatment outcomes exist, and if those differences are related to culture, needs to be an empirical endeavor that is guided by sound theory, research design, and data analysis.

Methods to Examine the Influence of Cultural Variables on Treatment

Awad and Cokley (2010) wrote that the key component to conducting any kind of multicultural research is intentionality:

> In other words, do individuals thoughtfully conceptualize and plan research with specific ethnic, cultural, or racial variables in mind, or do they simply collect data with the hope of finding something interesting because they have a sample that includes ethnic minorities?…research should be considered multicultural only when it involves intentionality; that is, the researcher(s) approaches the research project with a specific population(s) in mind, with specific ethnic, racial, or cultural constructs in mind, and with specific types of research questions. (p. 391)

Consequently, examining treatment generalizability requires intentional consideration of both the study design and the data analysis.

The initial step in cultural research on a treatment (or any other type of research, for that matter) is to have a strong theoretical and empirical rationale. Specifically, what theoretical and empirical evidence supports why a particular EBT should work differently in one population subgroup than another? For example, there is good reason to believe that providing treatments in the clients' primary language might be more effective than providing treatment in the dominant language of clinician and using an interpreter. Using interpreters can result in unintentional distortions of meaning by omitting or substituting keywords, abridging what the client/clinician said, or changing the focus from the speaker's actual messages (Marcos, 1979). Moreover, previous research has shown that adapting a treatment through matching clients to clinicians based on the client's primary language tends to produce better treatment outcomes than not matching (Griner & Smith, 2006; Kalibatseva & Leong, 2014). Consequently, there is both a theoretical and empirical rationale for thinking that an EBT developed and administered in English might work differently for clients not fluent in English if there is no language adaptation.

This initial criterion may seem overly burdensome, but there is good reason for it. First, there is a massive literature showing negligible differences in effects across many different treatments (e.g., Smith & Glass, 1977; Luborsky et al., 2002; Wampold et al., 1997). Second, efficacious treatments are often found to work for multiple population subgroups (Benuto & O'Donohue, 2016; Huey & Polo, 2008; Miranda et al., 2005).

If there is reason to believe that a treatment's effects may differ across population subgroups, then the design and data analysis should be set up specifically to determine if a treatment works (or works differently) for individuals in the population subgroups of interest. Huey and Polo (2008) delineated two different criteria for their meta-analysis to determine if a treatment worked for ethnic minorities, although the criteria can apply for other types of population subgroups as well.[2] A study had to meet at least one of the criteria (in addition to other indicators of study quality; e.g., Chambless & Hollon, 1998).

The first criterion was that an at least 75% of total sample were members of the population subgroup of interest. The 75% value was somewhat arbitrary; other meta-analyses have used lower thresholds (e.g., Wilson, Lipsey, & Soydan, 2003). The idea is that any conclusion made about a treatment's effects in a given population subgroup needs to be made using data from a sample that is large enough to be able to determine whether or not the treatment works (Kelley & Maxwell, 2012). The second criterion was the absence of an aptitude-treatment interaction, which is covered in the next section.

Although not part of Huey and Polo's (2008) study, a third criterion is that extraneous variables that may confound the results need to be collected and analyzed. The reason for this criterion is that research examining cultural differences is nonexperimental; people cannot be randomly assigned into groups based on cultural variables. Although common practice, finding differences in treatment outcomes between population

[2] There was a third criterion: separate analyses with ethnic minority youth show statistical superiority to control conditions. However, separately analyzing data from various population subgroups within a sample is generally not a good practice (Newsom, Prigerson, Schulz, & Reynolds, 2003); thus, it is discussed further in this chapter.

subgroups (often defined using coarsely measured demographic variables) is not sufficient evidence to conclude that cultural differences caused the differences (Awad & Cokley, 2010). To paraphrase Phinney (1996), population subgroup membership alone cannot predict behaviors or attitudes in any psychologically meaningful way. Thus, if there is a difference between population subgroups on a treatment outcome, it is important to determine if more proximal variables (i.e., variables that are more closely related to the treatment outcome than population subgroup membership) can explain these differences.

Bradley et al. (2004) provided an example of why it is important to control for other variables when examining differences in population subgroups. Although from a medical context, the same idea applies to psychological treatments. They examined race differences in time between hospital admission and treatment for individuals having a heart attack. Their initial analysis found that Black patients waited between 7.3 min and 18.9 min more for their treatment than White patients. (There is a range of times because Bradley et al. examined data from two different treatments.) After controlling for more proximal variables (e.g., typical waiting time at the hospital, insurance status, time since symptom onset, medical history), the difference in average time to treatment between the groups reduced to 5.1–8.7 min. Thus, Bradley et al. concluded that the differences in time to treatment might not be completely due to “race differences” in how hospital staff treat patients but (at least partially) due to lagging quality in the hospitals where Black individuals were likely to receive care.

Aptitude-Treatment Interactions

The idea of an aptitude-treatment interaction (ATI) has been around for centuries, but it was not until the mid-twentieth century that such studies were used clinically (Snow & Yalow, 1982). To understand ATIs, it is helpful to define the terms aptitude, treatment, and interaction (Snow, 1991a).

Aptitude is any measurable client characteristic hypothesized to influence readiness to profit from a particular treatment at a particular time. Traditionally, people tend to think of aptitude as being synonymous with stable traits such as intelligence, personality, or disorder classification (Dance & Neufeld, 1988). While traits can be aptitudes, aptitude is a much broader construct.

Snow (1991b) suggested that aptitude is the adaptation and fit of person and situation. Thus, aptitude is a relational construct that requires interpreting the behavior of people within situations. It can include stable characteristics, but it can also include those that vacillate or are malleable and can also include cultural variables. The idea is that aptitudes are characteristics of individuals within a certain context in time that may influence their readiness to profit from a particular treatment.

In the ATI context, *treatment* is a broad term (Barlow, 2004; Paul, 1967). It includes the actual activities involved as well as relevant characteristics of the environment in which treatment takes place (e.g., university clinic, school, client home) and clinician characteristics (e.g., language fluency, area of highest earned degree). As with aptitude, treatment is a relational concept because, to some degree, clients construct and adapt their situations to fit their own characteristics.

Interaction is a statistical term, indicating that a predictor-outcome relation differs based on the level of one or more other variables (Aiken & West, 1991). In the clinical context, it is the degree to which results for two or more treatments (or one treatment over two or more trials/sessions) differ for clients who also differ on one or more aptitudes.[3] For example, as previously noted, Griner and Smith (2006) found treatments administered by matching clients to clinicians based on the clients’ primary language were more effective than treatments that did not match.

[3]Another type of interaction is one where an ATI exists for one treatment outcome but not another, i.e., an aptitude-treatment-outcome interaction (Smith & Sechrest, 1991). This requires measuring multiple treatment outcomes, an extension of the ATI model I discuss later in the chapter.

Although both types of treatment had positive effects, the typical effect size for the language-matched treatments was more than twice the typical effect size for the non-language-matched treatments. Thus, there was an interaction between an aptitude (i.e., client primary language) and one aspect of the treatment (i.e., clinician ability to speak client's primary language).

If an interaction is present, this indicates that the treatment has a stronger or weaker effect as a function of aptitude. The presence of an interaction, alone, does not render the treatment ineffective for a population subgroup. There are different types of interactions, and it is the nature of this interaction—along with other aspects of efficacy and effective evidence—which should determine whether or not a treatment is appropriate for a given population subgroup (Smith & Sechrest, 1991).

Consider two different treatments that have previously been shown to be efficacious. Treatment 1 is expensive, but there is not an ATI for two population subgroups of interest (A and B). Treatment 2 is cheap, but there is an ATI. If the ATI is such that it works for both Subgroup A and Subgroup B but at different levels (i.e., Subgroup A benefits more than Subgroup B), then Treatment 2 may be considered appropriate for both Subgroup A and Subgroup B because (a) it works for both groups and (b) the presence of an ATI might be mitigated by its lower cost. However, if the ATI is such that Treatment 2 only works for Subgroup A, then, despite its cost, only Treatment 1 would be considered appropriate (at least for Subgroup B).

Designing a Study to Examine an Aptitude-Treatment Interaction

There are a variety of research designs that can examine ATIs (Snow, 1991a—see also Chambless and Hollon, 2012, for general research design issues in treatment studies). One way to study ATIs is to assign individuals to treatments randomly. If this is done, then randomization should be done in blocks so that there is approximately the same number of individuals from each aptitude group in each treatment condition. This basic design, like all group designs, can be extended to situations with more than one aptitude or more than one treatment (Kirk, 2014).

In addition, the design can be extended to a situation with a single treatment and many data collection time points, with the clinician attempting to improve the intervention over time according to aptitude. The goal here is to reach an "optimum" outcome by adapting the treatment to remove the low or negative effects for some aptitudes over a series of small correlational studies that, ultimately, add up to an experiment. In this situation, different adaptations represent the interaction since revisions may improve outcomes for one aptitude group but worsen outcomes for another aptitude group. If this occurs, it may suggest that something important for some aptitude groups has been altered in the treatment revision process and may also hint that the changes have helped other aptitude groups.

Another type of ATI design is the regression discontinuity design. This type of design is best explained by an example. Say a school district was interested in whether a new math treatment worked as well for those with limited English proficiency as it does for those who are proficient in English. The district administered a measure of English proficiency (the aptitude) to all students eligible for the treatment (i.e., students preforming poorly in math). The treatment the students received was completely determined by their score on the English proficiency measure. Those who scored below a certain threshold (e.g., ≤25%ile) were given the treatment in their native language, and those who scored above the threshold (e.g., >25%ile) were given the treatment in English. Students whose scores were close to the cutoff (e.g., 15–35%ile) are minimally different in their English proficiency and likely most other pertinent variables as well (e.g., cognitive ability, exposure to quality instruction). Thus, the situation is similar to a randomized experiment for students whose proficiency scores were close to the cutoff. Yet, part of this group received treatment in one language, while the other part of the group received the treatment in another language. Consequently, if there a difference in the outcome

between the two treatment groups (particularly those whose proficiency scores were close to the cutoff), then it is likely that the difference is due to the language in which the treatment was administered.

Implementing a regression discontinuity design is somewhat more complex than what was presented here, but the example gives the general idea. Interested readers can consult the literature on this design for more information (e.g., Braden & Bryant, 1990; Murnane & Willett, 2011; Trochim, 1994; West, Biesanz, & Pitts, 2000).

In addition to the study design, three other issues need to be considered when developing ATI studies: participant selection, variable measurement, and the influence of extraneous variables. Before selecting study participants, researchers should define the populations to which they plan to generalize their results and then select a sample that is projectable to the larger group (Pettus-Davis, Grady, Cuddeback, & Scheyett, 2011). This is not always easy to do with treatment studies and historically has been a weakness of EBT research (La Roche & Christopher, 2008). At a minimum, researchers should design studies to have approximately equal number of individuals in each aptitude group (if categorical) or individuals that span the range of aptitude values (if continuous). Moreover, researchers should be cognizant of the limitations of whatever sampling method they employ and frame their study's limitations accordingly.

The importance of purposefully selecting measures of the treatment outcomes is well documented (Blanton & Jaccard, 2006). Equally important in ATI studies is measuring the aptitude. Specifically, aptitude needs to be measured as precisely as possible to map onto the question of interest. For example, the variables of education, income, wealth, and occupational category are not interchangeable—they all reflect different aspects of an individual's socioeconomic status (Braveman et al., 2005). Likewise, variables like race and gender are not as simple to measure as they may appear because people do not always fit into one discrete category (Smiler & Epstein, 2010; Winker, 2004).

No matter how the aptitude variables are ultimately measured, it should be transparent how it was done so that others can replicate the study and valid comparisons can be drawn across studies (for descriptions of what should be reported about variables, see APA Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008). The importance of being able to replicate a treatment study cannot be emphasized enough (Asendorpf et al., 2013); it is accumulation of results across multiple high-quality studies—not the results of a single study—which should determine whether a treatment is effective or that there are subpopulation group differences. For example, in Griner and Smith's (2006) meta-analysis, a large portion of the studies they examined did not explicitly describe how they culturally adapted (or did not adapt) a given treatment, so not only is it very difficult to know what treatments are actually being compared, but it is virtually impossible to replicate many of the studies' results.

Finally, when interpreting ATI studies, Snow (1991a) recommended that each one be interpreted as a case study, limited to its time, place, and human constituents. He argued that the best way to understand ATI research—and subsequently link them to results of other EBT studies—is to obtain the richest possible description of the study's context and process and to limit simple generalizations thereof. This means that it is likely impossible to determine if a treatment works for a multitude of cultural variable combinations (e.g., race A vs. B, gender C vs. D, socioeconomic status E vs. F). Kazdin (2000) argued that such a line of investigation is not only unfeasible; it is not even desirable—there are far too many disorders, treatments, and possible moderating variables to investigate all possible combinations. If Awad and Cokley (2010) are correct that intentionality is the foundation for conducting multicultural research, then far more important than finding that treatment effects differ is an understanding of why the treatment works in the first place, which should then help guide investigations for purposefully examining why certain cultural variables would moderate this effect.

Table 19.1 Group means illustrating an aptitude-treatment interaction

	Aptitude One (A_1)	Aptitude Two (A_2)	Aptitude differences ($A_2 - A_1$)
Treatment A (T_A)	41.53[a]	55.00	13.47
Treatment B (T_B)	53.71	52.16	−1.55
Treatment differences ($T_B - T_A$)	12.18	−2.84	

[a]Reference group

Analyzing Data from Aptitude-Treatment Interaction Studies

The basic method to determine if an ATI exists is a multiple regression. The simplest ATI model is for two treatment groups and two aptitude groups, represented as

$$O = \text{Intercept} + xA + yT + z\text{ATI} + e, \quad (19.1)$$

where O is the outcome of interest, A is the aptitude grouping variable, T is the treatment grouping variable, ATI is aptitude-treatment interaction, and e is the error term (i.e., the difference between the observed and predicted outcome).

Like any regression model, there are a priori assumptions about the ATI model in Eq. 19.1 (Kelley & Maxwell, 2010). First, the error terms (e) are normally distributed with a mean of zero and constant variance across all treatment and aptitude groups (i.e., homoscedasticity). Second, the observations are made independently of each other (i.e., the treatments are administered individually). Third, the relation between the outcome and the predictors is linear. For details on examining these assumptions, see Andersen (2012).

There are three effects in Eq. 19.1. The x coefficient is the conditional (or simple) effect of aptitude.[4] It represents the average difference on the outcome between two aptitude groups for a specific treatment. In a similar fashion, y is the conditional effect of treatment: the average difference on the outcome between two treatment groups within a specific aptitude group. The third coefficient, z, is for the ATI. The ATI variable is created by multiplying the aptitude variable by the treatment variable (i.e., $A \times T$). z indicates how much the treatment effect is moderated by aptitude group membership. Or, put another way, how much the treatment effect differs between aptitude groups.

To understand the x, y, and z terms better, it is helpful to create the simplified equations that result from plugging in values for variables. For example, say there are two treatments and two aptitude groups. For simplicity, say both the treatment and aptitude variables are dummy-coded categorical variables (i.e., coded as either 0 or 1—for alternative coding schemes, see Wendorf, 2004). Treatment A (T_A) was coded as 0, and Treatment B (T_B) was coded as 1; likewise, Aptitude One (A_1) was coded as 0 and Aptitude Two (A_2) was coded as 1. This makes the reference group (i.e., the group to whom all other groups will be compared) be comprised of individuals in the A_1T_A group. Illustrative data for this scenario are in Table 19.1.

The simplified version of Eq. 19.1 for the A_1T_A group is in Eq. 19.2a. The simplified equations in 19.2b, 19.2c, and 19.2d are for A_2T_A, A_1T_B, and A_2T_B, respectively.

$$\begin{aligned} &\text{Aptitude One Treatment A}\left(A_1T_A\right) && O = \text{Intercept} + x(0) + y(0) + z\left(0\times 0\right) + e \\ &\left(\text{reference group}\right) && O = \text{Intercept} + e \end{aligned} \quad (19.2\text{a})$$

$$\begin{aligned} &\text{Aptitude Two Treatment A}\left(A_2T_A\right) && O = \text{Intercept} + x\left(1\right) + y\left(0\right) + z\left(1\times 0\right) + e \\ & && O = \text{Intercept} + x + e \end{aligned} \quad (19.2\text{b})$$

[4]The conditional/simple effects are not the same as main effects. The relation between predictor and outcome is not the same across all values of the covariates when there is an interaction. If an interaction was not present, the effects of x and y would be main effects.

$$\text{Aptitude One Treatment B}\left(A_1T_B\right) \quad \begin{aligned} O &= \text{Intercept} + x(0) + y(1) + z(0\times 1) + e \\ O &= \text{Intercept} + y + e \end{aligned} \tag{19.2c}$$

$$\text{Aptitude Two Treatment B}\left(A_2T_B\right) \quad \begin{aligned} O &= \text{Intercept} + x(1) + y(1) + z(1\times 1) + e \\ O &= \text{Intercept} + x + y + z + e \end{aligned} \tag{19.2d}$$

The simplified equations make the coefficients' effects clear. Equation 19.2a shows that the intercept is the mean value of the outcome for the reference group (A_1T_A), which in Table 19.1 is 41.53. The only difference between Eqs. 19.2a and 19.2b is the x coefficient in 19.2b. Thus, x represents the difference in means between A_1 and A_2 for T_A. If, on average, T_A has the same effect across both aptitude groups, then x should be approximately zero. In Table 19.1, x can be calculated as 55.00 − 41.53 = 13.47.

The same procedure for finding x can be applied to y. The only difference between Eqs. 19.2a and 19.2c is the y coefficient in 19.2c. Thus, y represents the difference in means between T_A and T_B for A_1. If, on average, T_A and T_B work the same for A_1, then y should be approximately zero. In Table 19.1, y can be calculated as 53.71 − 41.53 = 12.18.

The difference in means between T_A and T_B for A_2 is a little more complicated to compute. It is represented by the difference between Eqs. 19.2b and 19.2d, or $y + z$. If, on average, T_A and T_B work the same for A_2, then both y and z should be approximately zero. In Table 19.1, the combined effect of y and z can be calculated as 52.16 − 55.00 = −2.84. Since y = 12.18, this makes z

$$\begin{aligned} -2.84 = y + z = 12.18 + z \rightarrow z \\ = -2.84 - 12.18 = -15.02. \end{aligned}$$

If there was no aptitude-treatment interaction, then z should be approximately zero. In other words, the difference in means between T_A and T_B for A_1 should be approximately the same as the difference in means between T_A and T_B for A_2. Previously it was shown that the difference in means between T_A and T_B for A_1 was 12.18 and the difference in means between T_A and T_B for A_2 was −2.84. The difference between these differences is −15.02 (i.e., −2.84 − 12.18), which is the same value for z previously calculated.

Some graphical examples of these simplified effects are shown in Fig. 19.1. In the figures, there are four different outcomes. For the outcome in Fig. 19.1a, there are no differences in the outcome between aptitudes or between treatments. For Eq. 19.1, essentially x, y, and z are all zero. For the outcome in Fig. 19.1b, the mean value of the outcome is higher for T_A than T_B, and this difference is the same for both aptitude groups. Thus, there is no ATI as T_A and T_B are operating the same in both groups, even though A_1 tends to score lower than A_2 on the outcome measure. In Eq. 19.1, z is essentially zero, while x and y are different than zero.

Figure 19.1c, d both show ATIs, but of different types. Fig. 19.1c shows an *ordinal* interaction (i.e., nonparallel regression lines that do not cross).[5] In this data, T_A works (i.e., produces higher values on the outcome) for both aptitudes, but the difference between T_B and T_A is much more pronounced for A_1 than A_2. Fig. 19.1d shows a *disordinal* interaction (i.e., nonparallel regression lines that cross). Here, T_B produces higher values on the outcome than T_A for A_1, but T_A produces higher values on the outcome than T_B for A_2.

Determining if an Interaction Exists

The determination of whether there is an ATI is tantamount to determining whether or not to keep the z coefficient in Eq. 19.1. If all interactions were of the type shown in Fig. 19.1d, it would be easy to know if an interaction was present. Unfortunately, they are not. Historically, interaction effects tend to be relatively small and can be

[5]The definition of ordinal and disordinal interaction is a little more complex than simply whether their lines cross; see Leigh and Kinnear (1980) for more information.

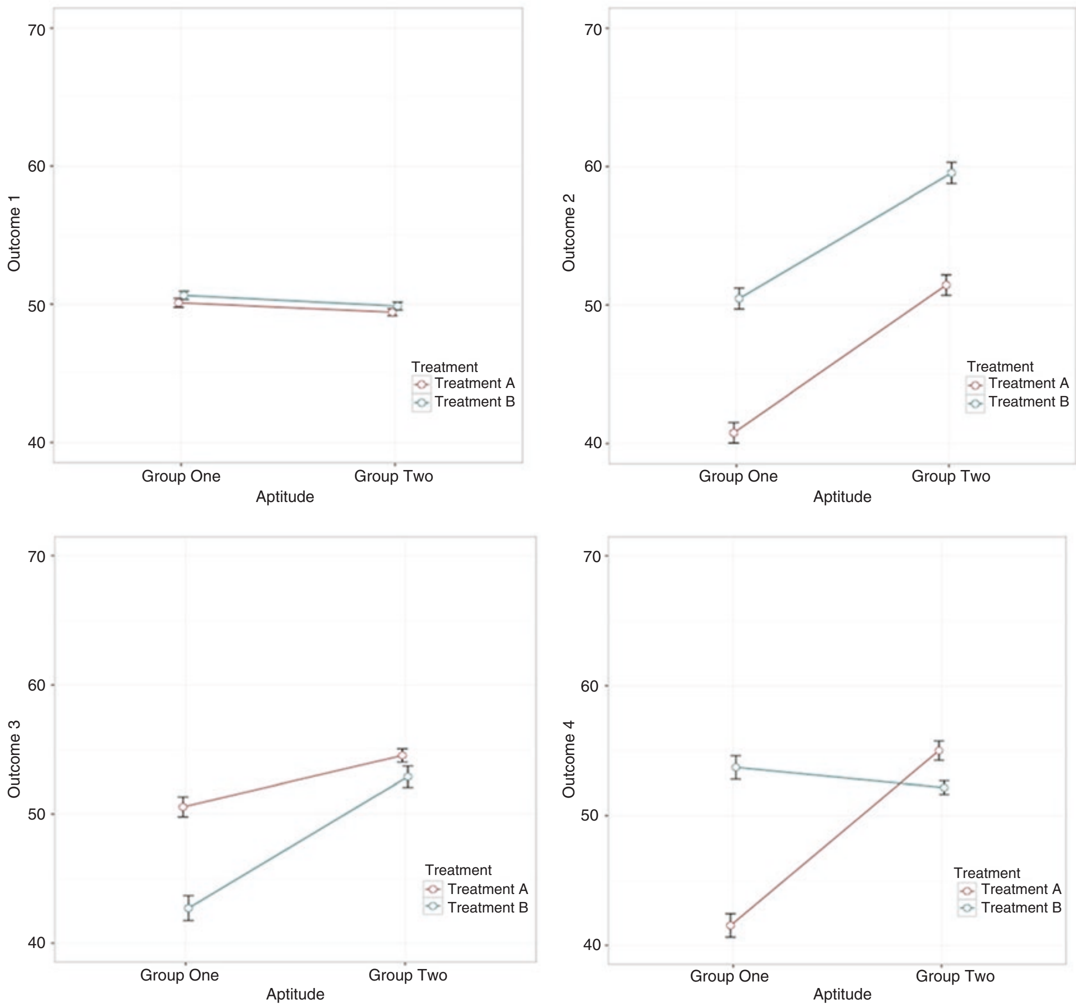

Fig. 19.1 Mean values with 95% confidence intervals for four types of relations of aptitude and treatment to outcome: no treatment or aptitude differences (**a**); treatment effects without aptitude differences (**b**); ordinal ATI (**c**); and disordinal ATI (**d**)

hard to find (Aiken & West, 1991), although this can be somewhat ameliorated through careful design and analysis (Smith & Sechrest, 1991).

The traditional way to determine if an ATI exists has been to examine the statistical significance of the z coefficient. Much has been written about the problems with significance testing (Cumming, 2014; Wilkinson & American Psychological Association Science Directorate Task Force on Statistical Inference, 1999; Wasserstein & Lazar, 2016), such as their strong dependence on sample size and that the resulting decision is a relatively uninformative yes-or-no answer (i.e., significant vs. nonsignificant). Kraemer, Wilson, Fairburn, and Agras (2002) wrote "*P* values are not and should not be used to define moderators and mediators of treatment, because then moderator or mediator status would change with sample size" (p. 881). Consequently, this approach is not discussed in this chapter. For those interested in using the statistical significance approach, Beaujean (2008) and Hayes (2013) provide detailed discussions and examples.

One alternative to significance testing for determining if there is an interaction is to compare theoretically driven models (Rodgers, 2010). In this approach, different models are developed

to represent different hypotheses, then they are all fit to the same dataset, and measures of fit are calculated for each model and compared across models. Good models are those that not only fit the data well but are theoretically justifiable and parsimonious and can generalize to other datasets with the same variables (e.g., Myung, 2000).

While the model comparison approach has a strong basis in the statistical literature—and it is the approach discussed in this chapter—it is important to be cognizant that it is not possible to make a definitive claim of capturing the "true" model or even identifying the model that best approximates reality. There are always plausible alternative models as well as important variables omitted (Tomarken & Waller, 2003). As human cognition and behavior are complex, it is only possible to aspire to represent these processes imperfectly through statistical models.

In a basic ATI analysis, there are four core models to examine:

Model 1	Intercept
Model 2	Intercept + Treatment
Model 3	Intercept + Treatment + Aptitude
Model 4	Intercept + Treatment + Aptitude + ATI

Model 1 is the most parsimonious and indicates that there are no treatment or aptitude effects. Instead, the best predictor of the treatment outcome is simply the average value of the outcome across all observations (i.e., the intercept). Model 2 indicates that there are only main effects for treatment, while Model 3 indicates that there are main effects for treatment and aptitude. Model 4 is the most complex and indicates that there is an ATI (this model is the same as Eq. 19.1). Of note, while it is possible to fit a model with only the interaction term (i.e., excluding the conditional effects for treatment and aptitude), it is typically not recommended because it substantially changes model interpretation (Aiken & West, 1991). In addition, all four models should be examined, even if Models 2 and 3 indicate there are no main effects, because it is possible that not accounting for the interaction masks differential treatment effects (Kraemer et al., 2002).

Including extraneous variables (i.e., variables that may influence the outcome but are not of particular interest in the study) in the models can be done in few different ways. One way is to include them in all four of the basic models. In this scenario, Model 1 examines the influence of the extraneous variables on the outcome; Models 2–4 examine if including treatment, aptitude, or their interaction, respectively, do a better job fitting the data than the extraneous variables alone. Another way to handle the extraneous variables is to fit Models 1–4 "as is" and then refit the models including the extraneous variables. If Models 3 and 4 provide a good fit without the extraneous variables, but Models 1 and 2 fit the data better when including extraneous variables, this indicates that the extraneous variables are likely explaining most or all of differences in the outcome variable between the population subgroups.

Model Fit There are only a few measures of model fit available for regression. Two recommended measures are the Bayesian information criterion (BIC) and small-sample corrected version of the Akaike information criterion (AIC_C). While a little oversimplistic, the general idea for both fit measures is they calculate the lack of model fit to the data and penalize the model for complexity (i.e., number of parameters the model estimates). Nonetheless, they are not interchangeable because they have different underlying philosophies, target models, and formulas (Burnham & Anderson, 2004). In general, BIC imposes a stronger penalty for models with more parameters than AIC^C does. Thus, if the AIC^C and BIC disagree, it is usually because the BIC favors a more parsimonious model than the AIC^C.

Kuha (2004) argued that both the AIC^C and BIC should be used when examining model fit. If the measures agree on the same model, this provides some reassurance on the robustness of the choice. If the measures disagree, then they will have at least ruled out some models and give an indication of the range of adequate models (and perhaps also suggest that other models besides that one fit should be examined).

The formulas for the fit measures differ somewhat by estimator (e.g., least squares vs. maximum likelihood) and computer program, so they are not present here. (Those interested in the computational details should consult Burnham & Anderson, 2002). Moreover, the values of both fit measures are strongly dependent on the sample size, so it does not make sense to interpret the actual value of either measure. Instead, it is the relative values of the measures over the set of theoretically derived models that is important.[6] Consequently, a procedure is needed to quantify the difference in fit measures between models and scale that difference to make it interpretable. One way to do this is convert the AIC^C and BIC values to relative weights (Wagenmakers & Farrell, 2004).

Say there are a set of K models (for the ATI scenario, $K = 4$). For each model, calculate the AIC^C, and then rank order the models based on the AIC^C values. (The same can be done with the BIC, but for simplicity, only the AIC^C is used to explain how to convert the values to weights.) The difference between the AIC^C for a specific model (Model i) and the smallest AIC^C across all the K models is

$$\Delta_i AIC_i^C = AIC_i^C - \min\left(AIC^C\right) \quad (19.3)$$

where AIC_i^C is the corrected AIC value for the ith model and $\min(AIC^C)$ is the smallest/minimum AIC^C value across all K models.

The ΔAIC^C is an indication of how differently the models fit the data. As with AICC and BIC values, values of ΔAIC^C are not directly interpretable. One way to make the ΔAIC^C values interpretable is to normalize them. To do this, divide each model's ΔAIC^C value by the sum of all ΔAIC^C values for the given set of models. Before doing this, however, the ΔAIC^C values need to be rescaled (see Burnham & Anderson, 2002, for details about this rescaling). The formula for rescaling is

$$\Delta_i AIC_{Ri}^C = \exp\left(-\frac{1}{2}\Delta_i AIC^C\right) \quad (19.4)$$

where $\Delta_i AIC_{Ri}^C$ is the rescaled ΔAIC^C value for the ith model and exp() is the exponentiation function. Using the AIC_R^C values, it is now possible to create a normalized version of the AIC for the K models under investigation.

$$w_i\left(AIC^C\right) = \frac{\Delta_i AIC_{Ri}^C}{\sum_i^K \Delta_i AIC_{Ri}^C}, \quad (19.5)$$

where w_i (AIC^C) is Model i's AIC weight for the K models examined.

The w_i (AIC^C) values are interpreted as the weight of evidence in favor of Model i being the best model out of the set of K models under consideration. The values will always fall between 0 and 1 because $\sum_i^K w_i\left(AIC^C\right) = 1$; thus, it can be interpreted the same as a (conditional) probability. As previously stated, BIC values can be substituted for AIC^C in Eqs. 19.3, 19.4 and 19.5 to give BIC weights, i.e., w_i (BIC).

In some situations, the w_i (AIC^C) or w_i (BIC) will clearly indicate that one of the K models is better than the others. In other situations, the weights will be somewhat equivocal and show that two or more models fit the data similarly. In the latter case, Burnham and Anderson (2002) argued for a "multimodel inference" approach to dealing with alternative models. The overall idea is that for a given set of models, more than one of them can potentially explain the data, with each one having a different amount of evidence (i.e., the weight). The exact implementation of multimodel inference differs depending on the purpose of the data analysis. For ATI studies, the best approach is likely to examine the w_i (AIC^C) and w_i (BIC) values for each of the four models and see if one model has particularly strong support (i.e., weight > 0.90). If not, then investigate the models with similarly strong support, and determine if they should all be interpreted.

[6] In many statistical software programs, models with lower values of the AIC^C or BIC are "better" than models with higher values, but this is not always the case. If the software you are using calculates the AIC^C or BIC values, consult the technical manual to verify whether higher or lower values indicate better fit.

Effect Sizes

In addition to comparing different models, it is important to interpret the effect sizes (ES) measures from the chosen models (Kraemer et al., 2002). There are a variety of ES measures to examine in a regression. The most typical is the R^2, which indicates how much of the variance in the outcome is explained by all the predictor variables. If the model fit measures indicate that there is an ATI (or models with and without an ATI fit equally well), it can be informative to examine the R^2 values (or the confidence intervals for the R^2 values) in the models with (Model 4) and without (Model 3) the interaction term. Since the metric of the R^2 ES (i.e., explained variance of the outcome) is directly interpretable, the idea here is to use the values as one way to describe model differences.

Another effect size to examine is the magnitude of the regression coefficients (i.e., x, y, and z in Eq. 19.1) and their confidence intervals (Kelley & Preacher, 2012). This is especially useful if the outcome variable is in a known metric (e.g., money, number of incidents). The simplified formulas in Eq. 19.2a–d allow for a determination how different the treatment effects are across the aptitude groups, as shown with the example data from Table 19.1. In addition, confidence intervals can be created for these values (for the formulas, see Cohen, Cohen, West, & Aiken, 2003).

Since the treatment variable will usually be categorical in an ATI study, the fully standardized versions of x, y, and z (i.e., "beta weights") should not be interpreted as it typically does not make sense to standardize categorical variables. It is possible to standardize only the continuous variables, however (for details, see Aiken & West, 1991). If this is done, it is important that the interaction term is not re-standardized after multiplying the aptitude and treatment variables; doing this removes the meaning of the regression coefficients.

Criticisms of the Aptitude-Treatment Interaction Approach

While the ATI framework does have support as one robust method for examining subpopulation group differences in treatment outcomes, it is not universally accepted. Typically, these critiques are ideological in nature and not arguments against the methods per se. For example, Yali and Revenson (2004) advised caution when using between-group designs, because finding differences in population subgroups could inadvertently encourage a cultural deficit model (e.g., individuals in the group that did not respond to the treatment because their culture is deficient in important ways from the group that responded). Similarly, Bernal and Scharró-del-Río (2001) contended that because many population subgroup comparisons have weak conceptualizations (e.g., why would race differences cause outcome differences?), comparison across these groups should not be done unless there is a clear theoretical basis for a comparative approach.

One alternative to the ATI approach would be to explore if a treatment works within specific population subgroups. Here, studies would only sample from one specific population subgroup. Questions of treatment differences across population subgroups would be eschewed, and, instead, the questions would focus on whether or not a specific treatment works in a specific group for a specific problem. Of course, such designs greatly limit the generalizability of the results, so they should be interpreted accordingly.

Another alternative would be to keep the ATI framework but to include more proximal aptitude variables that are thought to have a more direct influence on treatment outcomes (Alvidrez, Azocar, & Miranda, 1996). Thus, the question of whether there were differences in a treatment's effects for, say, Black and Hispanic individuals would be replaced with questions about whether communication styles, worldviews, perceived family

support, etc., can explain why there are treatment effect differences. Such models require assessing both moderation and mediation concurrently (i.e., mediated moderation), which requires altering Eq. 19.1 to account for the additional hypotheses (for details, see Edwards & Lambert, 2007).

Extensions of the Aptitude-Treatment Interaction Model

The ATI model presented thus far is for the simplest possible situation: two treatment groups, two population subgroups, and one continuous outcome variable—all of which were measured independently and without error. Equation 19.1 can be modified to handle a variety of other situations. For each of these modifications, however, the same model comparison approach applies, as does calculating w_i (AIC^C) and w_i (BIC) and interpreting effect sizes—although the nature of the effect sizes may change, depending on the model.

Aptitudes or Treatments with More than Two Levels It is not uncommon for aptitude or treatment variables to have more than two groups. Equation 19.1 can be modified to handle this situation. In general, if there are *G* groups, then *G-1* numerically coded variables are needed to represent the groups. While the *G-1* code variables will have their own effect and interaction terms, they really represent a single variable (e.g., treatment, aptitude). Thus, they need to be included or removed as a set when setting up the alternative models.

As an example, say that there are only two aptitude groups but three types of treatment: A, B, and C. Equation 19.1 needs to be modified accordingly

$$O = \text{Intercept} + x\text{A} + yC_1 + zC_2 + a(\text{A} \times C_1) + b(\text{A} \times C_2) + e \qquad (19.6)$$

where C_1 and C_2 are the two code variables that represent the three treatment groups.

The interpretation of the regression coefficients (i.e., *x*, *y*, *z*, *a*, and *b*) depends on the coding scheme used to represent the various categories (Wendorf, 2004). If the treatment variable was dummy coded to have T_A be the reference group, then C_1 and C_2 would be coded as

$$C_1 = \begin{cases} 0, \text{if Treatment A} \\ 1, \text{if Treatment B} \end{cases}$$

$$C_2 = \begin{cases} 0, \text{if Treatment A} \\ 1, \text{if Treatment C} \end{cases}$$

If the aptitude variable was coded such that A_1 was 0 and A_2 was 1, then the simplified equations become.

Aptitude One Treatment A (reference group)	O = Intercept + e
Aptitude Two Treatment A	O = Intercept + xA + e
Aptitude One Treatment B	O = Intercept + yC_1 + e
Aptitude Two Treatment B	O = Intercept + xA + yC_1 + a(A × C_1) + e
Aptitude One Treatment C	O = Intercept + zC_2+ e
Aptitude Two Treatment C	O = Intercept + xA + zC_2+ b(A × C_2) + e

Continuous Aptitude or Treatment Variables Neither the treatment nor the aptitude variables are required to be categorical. Either or both could be continuous or at least have enough possible values to approximate a continuous variable (e.g., Triandis, 1996). A continuous psychological treatment typically refers to a single treatment type with multiple doses (i.e., number of sessions).

If either the aptitude or treatment variable is continuous, centering the variables to minimize any possible problems with multicollinearity (i.e., predictor variables being too highly correlated)—as well as aid in interpreting the regression coefficients—is recommended. If the value of zero does not have any native meaning for the variable (i.e., complete absence), then mean centering the variable is the best option. This is done by subtracting the mean of the variable from each of the individual observed values. The value of zero for the new variable is the average value of the original variable. If zero is a plausible value

for the variable, then subtract a reference value from each of the observed values. For example, if a treatment typically has five sessions, but were studied using doses of four to ten sessions, then subtract five from each observed treatment value. The value of zero for the re-coded variable is the typical amount of the treatment.

The ATI analysis is generally the same if either the aptitude or treatment is continuous, although there are some differences. One major difference comes from creating the simplified equations. There are many values to choose from when setting the variable equal to a value, so choose values that will aid in the understanding of the results. If the aptitude variable has a directly interpretable metric, then it may provide sensible values (i.e., naturally formed categories). For example, if using family income, then the cut points may be the poverty levels or the different tax brackets set up by the IRS. If the variable's metric is completely arbitrary, then the values used are typically the mean and one or two standard deviations above and below the mean or the location of the crossover point of the interaction (Widaman et al., 2012). A different approach in this situation is to determine "regions of significance," which are the values of the continuous variable where groups differ (i.e., the Johnson-Neyman technique; Rogosa, 1980).

A second difference that arises when there are continuous predictors is the need to rule out the hypothesis that the interaction is not really masking a nonlinear relation (e.g., polynomial term) between a continuous predictor and the outcome (Lubinski & Humphreys, 1990; but see Shepperd, 1991). For example, say there are two versions a treatment: one that is administered individually and the other is administered in a group. The cultural variable of interest was clients' perception of their support network's individualism/collectivism, which was measured by aggregating scores from multiple items and creating a single continuous scale. It could be that being around individuals at either extremes of this variable (i.e., extremely individualistic or collectivistic) has a similar effect on the outcome, whereas being around individuals that are only moderately individualistic or collectivistic has a different effect. If this nonlinear relation between the aptitude and outcome was not properly modeled, then it could lead to (mistakenly) thinking that there was an interaction between the treatment and aptitude when an ATI did not really exist.

Count Outcomes It is not uncommon for a treatment outcome to be a count (e.g., number of times a behavior or thought occurred; Shadish & Sullivan, 2011). Such variables' distributions are typically not symmetrical, and much less follow a normal distribution. Thus, using a typical regression model is not appropriate because it violates the core assumptions that the error term follows a normal distribution. For count outcomes, it is best to use analysis techniques specifically designed for such data (e.g., Poisson regression).

The general setup of the models for count data is similar to Eq. 19.1, but the model has to be modified to account for the error term having a non-normal distribution as well as to prevent the regression model from predicting values lower than zero. Because of the modification involved, understanding the variable's effects is a bit trickier than with the model in Eq. 19.1. Beaujean and Morgan (2016) provide an introduction to regression models with count outcomes, and Atkins and Gallop (2007) provide a detailed example of interpreting a count regression with an interaction term.

Nested Data Sometimes treatments have to be administered in groups instead of individually. This is often the case in schools because teachers typically apply a treatment to multiple students concurrently (e.g., Chow & Gilmour, 2016) but also apply to group-administered clinical treatments (e.g., group therapy). Likewise, sometimes interest is in the change in the outcome across multiple treatment doses instead of just differences at the end of treatment (e.g., does the nature of the change process during treatment differ across groups; Muthén & Curran, 1997). In either situation, the outcome variable values are not independent of each other, which violate an assumption of the model in Eq. 19.1 (Kenny & Judd, 1986). Thus, Eq. 19.1 needs to be expanded to account for this nested nature of the data, which can be done though a multilevel model (Peugh, 2010).

Multilevel models are comprised of two or more equations, each representing different levels of the data. For example, say there were two treatments administered by teachers to their entire classrooms and the question of interest is if the treatment effects differed for students whose primary language spoken at home is not English. In this situation, students are nested within the classroom. Thus, the aptitude variable (primary home language) would be measured at the student level, but treatment would be measured at the classroom level. As another example, say multiple clinicians administered a treatment individually using a single-case ABAB design (i.e., baseline, treatment, treatment withdrawal, treatment). The question of interest is if the treatment effects differed according to the client's racial group membership. In this situation, treatment condition is nested within the client. Thus, treatment would be measured at the time level, but aptitude would be measured at the client level.

In situations requiring multilevel models, typically the ATI is between variables at different levels. This is called a cross-level interaction. While conceptually these interactions are similar to the interaction term in Eq. 19.1, the setup and interpretation are more complex (Aguinis, Gottfredson, & Culpepper, 2013). For those with nested data, Snijders and Bosker (2011) provide an introduction to analyzing multilevel models.

Multiple Outcomes or Unreliable Measures The ATI analysis methods presented in this chapter all assumed that all the variables were measured without error and there was only one outcome of interest. Having reliable scores might not be a tenable assumption for the outcome or cultural variable (there should not be any measurement error in the treatment variable). Ignoring the poor reliability in the measures can greatly reduce the magnitude of the coefficients in Eq. 19.1 (Ree & Carretta, 2006). Likewise, it is often the case that more than one treatment outcome is measured and the outcomes are related to each other. In such cases, it is better to analyze the outcomes together in a single model rather than multiple regression models as it allows for a better understanding of relation among the outcomes (e.g., does one outcome mediate the effect of another, and is this mediation process moderated by the aptitude variable?)

One way to handle measurement error or analyze multiple outcomes simultaneously is to use a structural equation model (Loehlin & Beaujean, 2017). The estimation of an ATI in structural equation models is much more complex than what is discussed in this chapter. Cortina, Chen, and Dunlap (2001), Edwards and Lambert (2007), and Marsh, Wen, Hau, and Nagengast (2013) all provide introductions to this area as well as some example analyses.

Example

Data

This section illustrates how to conduct an ATI analysis of treatment data. The data used in this example was simulated to represent a simplified version of clinical intervention study designed to examine the efficacy of a cognitive-behavioral therapy (CBT)-based intervention for depression in adolescents. Participants were randomly placed into one of two treatments: CBT or a placebo (i.e., a structured series of life-skills trainings). The researchers recorded the participants' race when they entered the study, which was used as the aptitude variable. For simplicity, only two races are used in this example: Black and White. The outcome variables are four norm-referenced measures of depression symptom severity (e.g., sadness/dysphoria, sleep difficulties, concentration difficulties, guilt/worthlessness), each of which have a population mean of 50 and standard deviation of 10.

On the book's accompanying website, there is a file called *atidata.dat* that houses data for this example. The data consists of 180 observations and 6 variables:

- One treatment variable (*treatment*)
- One aptitude variable (*aptitude*)
- Four outcome variables (*out1*–*out4*), each with a different relation to the predictors

What follows is an analysis of outcomes one (*out1*) and three (*out3*). Outcome one is the same

data used to create Fig. 19.1a, while outcome three is the data used to create Fig. 19.1c. The R syntax (R Development Core Team, 2016) used for analysis of outcome three is in the chapter's Appendix; the same syntax can be used for all the outcomes as long as the appropriate outcome variable name is substituted.

Typically, the first steps in any data analysis are to examine the data, clean it, determine if the models' assumptions are met, and examine any influential observations. These processes are well documented elsewhere (e.g., Andersen, 2012; Osborne, 2012). Consequently, these are not described for this analysis.

Since the aptitude and treatment variables are not numerically coded in the data, numerical versions of both variables are created using dummy coding. The placebo and White groups are set equal to zero, making White adolescents receiving the placebo the reference group for the analyses. Then, the interaction term is created by multiplying the two numerically coded versions of the variables together.

Results and Interpretation

For the analysis of outcomes one and three, the data is fit (separately) to the four basic ATI models, and for each model the AIC^C, BIC, their respective weights, and the R^2 effect size are calculated. The results for both outcomes are shown in Table 19.2.

For outcome three, both the AIC^C and BIC weights indicate that the ATI model has the strongest evidence out of the four models examined; both weights are >0.99. Moreover, adding the interaction terms explains an additional 5% extra variance in the outcome. The regression coefficients, as well as their 95% confidence intervals, for the ATI model are given in the top part of Table 19.3.

The regression coefficients in Table 19.3 are the *Intercept*, x, y, and z terms in Eq. 19.1. Consequently, substituting the regression coefficients values into the equation produces

$$\text{Outcome three} = 50.56 + 3.98\text{Aptitude} + \\ -7.84\text{Treatment} + 6.20\text{ATI} + e$$

Calculation of group means and interpretation of the results follow directly from the explanation in the *Analyzing Data from Aptitude-Treatment Interaction Studies* section. The group means (as well as their 95% confidence intervals) are shown in the bottom part of Table 19.3. The CBT group has lower values on outcome three than the placebo group for both White and Black adolescents, although the difference between treatments is much more pronounced with White adolescents than Black adolescents. Assuming lower values on the outcome indicate less severity, then the interpretation would be that CBT "works" for both the White and Black adolescents—even though there is an ATI. Unless the CBT intervention is very expensive, it would likely be the recommended treatment for both races, although the life-skills training placebo might also be an option for Black adolescents.

The results in Table 19.2 are more complicated for outcome one than they were for outcome three. As expected, the BIC favors the most parsimonious model (Intercept only), although it does not rule out the model with main effects for both treatment and aptitude. The AIC^C favors the model with main effects for both treatment and aptitude, although it does not completely exclude the model with an interaction.

While this situation might appear frustrating, it is not atypical for data encountered in the "real world." What to do in this situation? First, see where the fit measures agree: both indicate that a model including only a main effect for treatment is likely not a good representation of the data. Second, examine effect sizes. The R^2 value is the same (to the hundredths place) for the model with an interaction as it is for the model with only aptitude and treatment main effects. This indicates that the interaction term explains very little unique variance in outcome one. Thus, it is probably safe to conclude there is not an interaction in the data for outcome one.

The situation is now simplified for outcome one, going from four possible models to two: the model with no main effects (favored by the BIC) or the model with treatment and aptitude main effects (favored by the AIC^C, but not completely excluded by the BIC). To get a better

Table 19.2 Results from fitting four aptitude-treatment models for example data, outcomes one and three

Model	AIC^C	BIC	AIC^C weight	BIC weight	R^2
Outcome one					
Intercept	762	769	0.06	0.54	0.00
Treatment	762	771	0.08	0.16	0.02
Aptitude + Treatment	757	770	0.64	0.28	0.05
Aptitude + Treatment+ ATI	759	775	0.23	0.02	0.05
Outcome three					
Intercept	1211	1217	0.00	0.00	0.00
Treatment	1191	1200	0.00	0.00	0.12
Aptitude + treatment	1129	1142	0.00	0.01	0.38
Aptitude + treatment+ ATI	1116	1132	>0.99	>0.99	0.43

Note. AIC^C, corrected Akaike information criterion; BIC, Bayesian information criterion. Both the AIC^C and BIC are rounded to the nearest integer

Table 19.3 Regression coefficients and group means for example data, outcome three

Term	**b**	**95% Confidence interval**
Intercept	50.56	49.00–52.11
Aptitude	3.98	1.78–6.18
Treatment	−7.84	−10.04–5.65
ATI	6.20	3.09–9.31
Groups	**Mean**	**95% Confidence interval**
Placebo, White	50.56	49.00–52.11
Placebo, Black	54.53	52.98–56.09
CBT, White	42.71	41.15–44.27
CBT, Black	52.89	51.33–54.44

Note: b, unstandardized regression coefficient. CI, confidence interval. Aptitude coded as 0 = White, 1 = Black. Treatment coded as 0 = placebo, 1 = cognitive behavior therapy (CBT)

understanding of both models, Table 19.4 contains the regression coefficients, means, and 95% confidence intervals for both models.

The results in Table 19.4 indicate there is little difference in the means between treatments or aptitudes. The regression coefficients for the aptitude and treatment variables are small (the absolute value for both is <1) considering the outcome has a mean of 50 and standard deviation of 10. This translates to minimal mean differences between the four groups. The mean for all individuals if main effects are not considered is 50.01. If main effects are considered, then the group means only range from 49.40 to 50.62. Thus, little information is lost by assuming that there are no group differences (either treatment or aptitude) on outcome one and selecting the Intercept model for this data.

Table 19.4 Regression coefficients and group means for example data, outcome one

	Intercept		Aptitude + Treatment	
Term	**b**	**95% CI**	**b**	**95% CI**
Intercept	50.01	49.72–50.30	50.13	49.64–50.63
Aptitude	–	–	−0.73	−1.31–0.16
Treatment	–	–	0.49	−0.09–1.06
Groups	**Mean**	**95% CI**	**Mean**	**95% CI**
Placebo, white	50.01	49.72–50.30	50.13	49.64–50.63
Placebo, black	50.01	49.72–50.30	49.40	48.90–49.90
CBT, white	50.01	49.72–50.30	50.62	50.12–51.12
CBT, black	50.01	49.72–50.30	49.89	49.39–50.39

Note: b, unstandardized regression coefficient. CI, Confidence interval. Aptitude coded as 0 = White, 1 = Black. Treatment coded as 0 = Placebo, 1 = Cognitive behavior therapy (CBT)

Summary

Determining if a psychological treatment works is a difficult endeavor. New treatments do not always work better than what is usually done—and sometimes are even iatrogenic. Consequently, it is important to investigate treatments in a scientific manner. This chapter focused on one aspect of this investigation: do treatment effects differ across population subgroups?

This chapter discussed some theoretical and study design issues related to investigating

differences in treatment effects but largely focused on the analysis data from such studies. Specifically, it focused on an approach that sets up a priori statistical models representing different effects of treatments and population subgroups (e.g., models with and without aptitude-treatment interactions) and then testing these models empirically. Although a somewhat formidable approach, this should not detract from efforts to advance research in this area and, ultimately, improve the quality of treatments available for individuals in all population subgroups.

Appendix

On the Open Science Framework website (http://dx.doi.org/10.17605/OSF.IO/68HFU), there is a file called *atidata.dat* that houses data simulated for this chapter. It is a comma-delimited text file with variable names in the first row. The Open Science

```
# import data
ati.data <- read.csv("atidata.dat",header=TRUE)

# create dummy codes for variables
ati.data$treatment.c <- ifelse(ati.data$treatment=="Placebo",0,1)
ati.data$aptitude.c <- ifelse(ati.data$aptitude=="White",0,1)

#create interaction term
ati.data$ati  <- ati.data$aptitude.c * ati.data$treatment.c

#analysis of four regression models for outcome 3
model.1 <-lm(out3~1, data=ati.data)
model.2 <-lm(out3~treatment.c, data=ati.data)
model.3 <-lm(out3~aptitude.c + treatment.c, data=ati.data)
model.4 <-lm(out3~aptitude.c + treatment.c + ati, data=ati.data)

#regression coefficients, 95% confidence intervals, and R2 for each model
summary(model.1); confint(model.1, level=.95)
summary(model.2); confint(model.2, level=.95)
summary(model.3); confint(model.3, level=.95)
summary(model.4); confint(model.4, level=.95)

#corrected AIC and BIC
library(AICcmodavg)
AICc(model.1); BIC(model.1)
AICc(model.2); BIC(model.2)
AICc(model.3); BIC(model.3)
AICc(model.4); BIC(model.4)

#AIC weights
aic <- c(AICc(model.1), AICc(model.2), AICc(model.3), AICc(model.4))
delta.aic <- aic - min(aic)
L.aic <- exp(-0.5 * delta.aic)
aic.weights <- L.aic/sum(L.aic)
aic.weights

#BIC weights
bic <- c(BIC(model.1), BIC(model.2), BIC(model.3), BIC(model.4))
delta.bic <- bic - min(bic)
L.bic <- exp(-0.5 * delta.bic)
bic.weights <- L.bic/sum(L.bic)
bic.weights

# means and 95% CI for each group of the final model (Model 4)
new.data <- data.frame(aptitude.c = c(0, 1,0,1), treatment.c = c(0, 0,1,1),ati=c(0,0,0,1))
predict(model.4,new.data, interval = "confidence", level=.95)
```

Framework website also contains **R** syntax for the analysis of an aptitude-treatment interaction:

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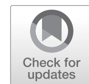
Part IV

Cultural Competence Issues with Special Populations



20 Contemporary Issues in Latino Communities

Lorraine T. Benuto and Brian D. Leany

Latinos constitute the largest minority group in the United States making up approximately 17% of the total US population (US Census Bureau, 2016). The Center for Disease Control defines Latinos and Hispanics as peoples of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race." In addition to nationality, there is substantial heterogeneity among Latinos with regard to immigrant status, English-language fluency, acculturation level, and even language background (Portuguese vs. Spanish) among other factors.

In the United States, persons of Mexican origin comprise the largest proportion of Latinos (almost two-thirds), with the remaining third distributed primarily among persons of Puerto Rican, Cuban, and Central American origin (US Census Bureau, 2010). With regard to immigrant status, 6% of the total US population are immigrants; thus a large number of Latinos are Spanish speakers. In fact, 78% of Hispanics aged 5 and older speak Spanish as their primary language in the home (Weil, 2010), and less than half of Hispanic immigrants residing in the United States have *even* limited English language proficiency (Pew Hispanic Center, 2012). Latinos are clearly a heterogeneous with regard to nationality, immigration status, and language preference and proficiency. The bulk of the literature on Latinos places emphasis on Latino cultural characteristics (i.e., heavy emphasis on the family), yet this group faces many unique contemporary issues in this country. These include issues regarding immigration status, acculturation, self-identification, language, poverty, discrimination, and access to healthcare. These are discussed below.

Self-Identification

In 1976, the US Congress passed the only law in this country's history that mandated the collection and analysis of data for a specific ethnic group: "Americans of Spanish origin or descent." The language of that legislation described this group as "Americans who identify themselves as being of Spanish-speaking background and trace their origin or descent from Mexico, Puerto Rico, Cuba, Central and South America and other Spanish-speaking countries." Standards for collecting data on Latinos were developed by the Office of Management and Budget (OMB) in 1977 and revised in 1997. Using these standards, schools, public health facilities, and other government entities and agencies keep track of how many Latinos they serve (which was a primary goal of the 1976 law). However, the Census Bureau

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does not apply this definition in counting Latinos. Rather, it relies entirely on self-reporting and lets each person identify as Latino or not. A 2006 survey by the Pew Hispanic Center found that 48% of Latino adults generally describe themselves by their country of origin first, 26% generally use the terms Latino or Hispanic first, and 24% generally call themselves American. As for a preference between "Hispanic" and "Latino," a 2008 Center survey found that 36% of respondents prefer the term "Hispanic," 21% prefer the term "Latino," and the rest have no preference.

In addition to self-identifying as Latino vs. Hispanic, Latinos may also self-identify with their nationality. Self-identification is an important topic because of the heterogeneous nature of this group and also because it is relevant to psychological development. Brittian, Umana-Taylor, and Derian (2013) illustrated how according to social identity theory people maintain a positive identity through their group membership and ethnic identity specifically involves a person's sense of belonging to an ethnic group. They indicate that ethnic identity is a key component of psychosocial development, and it may serve as a resource for people who experience discrimination or inequitable treatment. Because the Latino population is so heterogeneous, identity is equally variable. With 20 of Latin American countries, Latinos can have a large variety of identities. Indeed, it is important to note that individuals from different countries will have different histories and cultural experiences. While some of these differences may be as nuanced as differences in food, these differences can be substantial. For example, Colombia has a long history of civil conflict (BBC, 2013), and since 2003, the panorama of Mexico has experienced drastic changes with the advent of the drug cartel (Wood, 2014). Thus, self-identify may not only be impacted by the person's country of origin but also the unique historical factors that are specific to their country of origin (and also by the time period during which they lived in their country of origin). Relevant to self-identity is acculturation, which is discussed below.

Acculturation

Acculturation occurs when two or more cultural groups come in contact with each other and cultural and psychological changes occur as a result. These changes may include adaptation to the host culture, maintenance of the cultural practices and values of culture of origin, or a combination of both (Berry, 2005). Forster and colleagues (2015) discussed how the acculturation process is not a linear process (whereby immigrants assimilate exclusively to White American mainstream culture) but rather a nonlinear process where immigrants assimilate into *sectors* of American society. The acculturation process may be "(a) *selective*—those who experience rapid economic and social success while preserving heritage values; (b) *consonant*—groups who acculturate to U.S. middle-class values, practices, and status through academic achievement and business success; or (c) *dissonant*—if children adopt the majority culture's language, practices, and values faster than their parents" (Forster et al., 2015). A related phenomenon is referred to as acculturative stress. This simply refers to a stress reaction to the life events that are related to the acculturation process (Berry, 2005).

The acculturation process can be challenging. While certainly the tasks of acquiring a new language and being exposed to different foods and cultural customs can be stressful, the loss of the customs of the host culture can present challenges for the individual. Behrens, del Pozo, Großhennig, Sieberer, and Graef-Calliess (2015) discuss how the acculturation process can be likened to (a new) fundamental developmental task that involves integrating two different cultures. Because the person must integrate two different cultures, s/he must make fundamental changes to his/her identity, which puts the person at increased risk for emotional vulnerability. Individuals who are undergoing the acculturation process (either because they are immigrants or because their social support system embraces the culture of origins' values and traditions) must make changes to their identity, which can create distress.

A link has been noted between acculturation and prevalence of mental health disorders such as

depression (Henkin et al., 2011; Ramos, 2005; Torres, 2010), and US-born Latinos have been noted across the board to have higher rates of mental health disorders, including depression and anxiety (Alegria et al., 2008). Thus, acculturation may play a role in the development and/or maintenance of mental health conditions as the acculturation process may result in added stressors or maladaptive coping and may result in a loss of indigenous protective factors (Alamilla, Kim, & Lam, 2010). Regardless of immigrant status, Latinos may experience some form of the acculturation process, and there may be large variations across Latinos in terms of how acculturated they are and and/or how closely they relate to their culture of origin.

Immigration Status

Approximately 6% of the total US population are Latino immigrants. Specifically of the 54 million people in 2013 who self-identified as Hispanic or Latino, 35% (19 million) were immigrants (defined as changing countries in their lifetime) (Zong & Batalova, 2016). Latinos who are American citizens may be born in the United States to citizens or to undocumented Latino parents or they may have obtained citizenship through the naturalization process. Latinos who are not American citizens may have legal residency or may be unauthorized to live in the United States. Of those Latinos who are unauthorized to live in the United States, they may have entered the country undocumented as adults or as small children or they may have entered the country with legal documentation as adults or small children but "overstayed" their visa. These individuals may be referred to as undocumented, unauthorized, or as illegal immigrants. Each of these individuals presents with unique life experiences, which are detailed below.

Undocumented Latinos

As indicated above, undocumented Latinos (like other immigrants) may have entered the country undetected or they may have entered the country legally but overstayed their visa. Visas are typically granted on a tourist basis and statistics suggest that 40% of undocumented immigrants overstayed their visa (Murray, 2013). In 2014, there were 11.3 million unauthorized immigrants in the United States with Mexicans making up 49% of the unauthorized immigrants in this country (Krogstad & Passel, 2015). Undocumented Latinos have a diverse range of experiences with regard to how they arrived in this country and also with regard to how their immigration status impacts their day-to-day lives and overall functioning in the United States.

Why Immigrate? As described earlier in this chapter, a large number of individuals leave their home country to migrate to the United States. While the country of origin may best dictate why people immigrate (i.e., some Latinos immigrate to the United States because of political circumstances in their home country), undeniably economic variables play an important role in the decision to migrate illegally (Ryo, 2013). Thus, the decision to cross the border illegally may be largely rooted in a person's economic situation. The living conditions across Latin American are hugely variable with some Latin American countries being poorer than others and living conditions ranging from a reasonable home (by American standards) to a home that is made from cardboard and scrap metal without any plumbing. With regard to income and wages, as an example, let's consider Mexico. The average monthly wage in Mexico has remained relatively stable since 1992 and is a whopping $412 a month (Montes, 2014). While the cost of living in Mexico is certainly lower in Mexico than in the United States, $412 is not a sufficient amount of money to survive on. Thus, the majority of Latinos immigrate to the United States in hopes of an improved economic situation. While they may arrive to the United States and work in low-paying menial jobs, those wages are sufficient for them to feed themselves and send money back to their home country so that their families can eat as well. Alternatively, Latinos may also migrate to the United States in the hopes of saving money and

ultimately returning to their home country with sufficient money to build a small house or open a small business.

Crossing the Border Crossing the border illegally can be a dangerous endeavor. Individuals who embark on this perilous journey are at risk of being robbed, assaulted, made to carry drugs across the border, or murdered. Individuals who cross the border illegally have been known to die from heat exhaustion, dehydration, or drowning. In 2012, 477 immigrants died along the US Mexico border (Rueda, 2013).

The majority of individuals who cross the border illegally use the assistance of a *coyote*. The *coyote's* job is to guide the person across the border. The coyote industry is substantial, and a single operation requires a multitude of individuals. These individuals may be responsible for taking people to safe houses, driving individuals from one location to another, walking people across the border, watching for border patrol to alert the *coyote* who is doing the actual crossing, tracking border patrol patterns so that they can estimate the best time to cross, transporting the person to their family member once they have crossed the border, etc. *Coyotes* are typically found via word of mouth and are expensive. Ten years ago the price for a *coyote* was approximately $2,000. The current rate for a coyote is well above $7,000. The following case example illustrates what Latinos may experience as they cross the border illegally.

> Ten years ago Jose and Carmen decided to come to the United States with their 1-year-old son, Paco. Jose contacted his uncle who had recently crossed the border, and his uncle referred him to a coyote. Jose contacted the coyote via phone and the coyote asked him who had referred him. Once the coyote determined that Jose had been referred by someone he knew, he and Jose negotiated a price for the crossing of their family of three. Around 4 am on a spring day in a Latin American country, Jose, Carmen, and Paco said goodbye to their family. There were tears, hugs, blessings, and well-wishes. Each family member had no idea if they'd ever see each other again. The family took a bus and then an airplane to Tijuana. Once they landed they took a taxi to the location where they were supposed to meet the coyote. They waited approximately 4 hours, and the coyote arrived and took them to a safe house. Paco was then taken by one of the coyotes across the US/Mexican border using the birth certificate of a US-born child. He was taken to Los Angeles to a family member who he had never met. Jose and Carmen struggled to get across the border and were separated from their son for 3 weeks. They were apprehended in the desert four different times, and on one occasion, they were separated by immigration and taken on different buses to different border crossing points. Neither one of them had a cell phone, but they both managed to make it back to the safe house so that they could attempt to cross again. On their last attempt, they lay in the dirt, in the middle of the desert looking at the sky and feeling sad and terrified both at the same time. They wondered where their son was, if indeed he had been taken to Carmen's family, and they prayed that nothing had happened to him. They spent several days in the desert crossing rugged terrain, stripping down to their underwear to cross a river while carrying their clothes above their head to keep them dry, feeling dehumanized by the process and wondering if this journey was really worth it. Eventually, they were reunited with their son who they observed had lost weight and seemed distant. Carmen ruminated that something bad had happened to him. They continued their journey to Jose's uncle's where they arrived dirty, hungry, and emotionally numb. Over the last 10 years, they've built a life here and sent money back to their home country where they are constructing a house that they hope to return to someday. Carmen misses her family terribly and struggles with bouts of depression and both of them wonder if they should stay or go back. They both worry about Paco—while he speaks Spanish, they worry what it would be like for him to go to a country that he doesn't even remember.

While Jose and Carmen certainly suffered when they crossed the border and they continue to struggle with being apart from their family, there are worse circumstances that can occur during a person's journey to the United States. It is not uncommon for individuals who cross the border to be assaulted and robbed as was the case for Maria.

> Maria's sisters left their home country when she was very young. In her early 20s, she asked them to bring her to the United States. They hadn't seen her in 15 years but they loved her dearly, and so they worked hard to gather the $10,000 it would cost to get her to the United States. Maria had to cross several borders to arrive in Mexico, and with each crossing, she utilized the assistance of a coyote until she finally arrived at the Mexican-United

States border. Generally speaking she had crossed with ease and was looking forward to the end of the last leg of her journey and being reunited with her sisters. As she embarked in a group of six people and two coyotes, she felt hopeful—she was almost at her destination. That night she had to sleep on the desert floor as they waited for immigration to clear from the area that they needed to get through. As she lay sleeping, she felt someone shake her awake. She awoke startled and observed the coyote covering his lips with his finger in a gesture that she should be quiet. Fearful that immigration was nearby, she remained silent as the coyote led her through the desert. Suddenly she felt fearful; why was he leading her away from the group? She felt helpless, afraid, and trapped. Finally, he stopped as they approached the other coyote who had been with their group. She was sexually assaulted by both of these men. She did not scream or fight as she was terrified for her life. After they assaulted her, they threatened her, telling her that if she didn't keep this to herself that they would leave her in the desert to die. The next day Maria was apprehended by immigration. She was relieved to be away from the coyotes and felt safe for the first time since being assaulted. While she was processing through the deportation process, she told an immigration officer what had occurred and was taken into protective custody. She now is going through the U visa process.

Undocumented Women: VAWA and the U Visa The case of Maria introduces specialized visas that are available for individuals who are unlawfully in the United States but meet certain criteria. Specifically, there are two pieces of legislation that are designed to help individuals who are undocumented in the United States: the U nonimmigrant status visa (U visa) and the Violence Against Women Act (VAWA). According to the US Citizenship and Immigration Services (n.d.), the U visa "is set aside for victims of certain crimes who have suffered mental or physical abuse and are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity." Conyers (2007) provided an overview of the Violence Against Women Act's (VAWA) history indicating that in 1994 VAWA was authorized and provided protection for battered immigrants. The original focus was largely on interpersonal/domestic violence but since then has expanded to offer protection for victims of sexual crimes and their family members (e.g., a parent of a child who has been sexually abused can petition for legal status under VAWA) among other classes of victims. Specifically, Conyers asserted that, "…VAWA 2005 expanded protections to a broader class of victims by reauthorizing and increasing funding for programs that offer help to victims of domestic and dating violence, sexual assault, and stalking." Moreover, protection for victims of crime was enhanced by making it possible for undocumented secondary victims to remain in the United States or for petitioners to bring their loved ones from their home country to the United States. Maria, in the scenario described above, was able to file a petition for a U visa.

The expansions under VAWA highlight implications for different classes of victims to benefit under this legislation. With regard to what is (empirically) known about why undocumented women do not report incidents of interpersonal violence, it has been noted that perpetrators of interpersonal violence may use immigration laws and the threat of deportation to control, manipulate, and perpetrate additional violence against the victim (Lindhorst and Tajima, 2008) and that Latinas need to be aware of resources and protections available to them via VAWA (Conyers, 2007). Researchers have identified that there are barriers to disclosure for ethnic minority females and their families including possible economic dependence on the perpetrator, fear of not being believed because of their ethnic minority status, belief that their silence protects ethnic minority boys and men from racially biased criminal justice systems, and distrust of social and legal agencies (Tyagi, 2002). The possibility of deportation disempowers immigrant women, who are often afraid of losing children (Erez & Hartley, 2003). This latter assertion may explain why some mothers choose not to report crimes that are committed against their children.

There are no specific studies on sexual assault or abuse with migrants and why some women choose to report such crimes and others do not. The most relevant studies identified were on sexual harassment and on treatment-seeking

behaviors of immigrant victims. With regard to the former, Morales-Waugh (2010) examined the sexual harassment experiences of Mexican immigrant farm-working women. She found that her participants were aware that their financial situation was unstable and that their poverty was used as a leverage of power against them by their perpetrators. An astounding 88% of her sample had experienced some form of sexual harassment. Interestingly, 22% of her sample reported that they had not told anyone that they were being sexually harassed at work and that they experienced feelings of anxiety and fear of retaliation. Reasons for this included fear that their husbands would blame them and concern that rumors and gossip would impact their reputation or cause them to lose their jobs. Morales-Waugh also described that farm-working women may not receive the same protective factors of social support because of economic and family responsibilities.

With regard to the latter, Benuto and Bennett (2015) described a case study where an undocumented Latina woman was treated for PTSD after she witnessed her child being sexually assaulted. They noted that there were several factors that made the case complex including her undocumented status and limited social support system (she had no friends and all of her family lived out of state or in Latin America). The client was extraordinarily socially isolated (she could not travel to see her family or they could not travel to see her as none of her family members possessed a visa to travel to the United States). Moreover, her financial situation (she was financially dependent on her ex-boyfriend, and after he was arrested, she had to rent a room from someone she had met at church), lack of mastery of English, and undocumented status made it difficult for her to find employment. Both of these studies highlight that undocumented women face unique challenges when sexual crimes are committed against them and/or their children. For women who are victims of domestic violence or sexual assault, legal assistance may be key in their recovery.

Working in the United States as an Undocumented Immigrant Immigrants who are undocumented have experiences that are unique. While some undocumented immigrants may work for cash pay (oftentimes for well below minimum wage), many utilize fake documents to obtain employment. Undocumented immigrants are US taxpayers and also contribute to social security and unemployment (although they cannot make withdrawals from either of these). In 2010, undocumented immigrants paid an estimated $10.6 billion in state and local taxes. Their undocumented status disqualifies them for most public benefits (i.e., welfare, food stamps, Medicaid, etc.) (Santana, 2014). Additionally, immigrants who are undocumented may be victimized by their employers by working long hours for low pay and run the risk of their employers calling immigration on them if they speak up and complain (Harris, 2013). Indeed, the threat of deportation can be used against workers who try to unionize or complain about safety standards or stolen wages (Smith, 2013). As described above, women in particular may have their poverty used as a leverage of power against them by their perpetrators (Morales-Waugh, 2010). Undocumented workers may experience abuse and be exposed to occupational hazards putting them at risk of death and work-related injuries including musculoskeletal injuries, joint pain, burns, lacerations, and crush injuries (Arellano-Morales, Liang, & Rios-Oropeza, 2016). Racism and discrimination is also an issue that this population faces in the workplace (see below for a discussion on this).

Recent Immigrants Earlier, the process of acculturation and acculturative stress were discussed. While both the acculturation process and acculturative stress are relevant to all Latinos, recent immigrants may be more susceptible to acculturative stress, as demonstrated in the case of Jesus:

> Jesus is a 25-year-old Mexican male who has just immigrated to the United States. He left his small Mexican village in Central Mexico as there were no employment opportunities there, and he had grown tired of watching his wife struggle to feed his small children. He also bore the responsibility of helping his extended family and felt like a failure because he couldn't feed his small children much less contribute to his aging parents' household. He left his small village with nothing more than a small backpack and $100 that his brother had sent him from the United States. He trekked

across Mexico taking buses and an airplane to the border where he was picked up from the airport by a coyote. The coyote had already been paid for by his brother. Jesus had some good luck and some bad luck. The good luck was that it took him only three tries to get across the border. The back luck—it took him three tries to get across the border and the two failed attempts occurred after he had spent several days in the middle of the desert with little water and no food only to be picked up by la migra and taken back to the Mexican side of the border. The third time he attempted to cross the border was a success, but in the middle of the desert, he and his fellow Paisas and the coyote had been accosted by gangs and the $100 and his shoes had been taken from him. Thus, he arrived to the United States 20 pounds lighter, with no money, and barefoot.

The case of Jesus illustrates how recent immigrants may arrive to the country distressed. In the case of Jesus, the actual crossing was distressing and so was leaving his family. As discussed earlier in this chapter, the acculturation process can cause stress. Recent immigrants are bombarded with new foods, new language, and a loss of the host culture and are typically distanced from their family. They often arrive to the United States without any money and are unable to access social service programs. They may also face challenges in accessing employment due to their lack of legal status in the United States. Ibanez and colleagues (2015) discussed how both the pre-immigration context (e.g., the reason for the immigration) and the post-immigration context (e.g., the degree to which the host culture is open to the immigrant group) can impact the acculturation process. Thus, a recent immigrant may experience challenges and stressors that are unique and specific to the recency of their arrival.

Non-DREAMers In addition to the U visa and VAWA legal processes discussed above, there is another relevant legislation.

Sandra was brought to the United States by her parents when she was 3 along with her four older siblings. Sandra's family placed a large premium on education, and while they lived in poverty in a small two-bedroom apartment, both of her parents worked hard so that she and her siblings could focus solely on school. Sandra watched as each of her brothers and sisters graduated from high school and went on to work their way through college, paying out-of-state tuition all throughout. As Sandra was approaching her senior year, it became evident that she would be valedictorian at her school. Her family could not have been prouder. This honor also came with a huge benefit—free tuition at one of the state schools. Unlike her siblings, who took 8 years to finish their degrees because they had to attend part time given the soaring costs of out-of-state tuition, Sandra would be able to finish her degree in a mere 4 years and planned on attending medical school thereafter. Unfortunately, Sandra did not qualify for the scholarship as she did not have a valid Social Security number. This did not defeat her—Sandra spent 3 years at community college and then 2 years at a state school and graduated with honors from a premed program. Feeling highly accomplished, Sandra applied for medical school. Unfortunately, her academic pursuits ended there. Without a valid Social Security number she was not able to gain acceptance to medical school. Sandra also did not qualify for DACA (discussed below) as by the time the policy was implemented, she was over 31. She remains in the United States, undocumented and underemployed.

This vignette highlights some of the issues faced by adults who were brought into the United States as children and who remain in this country illegally. There has been some recent legislation that has benefited members of this group (this is discussed below) although not all individuals qualify (as illustrated in the vignette above).

Documented Latinos

US-Born Latinos, Permanent Residents, and Naturalized Citizens Two-thirds of Latinos (64%) living in the United Sates were born in the United States (Zong & Batalova, 2016). All US-born Latinos are US citizens by birth regardless of whether their parents are legal residents, US citizens, or undocumented citizens in the United States. Approximately, 7% of K-12 students have at least one unauthorized immigrant parent (Krogstad & Passel, 2015). US-born Latinos have access to all rights and privileges of any American citizen (as they are American citizens), but these individuals do experience issues that undocumented Latinos experience as well. This includes issues related to acculturation, self-identity, etc. which are discussed above. US-born Latinos are not immune to the acculturation process or acculturative stress. In fact, US-born

Latinos may experience acculturative stress related to incongruent cultural values and practices, language difficulties, and discrimination (Santiago, Gudino, Baweja, & Nadeem, 2014). Consider the case of Carlitos:

> Carlitos is a 12-year-old US-born Latino. His parents are both undocumented immigrants. At home Carlitos' family all speak Spanish, they eat traditional Mexican foods, and they engage in traditional Mexican customs. When Carlitos started school, he did not speak English and the school he attended was attended by mostly White, English-speaking children. The other children at his school experienced him as odd—he didn't speak English and his parents were not involved at his school as they did not speak English. He struggled to make friends, was teased, and did not excel academically because of the language barrier. Over the course of elementary school, Carlitos acculturated to the culture at school—he learned English and began fitting in with the "White" kids—they even began to refer to him as Charlie. When Carlitos was 10, the family moved to a predominately Latino neighborhood putting Carlitos in a school with other Latino children with similar backgrounds. These children rejected Carlitos and teased him for being "White," mocked his Spanish, and laughed when he introduced himself as Charlie. Carlitos again felt isolated and alone. Around this same time, Carlitos' mom began having health problems. Because she did not speak English and Carlitos did, she took him to her doctor appointments and had him act as a translator. This caused Carlitos a great deal of distress (which he concealed from his mother because he was worried about her) as he learned more and more about his mother's illness and about his family's inability to pay for her treatment.

This case illustrates the issues with acculturation, self-identity, language barriers, and acculturative stress that US-born Latinos may experience. It also illustrates how family language barriers can impact Latino children and adolescents. Language brokering (using a child or adolescent as an interpreter, to assist in navigating across cultures, to act as an advocate for the family, and to mediate relationships) is common with 70–90% of children or adolescents (Guan & Shen, 2015). While this can be congruent with Latino cultural values of family obligation, depending on the context, this can have iatrogenic effects on the child or adolescent (as in the case illustration of Carlitos).

Also worth mentioning, US-born Latinos have been documented to have substantially higher rates of mental health disorders particularly anxiety and depression than their foreign-born counterparts (Alegria et al., 2008). In addition to US citizens, documented Latinos also include those Latinos who possess permanent residency or those who are naturalized citizens. These individuals also may experience issues related to acculturation and self-identity.

DREAMers The Latino immigrant group that merits discussion in this chapter are DREAMers. The following case example illustrates the phenomenon of being a DREAMer.

> Julio is a 20-year-old Latino who is in college. He was brought to the United States as an infant. His mother spent 3 days with him in her arms as she crossed the border through the desert to join Julio's father who had come to the United States a few months ahead of her. Julio speaks both English and Spanish fluently, and while he identifies strongly with his Latino roots, he has no memories of his birth country. Julio's family is hardworking, and at a very young age, it became clear that Julio was very bright. Julio went through elementary, middle, and high school actively involved in student government and sports. He excelled academically, and in his adolescence, his parents worried about how they would send him to college. As a DREAMer Julio is able to attend college (he is majoring in engineering) although not without challenges. While the Deferred Action for Childhood Arrivals (DACA) policy allows Julio to be in this country and work, he does not qualify for most financial aid. He also worries about the renewal of DACA and wonders whether he will be able to work as an engineer when he finishes college.

The term *DREAMer* is a newer term that was born out of the proposed (but not passed) Development, Relief, and Education for Alien Minors (DREAM) Act (American Immigration Council, 2012). The DREAM Act was originally proposed in 2001 as a path for undocumented immigrants who arrived in the United States as children to permanent legal status provided that they attended or graduated from an institution of higher learning, be under 30, were physically in the United States for a specified number of years, had good moral character, and had not violated any additional immigration laws (LawLogiz, 2013).

Since then the Deferred Action for Childhood Arrivals (DACA) policy was created in 2012 by President Obama. The DACA grants deferred deportation to people under age 31 who came to the United States when they were younger than 16 years of age and meet other criteria. Individuals, who apply for and qualify for DACA, are allowed to remain in the United States legally, apply for employment authorization, and receive a Social Security number. The DACA provides legal presence, but not legal status and only lasts 2 years, but can be renewed. As illustrated in the case example above, this legislation has created positive benefits for immigrants who were brought to the United States illegally as children. They are able to work and cannot be deported, and many institutions of higher education no longer require these individuals to pay out of state tuition. Despite these benefits, DREAMers still remain concerned about their uncertain future in this country. As illustrated in the vignette, Julio remains concerned about the elimination of the DACA policy and worries that he may not be able to work as an engineer if the policy is eliminated after he graduates. Because he does not qualify for most financial aid, his family struggles to pay his tuition.

Racism and Discrimination

Regardless of a Latino's legal status, racism and discrimination in the United States against Latinos remains a problem. In terms of the prevalence of discrimination, 25% of Latinos report having experienced discrimination in their place of work, in dealings with police, while getting healthcare, and at an entertainment venue such as a bar or restaurant and/or at a store while shopping (McCarthy, 2015). Moreover, 32% Latino/Latinas reported that a family member or a close friend had experienced discrimination in settings such as school and/or the workplace (Pew Hispanic Center, 2009). Arrellano-Morales and colleagues (2016) discuss how the chronic experience of racism is a risk factor in the development for depression, isolation, and psychological distress. They further discuss how discrimination may be based on phenotypic characteristics (i.e., skin color) or cultural characteristics (i.e., language). Arrellano-Morales and colleagues highlight how undocumented Latino immigrants report more experiences of racism than Latinos who are born in the United States and how race-related stressors are amplified among undocumented Latinos because of prolonged exposure to stress and constant fear of being deported. Discrimination is not isolated to the workplace and has been documented to occur in the educational system, healthcare settings, and housing sector (Alamilla et al., 2010).

In most metropolitan areas, there are neighborhoods with concentrated Latino populations. These neighborhoods may include stores, restaurants, etc. that are specific to the Latino community. While in these neighborhoods acculturation may occur at a lesser rate than in other neighborhoods and Latinos may feel insulated from mainstream American culture, other issues may exist. For example, over one-third of Latinos report that they live within a mile of areas that they are scared to walk in at night; this is not surprising given the high rates of gang participation and with homicide as a leading cause of death (Malavé & Giordani, 2015).

Language

Given the large number of Latinos who are immigrants, it is not surprising that a large portion of Latinos don't speak English. Approximately 78% of Hispanics aged 5 and older speak Spanish as their primary language in the home (Weil, 2010), and less than half of Hispanic immigrants residing in the United States have *even* limited English language proficiency (Pew Hispanic Center, 2012). These statistics illustrate an important contemporary issue that Latinos face—language barriers. Not having mastery of the English language makes it challenging for Latinos to access healthcare, impacts their ability to be employed, and can impact how others perceive and treat them. As discussed earlier in this chapter, the language barrier can also create challenges for English-speaking Latino children and adolescents who may be used for language brokering.

Poverty

Latinos are disproportionately impacted by poverty and have lower household income than Whites in this country. The poverty rate for Latinos is 24% compared to 10% for non-Hispanic Whites with 10% of Latinos living in deep poverty defined as having an income of 50% below the federal poverty level. The median income for Latino households is $42,291, which is substantially lower than the median income of White, non-Hispanic households ($60,256: Feeding America, n.d.). Despite these high levels of poverty on 10% of Latino households receive SNAP benefits compared to 40% of White, non-Hispanics (Feeding America, n.d.). While the effects of poverty apply to all individuals who live in poverty (not just Latinos), it is worth noting that effects of poverty are substantial. The effects of poverty include substandard housing, homelessness, inadequate nutrition and food insecurity, lack of access to healthcare, unsafe neighborhoods, under-resourced schools, poor academic achievement, and physical health problems to name a few (American Psychological Association, 2016). Moreover, the barriers that Latinos experience, with regard to access to healthcare, are all largely related to socioeconomic status (Benuto & Leany, 2011). While Latinos may be perceived as upwardly mobile given that they move from making $412 a month (Montes, 2014) to earning (at a minimum) nearly triple that amount (based on the US federal minimum wage), ethnic income disparities in this country continue to be substantial with the median household income in the United States at approximately $51,400; Mexican families only earn an average of $38,000 per year (Ferdman, 2014). Richwine (2015) highlights what he describes as "downward assimilation"; while there is an initial spike up, very quickly Latinos move down the socioeconomic ladder. Specifically, Lucas describes that, with regard to education, only 12% of Latino immigrants have a 4-year college degree (compared to 37% of White adults). Among second-generation Latinos, the rate of college graduation goes up to 23% but then decreases to 18% in the Latino "third-plus" generation (meaning US-born with two US-born parents). This pattern extends beyond education and is observed with regard to income, poverty level, and household welfare receipt, and it is believed that the norms of hard work and discipline that are embodied by Latino immigrants are not present among subsequent generations (this is referred to as "downward assimilation" to the American underclass). It has been noted that while 10% of Latino immigrants are out of the labor force, the rate of unemployment is over double among the third-plus generation (Ford, 2015). While this may not be unique to Latinos (and perhaps applies to many immigrant groups), it is important to note that Latinos are impacted by this phenomenon.

Latinos and Healthcare

Mazzula and Torres (2017) discussed how, while a large percentage of Americans have challenges accessing healthcare, ethnic minorities experience even more substantial barriers than their White counterparts. Specific to Latinos, Mazzula and Torres described that this group has one of the worst access to healthcare in the United States with an astounding 35.2% of Latinos experiencing barriers to accessing healthcare with one of the main barriers to access being the lack of medical insurance coverage. This is problematic as the prevalence rates of mental health disorders among Latinos is high. Indeed, in the most comprehensive study of Hispanics/Latinos of different national backgrounds conducted to date (the HCHS/SOL), the prevalence of depression among Latinos was 27% indicating that a large number of Latinos experience depression and anxiety. This study also found that being born in the United States was related to an increased prevalence rate of depression and anxiety (Alegria et al., 2008). Alegria and colleagues also found similar results with Latinos who were born in the United States having increased prevalence rates of depression,

anxiety disorders, and substance use disorders. They also found that lifetime prevalence rates of mental health vary by country of origin with Puerto Ricans experiencing the highest lifetime disorder rate (37.4%), followed by Mexicans (29.5%), Cubans (28.2%), and other Latinos (27%). Despite that Latinos experience substantial prevalence rates of mental health conditions, they also experience barriers to accessing behavioral healthcare. The majority of these barriers are related to socioeconomic status and include lack of transportation, long waits, inflexible hours, distance between the home and treatment location, lack of health insurance, costs, language, and stigma surrounding the use of mental health disorders (Benuto & Leany, 2011).

While the extant literature has indicated a need for culturally sensitive interventions, it remains unclear as to whether or not Latinos require interventions that are modified on account of culture to experience treatment success. Specific to Latinos, Benuto and O'Donohue (2015) reviewed the literature to determine what "culturally sensitive" interventions (all studies that included a specific focus on the cultural group of interest were included) could be considered well-established, beneficial treatments for use with Latinos. Despite the several hundred publications on Latinos and cultural sensitivity, Benuto and O'Donohue only identified 12 peer-reviewed articles that evaluated empirically supported treatments for the mental health disorders most commonly diagnosed among this population. While these 12 studies had substantial methodological limitations (i.e., few employed the "gold standard" designs associated with randomized clinical trials), they concluded that there is evidence that Latinos may be effectively treated using conventional cognitive behavioral therapy and that there is little evidence that cultural adaptations result in consistently improved effect sizes. Thus, it seems that the delivery of evidence-based interventions (without cultural modifications) can be an effective means to improving the behavioral health of Latinos.

Latinos and Education

Across K-12 education, Latinos have lower levels of educational attainment, and high school drop-out rates remain higher than other groups (except for African Americans). They also perform poorer on standardized tests. Those who do attend college are mostly concentrated at Hispanic-serving institutions. While Latinos are receiving college degrees at a much higher rate than they were 10 years ago, they still are behind most other groups including Whites and Asians (Azziz, 2015). Santiago et al. (2014) discuss how acculturative stress, discrimination experiences (which have been linked to poor grades and low academic self-efficacy), stress related to family obligations and responsibilities (that can interfere with academic functioning), and limited English language proficiency may explain (to some degree) the lower educational attainment of this group. Despite lower levels of educational attainment than other groups, Latinos have ranked education as an extremely important issue (substantially above immigration) (Krogstad, 2014) highlighting that education (and specifically the low attainment thereof) is an issue for this group.

Summary and Conclusions

As illustrated throughout this chapter, Latinos are a highlight heterogeneous group. While the bulk of the literature on Latinos is focused on anthropological characteristics of this group (i.e., they are family-oriented), the extant literature poorly captures the contemporary issues that this group faces. These issues include issues related to self-identification, acculturation, immigrant status, experiences of revision and discrimination, language barriers, poverty, challenges in accessing healthcare, and low educational attainment. As the healthcare system in the United States evolves, it is important that the concept of cultural competence in general (and specifically to Latinos) evolve as well. Currently the extant literature

suggests that training mental health professionals to be culturally competent practitioners requires improvements (Benuto et al., In Progress), and as training mechanisms and paradigms evolve, contemporary issues faced by this group should be integrated into the training for mental health practitioners.

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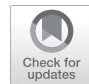

21 Cultural Competence Issues in Counseling and Therapy for Asian Americans

Paoze Thao

Being recognizant of this topic of research, I [the author] have realized that conducting research on the contemporary problems facing Asian Americans has become so complex. Today, it is not easy to capture the real problems facing Asian Americans in a holistic manner due to their heterogeneity and diversity of the Asian American communities themselves. Asian Americans came from 43 different ethnic groups with over 100 languages and dialects. As much as I want this chapter to be the most up-to-date resources for mental health professionals and applied psychologists, I believe that I merely touched the surface of the contemporary problems in Asian American communities. However, I hope that this chapter will be the beginning to shed some light on issues of mental health problems in the Asian American communities. I also hope that the information presented in this chapter will be useful for mental health professionals and applied psychologists as they provide mental health services to their Asian American clients in the USA. I am extremely indebted and privileged to have Drs. Craig L. Frisby and William O'Donahue edit this entire manuscript for this edition. Their valuable comments provided me with perspectives into my own writing on the contemporary problems in Asian American communities. During this process, I have been educated by their insightful comments and cannot thank them enough for their valuable time and suggestions. Not only did they generate valuable comments, but their suggestions helped me solidify my own thought. Although I have incorporated the majority of their comments into this chapter, I have gone out in my own way in a number of instances. Therefore, the errors of facts, arguments, interpretations, and recommendations remain in this chapter are mine alone.

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Demographics of Asian Americans

As of September 21, 2017, the US Census Bureau estimated the US population to reach 325 million (U.S. Census Bureau, 2017) adding to the projected world population of 7.5 billion (Worldometers, 2017). Even though Asian Americans in the USA only account for about 4% of the US population, they have grown from 10.2 million in 2000 to 16 million in 2013. As a group, they were reported to be the fastest-growing minority population in the USA and have become increasingly visible in the total population (New Geography, 2016; Schaefer, 2006). While Asian Americans may share similarities in their physical traits, there are major differences in their cultures, languages, education, spirituality, immigration experiences, and socioeconomic levels.

Asian Americans came to the USA from several regions in Asia: East Asia, Southeast Asia, and South Asia. *From East Asia* are the Chinese, Japanese, South Korean, North Korean, Taiwanese, Hong Kong, Macau, Mongolian, and Tibetan (Yoon & Cheng, 2005). *From Southeast Asia* are the Khmers (Cambodians), Mong [Hmong], Laotians, Thai Dam (Black Thai), Khmu, Lahu (Thao, 1999), Burmese, Thai, Vietnamese (Library of Congress, 2016; Neher, 1999; SarDesai, 1989; Tarling, 1998), Malaysians,

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Indonesians, East Timorese, Filipinos, and the Singaporeans (Meyer, 1997). *From South Asia* are the Bangladeshi, Bhutanese, Indians, Maldivians, Nepalese, Pakistanis, and the Singhalese (Meyer, 1997).

The term "Asians" refers to "people having origins from the original peoples of the Far East, Southeast Asia, or the Indian subcontinent" (U.S. Census Bureau, 2002, p. 1). The US Census Bureau (2013) revealed that the number of Asian Americans in 2013, either one race or in combination with one or more additional races, is estimated at 19.4 million. The state with the largest Asian American population is California with 6.1 million followed by New York with 1.8 million. Chinese Americans are the largest Asian group with 4.3 million, followed by 3.6 million Filipinos, 3.5 million Asian Indians, 1.9 million Vietnamese, 1.8 million Koreans, and 1.4 million Japanese (U.S. Census Bureau, 2013 American Community Survey). The states with the largest Asian population ranked in terms of number are New York and California. "New York had the largest Asian population with 872,777, followed by California, which has 407,444 Asians in Los Angeles" (p. 7). With regard to the percentage of Asian population when comparing to the total population in each of the cities, Honolulu has the largest proportion of Asians (67.7%), followed by Fremont (39.8%), San Francisco (32.6%), San Jose (28.8%), San Diego (15.5%), Seattle (15%), Los Angeles (11%), and New York (10.9%).

Brief History of Asian Immigration into the USA

The following material will chronicle major Asian groups that immigrated to the USA. For the purpose of this discussion, Asian Americans will be divided into two groups: (1) Asian immigrants and (2) Asian refugees.

Asian Immigrant Group

The label "Asian immigrant group" refers to the first group of Asian Americans that came to the USA prior to 1975, whereas the label "Asian refugee group" refers to the second Asian American group that arrived in the USA after 1975. The Immigration and Nationality Act (INA) broadly defines "immigrant" as "any alien in the United States, except those legally admitted under specific nonimmigrant categories, section 101(a)(15). On the other hand, the Refugee Act of 1980 (PL. 96-212), Title II defines the term "refugees" as "people subjected to persecution in their homeland" (p. 1). In general, the term "immigrants" applies to individuals who came to the USA to seek a better life and/or for social and economic mobility, whereas the term "refugees" refers to individuals who were forced out of their country of origin in large numbers because of political persecution.

Within the context of these two definitions, the Asian immigrant group consists of Chinese, Japanese, Koreans, Filipinos, Thais, Indonesians, Malaysians, Burmese, Singaporeans, Asian Indians, and Pakistanis, whereas the Asian refugee group consists of the Khmers or Cambodians, Laotians, Mong [Hmong], Mien, Thai Dam, Vietnamese, and Chinese Vietnamese. The Asian immigrant group was more educated and had more exposure to Western culture (U.S. Census Bureau, 2000). In contrast, the Asian refugee group received less formal education in their countries of origin and had less exposure to the Western culture prior to coming to the USA. The Asian refugee group refers mainly to those who came from Southeast Asia (SEA), particularly from Cambodia, Laos, and Vietnam. In 1975, when the SEA governments fell to the Communists as a consequence of the US withdrawal from Southeast Asia, the SEA refugee group came to the USA in large numbers.

Many early immigrants came to America due to fear of religious or political persecution in their homelands. Former Commissioner of the Immigration and Naturalization Service (INS) noted that "family reunification has long been a cornerstone of both American law and INS practice" (Hatch, n.d., p. 1). In the twentieth century, immigrants came from Central and Eastern Europe and the Pacific Rim countries. The US conquest of the Philippines, Puerto Rico, Hawaii,

and the Pacific Islands caused a large influx of immigrant populations from these areas to the USA, followed by refugees from Southeast Asia after the Communists took over Cambodia, Laos, and Vietnam. This event led many Southeast Asian immigrants to come to the USA (Diaz-Rico & Weed, 2006).

The Asian Immigrant Group

Lumping all Asian American ethnic groups together, Pew Research Center (2012a, b) found that "Asian Americans are the highest-income, best-educated and fastest-growing racial group in the United States" (para. 2). Seventy-four percent (74%) of all Asian Americans were foreign-born, except for the Japanese in which 73% were born in the USA (Pew Research Center 2012a, b). With regard to education, 28% of all US adults completed a bachelor's degree, and 48% of the 28% are Asian American. The median income for Asian Americans vs. US adults was $66,000 vs. $49,000; their median household wealth was $83,000 vs. $68,529, respectively. Berman (2016) examined the weekly earnings by ethnicity and reported that the weekly earnings for Asian Indians were $1292 per week, $1100 for Japanese, $1093 for Chinese, $992 for Korean, $987 for an average Asian American and Pacific Islander, $865 for White, $692 for African American, and $641 for Hispanic. This information is based on data provided by the US Department of Labor in 2015.

The following paragraphs provide a brief history of the immigration of the major Asian immigrant groups from East Asia and South Asia and of the major refugee groups from Southeast Asia to the USA. This is based upon their arrival in the USA in chronological order, starting with the Chinese, Japanese, Koreans, Thai, Indonesians, Malaysians, and Asian Indians. For the context of this chapter, this discussion only covers the immigration of the major Asian American ethnic groups with substantial numbers, but does not cover those with smaller populations.

Chinese Americans Chinese Americans are the earliest group of Asians that came to the USA dating back to the early eighteenth century. As a group, they have developed concentrated populations in various community spaces throughout the USA, which are sometimes known as Chinatowns. These enclaves are public spaces that celebrate traditional Chinese festivals and have transformed Chinese businesses into tourist attractions in a number of cosmopolitan cities, like Chicago, San Francisco, New York, and Los Angeles. In terms of sociocultural assimilation, the Chinese Americans have adjusted amazingly well but, at the same time, have preserved their culture and kept their traditions intact (Fong, 2008). Even though many Chinese immigrants have converted to other religions, their main beliefs still cling to the combination of elements from Confucianism, Taoism, and Buddhism. The combination of these three religious beliefs has preserved the Chinese American communities in the USA up to this day. Smith (1991) is a leading scholar in Chinese religions and stated that the underlying Chinese religion focuses on the human social relationships. Smith (1991) noted that human social relationships involve the concept of filial piety combined with the Taoist philosophy. This has been the major force behind the strong work ethics of the Chinese people until today and has led them to become good, law-abiding, and contributing members in the society. According to Rueda (2012), of the four million Chinese Americans in the USA today, 31% are Christian, 15% are Buddhist, 52% are unaffiliated, and 2% are of other religions (Pew Research Center, 2012a, b).

Japanese Americans With regard to the socioeconomic status and education of Japanese Americans, it is not easy to determine how the entire 1.2 million Japanese Americans in the USA are doing (Asia Matters for America, 2011). Despite the plethora of research on Asian Americans as a group, there is a lack of specific, disaggregated data on Japanese Americans. It is believed that as a group, the Japanese Americans have already integrated well and achieved much success in the American society (Asia Matters for America, 2011; Berman, 2016; Pew Research Center's, 2012a, b; U.S. Department of Labor, 2015). For a detailed history of Japanese immi-

gration to America, readers are encouraged to consult Ichioka (1988), Fong (2008), Hing (2004), Fujimomto and Sandoval (2007), Kitano (1997), Gutek (2006) and Schaefer (2006 & 2012).

Korean Americans Culturally, Park (1999) asserted that traditional Korean culture has been influenced largely by Confucian values centered on the concept of filial piety. Korean culture is organized into a patriarchal and male-centered structure with the head of the family holding the absolute power. The sons pay respect to the father which extends from the interfamily to the extended family (p. 50). The concept of filial piety permeates from the family to the rest of the society. Spiritually, Korea is a country where major religions (Christianity, Buddhism, Confucianism, and Islam) have coexisted. It is important to note that the number of Korean Christians is on the rise and accounts for 29% of the Korean population, whereas 15.5% are Buddhists, 7.9% are Catholic, and the remaining are others (Pew Research Center, 2014).

Historically, these three East Asian immigrants (Chinese, Japanese, and Koreans) have shared similarities in terms of their geographic proximity, interests, shared values, and spirituality for centuries as neighboring countries. This does not mean that their relationships have been good. There has been some intergroup conflict between the Chinese and Japanese and between the Japanese and Koreans. Wang (2014) indicated that China and Japan have "historical problems in the bilateral relationship" (p. 1) dating back to the "First Opium War (1839–1842) through to the end of the Second Sino-Japanese War in 1945" (p. 1). Sugiman, Gergen, Wagner, and Atsumi (2008) asserted that "the formal cessation of hostilities (e.g., warfare) does not mean that the two groups have reconciled" (p. 1). By the same token, past historical issues continue to affect the bilateral relationship between Japan and Korea. Pollmann (2015) of *The Diplomat* interviewed Glosserman and Snyder (2015), the authors of *The Japan and South Korea Identity Clash*. Pollmann (2015) commented that the notions of divergent national identity between Japan and South Korea are the main problem to their productive partnership and hinder the prospects for peace in that region. Past historical events between the two countries have also led the bilateral relationship of the Japanese and Chinese in the USA to become fragile. For a detailed account of the Korean immigration to the USA, readers are encouraged to consult Fong (2008), Gutek (2006), and Hickey (2011).

Filipino Americans The Filipinos' value systems have been deeply influenced by Christianity, especially Roman Catholicism combined with unique elements of their indigenous cultures, e.g., shamanistic Animism and Polytheism. The basic institution in the Filipino society is the family and the extended family. The nuclear and extended family plays an important role in providing an identity to its members (Panapio, Cordero, & Raymundo, 1978) and child development (Guthrie & Jacobs, 1967; Park & Chi, 1999) and functions as the socialization agent (De la Torre, 1992; Jocano, 1972; Mendez, Jocano, Rolda, & Matela, 1984; Panopio et al., 1978; Park & Chi, 1999). Kinship is very important to the Filipino family (Jocano, 1972) as it is formed through blood relation, affinity, marriage, adoption, and religious affiliation, such as baptism (Mendez et al. 1984).

Jocano (1972), Guthrie and Jacobs (1967), and Litton (1994) described the Filipino kinship as bilateral. Filipino children learn to observe the relationship between their parents and then extend it to other people (Park & Chi, 1999). The concept of respect also plays an important role for the young Filipino, who must pay respect to the older members of the family (Agbayani-Siewert, 1994) and revere family interdependence (Agbayani-Siewert, 1994; Agbayani-Siewert & Revilla, 1995). Other Filipino values include self-esteem (Ponce, 1980), shame or fear of losing face (Andres, 1989), gratitude or reciprocity (Ponce, 1980), and the ability to get along and avoid conflict (Andres, 1989). For a deeper understanding of the Filipino culture, readers are encouraged to consult *Culture and Customs of the Philippines*

(Rodell, 2002). For a detailed discussion of Filipino immigration to the USA, readers are encouraged to consult Fong (2008), Gutek (2006) and Yoon and Cheng (2005).

Thai Americans In Thailand, the ethnic groups consist of the Thai (75%) and various ethnic groups, such as the Chinese and Malay, and various tribal ethnic groups, like the Mong [Hmong], Mien, Lisu, Luwa, Shan, Karen, and Vietnamese (CIA World Factbook, 2003; Vecoli, 1995). Thai immigrants came to the USA after the 1960s when the US Armed Forces were deployed in Khlong Toei, Bangkok, and Udon Thani in Thailand during the Vietnam War. Vecoli (1995) asserted that the number of Thai immigrants in the USA was 5000 with their largest concentration in Los Angeles, New York City, Houston, and Dallas. Thai immigrants mainly consist of medical professionals, business entrepreneurs, and spouses of the US Air Forces airmen.

By 1990, the total population of Thai immigrants in the USA reached 91,275 (Vecoli, 1995). The Thai family is highly structured and gender specific. The family and extended family are the basic institutions in the Thai society. Thai culture is deeply influenced by Hindu-Buddhism from India which has played a big role in people's daily lives. The Thai people are divided into a hierarchy system with five different social classes influenced by the Indian caste system. Traditionally, Thai families are very close-knit. The head of the household is responsible for raising all the people under his household. Other important values in the Thai society include respect, self-control, and non-confrontational attitude.

Indonesian Americans The Indonesians consist of many different ethnic groups: 45% are Javanese, 14% Sundanese, 7.5% Madurese, 7.5% coastal Malays, and 26% others (CIA World Factbook, 2003; Vecoli, 1995). The US Census Bureau (2000) reported that 30,085 Indonesian immigrants came to the USA (0.4%). They now live in big cities, like Los Angeles, San Francisco, Houston, New York, and Chicago. It is difficult to determine a set of cultural values that are shared by the diverse ethnic Indonesian immigrants in the USA. However, Indonesians are very attached to the traditions of their homeland, especially their attachment to the arts, e.g., "dance dramas of Bali and the Mataram court tradition" and "puppet dramas" ("wajang") (Vecoli, 1995, p. 712).

Asian Indian Americans The Nathan Kline Institute (NKI) Center of Excellence in Culturally Competent Mental Health (CECCM) (n.d.) put together a cultural profile of Asian Indians and other South Asian Americans. The profile indicates that South Asians consist of many diverse groups who speak different languages with different norms, religious affiliation, education, income, English proficiency, and immigrant status. In the USA, South Asians consist of Asian Indians, Sri Lankans, Bangladeshis, Pakistanis, Nepalese, and Maldivians. They speak primarily Hindi, Gujarati, Nepali, Punjabi, Singhalese, Bangla, Burmese, Tamil, and Urdu. With regard to their religious affiliations, PEW Research Center (2014) reported that "Indian Americans represent about 18% of all U.S. Asians, and about half identify as Hindu (51%); fifty-nine percent (59%) say they were raised Hindu" (p. 1), 11% Protestant, 10% Muslim, 10% Unaffiliated, 5% Sikh, and 5% Catholic (p. 1). For more detailed information on Asian Indian immigration, readers are encouraged to consult Fong (2008) and Khare (1997).

Today, Asian Indians can be found in the Marysville/Yuba City in Northern California (Khare, 1997, p. 21). This area is considered the farming heartland of the northern Sacramento Valley. In addition, in the last two decades, more Asian Indians were attracted to the USA to work in the technology industry. Dave (2015) stated that "nearly 16% of start-ups [technology companies] in Silicon Valley had an Indian co-founder even though Indians represented just 6% of the region's population" (p. 1) and "Indian immigrants are reaching the top executive ranks at major U.S. corporations" (p. 1). Gibbs (2014) of *The Guardian* reported that Asian Indians were

the most powerful technologists in Silicon Valley, e.g., Satya Nadella served as Microsoft's chief executive in February 2014; Sundar Pichai "overseeing Android, Chrome and apps at Google" (p. 1); and Vic Gundotra "known as Google's social tsar and the man behind the Google+ social network" (p. 1). Without a doubt, Asian Indians have make up a remarkable fraction of Silicon Valley millionaires.

Spiritually, 79% of Asian Indians are Hindus (The CIA World Factbook, 2016). Hinduism or Brahmanism is a Hindu philosophy that has influenced Asian Indians since 1750 BCE. It holds that Brahma, a supreme being, exists in several forms and has different lives and different wives for each form at the same time. He manifests himself as Brahma (the Creator), Vishnu (the Preserver), and Siva (the Destroyer) (Bounkeo et al., 1989; Luangpraseuth, 1994). Brahmanism divides the Indian society into five caste systems: (1) *Brahmana* or *Brahmin* (traditionally priest or scholar), (2) *Ksatriya* (ruler and soldier), (3) *Vaisya* (merchant), (4) Sudra (peasant, laborer, and servant), and (5) *Harijans* (the untouchables, who are considered dirty and not fit to be touched by other castes). The Harijans means God's children, but rather refers to "Dalit," meaning the oppressed (Srinivas, 1954 as quoted in Khanna, 2014; Rao, 2003).

Brahmanism or Hinduism introduced *karma* to the Indians. *Karma* is the Hindu theory of the transmigration of souls where human beings live a temporary life and that life itself is nothing but a fatalistic interlude between other lives. Furthermore, one's next life will depend on the deeds of their present life. Brahmanism suggests that thirty-two souls (32) exist and reside in the human body, so Asian Indians typically perform a ceremony called *baci* to call the 32 mobile souls to preside over the human body. The "king" soul is believed to "live" in one's head. This is the rationale for why Asian Indians and certain Asian ethnic groups from Southeast Asia do not wish to be touched on their heads or even pointed at by others. They believe that if two or more souls leave the body, eventually that individual will perish (Luangpraseuth, 1994).

The Asian Refugee Group

The second group is the Asian refugee group. The following material provides an overview of the unique social and educational challenges for some of the major Asian refugee group. The Asian refugee group originally came from Southeast Asia. This Asian refugee group consists of the Cambodians (Khmers), Laotians, Mong, and Vietnamese and other minorities. Each group will be discussed in the following chronological order: Cambodians (Khmers), Laotians, Mong or Hmong, and Vietnamese. The "Asian refugee group" came to the USA during the last four decades since 1975 after the Communists took over Cambodia, Laos, and Vietnam. The following section will provide a brief description of their major groups, but will not cover those with smaller populations.

Cambodian (Khmer) Americans The influx of Cambodians to the USA started in 1979. Those in the Thai refugee camps were admitted to the USA. In 1990, the US Census Bureau reported that 150,000 of US refugees were identified as Cambodian. Approximately 70,000 Cambodians (50%) lived in California (17,000 in Long Beach and 10,000 in Stockton), 14,000 in Massachusetts (half of them in Lowell), 6000 in Texas, 5500 in Pennsylvania (Philadelphia), 4000 in Virginia, 4000 in New York, 4000 in Minnesota, and 3000 in Illinois (Vecoli, 1995).

Lewis (1994) conducted a study to examine the profile of Cambodian, Laotian, and Vietnamese people in the USA based on data from the 1990 US Census for the National Association for the Education Advancement of Cambodian, Laotian, and Vietnamese (NAFEA). His findings revealed that Cambodian Americans were substantially younger than the American population with 47% under the age of 17 as compared to 25% for other Americans. About 64% of Cambodians had less than a high school education, and only 6.4% were college graduates.

In terms of spirituality, the Cambodians are mainly Buddhist, family-oriented, and artistic.

The Cambodian society was divided into hierarchical social classes reflecting their former monarchical system and religion. Although Cambodians are often described as shy, humble, submissive, and easy-going, they are also honest in their opinions and feelings (Thao, 1999). For a deeper insight into the Khmers or Cambodian American ethnic groups, readers are encouraged to consult *Introduction to Indochinese Cultures* (Chhim, Luangpraseuth, & Te, 1994) and *Handbook for Teaching Khmer-Speaking Students* (Ouk, Huffman, & Lewis, 1988).

Laotian Americans The Laotians fled their homeland after the Pathet Lao (Communists) took over Laos in 1975, and about 8000 Laotians were admitted to the USA in 1978. From 1978 to 1981, the number of Laotian refugees entering the USA increased from 8000 to 105,000, and their flow continued until the early 1990s (Vecoli, 1995). In 2000, the US Census Bureau reported that the number of Laotians in the USA reached 198,203. Under the category of SEAs, the Laotian American population ranked fourth in terms of size after the Filipinos, Vietnamese, and Khmers and Cambodians.

Demographically, the median age for Laotian Americans was 20.4, as compared to the American national average of 34.1. The average number of members in Laotian American families was 5.01, as compared to 3.06 members in White families. The Laotian Americans are mostly concentrated in California with a population of 65,058, which accounts for 41% of the total Lao population in America (McKee, 2000), followed by Texas with 11,626 and Minnesota with 11,516 (U.S. Census Bureau, 2000).

Culturally, the Laotians value flexibility, adaptability, harmony, interpersonal relations, autonomy, and a gentle lifestyle (Thao, 1999). Like the Cambodians (Khmers) and the Thai, the Lao society was also divided into hierarchical social classes that have been influenced by their former monarchy and religion (Thao, 1999). For deeper insight into the culture of the Laotian American ethnic group, readers are encouraged to read *Introduction to Indochinese Cultures* (Chhim et al., 1994) and *Handbook for Teaching Lao-Speaking Students* (Bounkeo et al., 1989).

Mong Americans It was estimated that over 80,000 Mong refugees were resettled throughout the USA from 1976 to the 1980s (Thao, 1999). In 2000, the US Census Bureau indicated that the Mong population increased to 186,310. Pew Research Center (2013) estimated that the Mong [Hmong] population may have grown to 260,000. The Mong Americans are now mainly concentrated in three states: California, Minnesota, and Wisconsin (McKee, 2000). California accounts for 38.43% of the national Mong population, Minnesota at 24.38%, Wisconsin at 19.75%, and the rest scattered throughout the USA (U.S. Census Bureau, 2000).

In terms of culture, the family is the basic nurturing institution in the Mong society. The concept of the family consists of all the people living under the authority of the same household and also includes the extended family. One of the most distinctive characteristics of the Mong family is that it is organized strictly from the patriarchal side in a patrilineal clan system originating from a common ancestor. There are a total of 21 clans in the Mong society, some of which are the Chang, Hang, Her, Moua, Thao, Vang, Xiong, and Yang. This clanship is the basic social and political organization in the Mong society (McKee, 2000; Thao, 1999). Even though the Mong in America have gone through different episodes throughout history which includes leaving China to live for two centuries in Southeast Asia and the last four decades in the USA, the Mong have been adept at maintaining their language and oral traditions and have kept them intact. For deeper insight into the Mong American ethnic groups, readers are encouraged to consult *Mong Education at the Crossroads* (Thao, 1999).

Vietnamese Americans The Vietnamese culture is more similar to the Chinese culture than any other Asian country while also different from its neighboring countries. Although

Buddhism plays a major role in Vietnamese society, Confucianism has influenced many Vietnamese people for a long time (Thao, 1999). Confucianism stresses the importance of applied politics, correct social comportment, and political relationships (Koschmann & Tobin, n.d.). Due to French influence, many Vietnamese people were also converted to Catholicism. It is important to note that Sinitic civilization has influenced the Vietnamese for centuries. In fact, Confucianism and Taoism have played an important role in the formation of the Vietnamese culture (Keyes, 1995).

The Vietnamese are tend not to do anything independently, but together as a family. A Vietnamese individual adheres to living in harmony with himself or herself as well as with the outside world by observing certain virtues, e.g., moderation, modesty, moral probity, and self-control. The family is the basic institution in the Vietnamese society and shares collective and bilateral responsibilities in terms of legality, morality, and spirituality. The Vietnamese mother shares the same status as the father while also being the embodiment of love and the spirit of self-denial and sacrifice. Vietnamese children are taught the concepts of filial piety and social courtesy at a very young age. Filial piety encompasses one's love, respect, and obedience to one's parents as well as to others for fear of losing face which could reflect negatively onto their parents and their ancestors (Chhim et al., 1994). For deeper insight into the culture and history of the Vietnamese American ethnic group, readers are encouraged to consult *Introduction to Indochinese Cultures* (Chhim et al., 1994) and *Introduction to Vietnamese Culture* (Te, 1996).

Approach to Life

A few groups of Asian Americans, such as the Mong and Iu Mien, are still accustomed to making decisions with the community-based approach, as opposed to the individualistic approach that is typical in American society (Thao, 2005). The community-based approach can be understood as consisting of four embedded circles that represent the self, family, community, and society.

The Community-Based Approach to Life For some Asian American communities, society operates at the center of the circle and is the core of the decision-making process. The community lies at the second outer circle, the family at the third outer circle, and the self at the fourth outer circle, where the individual accepts and respects the decisions made by the upper echelons. In other words, the community is considered first before the family and the society before the community. For example, before the New Year's celebration takes place in an Asian American community, a community meeting will be called upon for each member to come together and organize the activities (Thao, 2005). This approach to life is still practiced among certain Asian traditional ethnic groups, such as the Mong and Iu Mien for organizing their New Year celebration in November or December and the Laotians and Cambodians for their New Year celebration in April.

However, for some other Asian groups who have been more acculturated and acclimated to Western influences, such as the Chinese, Japanese, Korean, and Filipino, perhaps some elements of their cultures still remain intact, but their approaches to organizing their New Year celebration have been changed. For instance, Chinese New Year and Vietnamese Tet are celebrated in February, but they are not organized in the same way. Japanese Ubon festival is organized differently than the festivals of the typical Asian refugee groups who, as discussed previously, are not yet fully acculturated into the mainstream American life. Therefore, several of the festivals of an Asian community may not follow the way that has been practiced for previous generations.

Despite all the cultural differences, a cultural aspect that is commonly shared among Asian American groups is the concept of respect for the elderly and authorities. Groups that regard the concept of respect for the

elderly include the Chinese (Cheng, 1999, p. 3), Japanese (Nishida, 1999, p. 100), Korean (Park, 1999, p. 50), Filipinos (Litton, 1999, p. 136), Mong (Thao, 1999), Laotian (Luangpraseuth), Cambodian (Chhim et al., 1994), and Vietnamese (Te, 1989 & 1996). When a young person from an Asian ethnic community does not respect the elderly, they are labeled "ill-bred" and become the target of gossip in their tight-knit community. This remains true in the case of the Vietnamese culture where the behavior will lead the parents to "lose face" in the community and bring shame to one's ancestors (Chhim et al., 1994, p. 160; Te, 1989, p. 160, 1996). In the meantime, please be advised that the community-based approach to life does not apply to all Asian Americans.

The Individual-Based Approach to Life On the other hand, the individual-based approach to life is the opposite of the community-based approach. For individual-based approach, the self or the "me" or "I" is always operated at the center of the circle; the family lies at the second outer circle, followed by the community in the third outer circle and the society in the fourth outer circle. In other words, in the USA, the nuclear family has been the predominant factor or "the central control system for many generations" (Vacc, Wittmer, & DeVaney, 1988, p. 17). It is also essential to note that every Asian American community may not have fully adopted this individual-based approach to life yet. However, each Asian American ethnic group may have changed their approach to life overtime while adjusting to the mainstream American culture that they now live with (Thao, 2005). These two approaches to life have deep underlying implications for counseling and therapy purposes; therefore, mental health professionals (e.g., psychologists, mental health counselors, therapists, and practitioners) need to keep these approaches in mind when counseling Asian American clients.

Model Minority Myth and Mental Health Issues in the Asian American Communities

The concept of buffer theory (Alloway & Bebbington, 1987; Chafe, 1968) may also be helpful in explaining the implications of the "model minority stereotype" for labeling Asian Americans. This theory relies on the three tiers of strata of races (Whites, Asians, African Americans, and Latinos) where Asian Americans consequently stand in as a buffer between Whites, African Americans, and Latino Americans. Furthermore, the buffer serves to protect the status quo of the dominant race (White) in society, and skin color plays the role of the dividing line between the different races and social strata in society.

Alloway and Bebbington (1987) stated that "[t]he buffer theory postulates that social support moderates the power of psychosocial adversity to precipitate episodes of illness" (p. 1). Cohen and McKay (1984) utilized the buffer theory (within the context of the "model minority myth") to further explain a model of stressor-buffer specificity to be implemented in mental health and has been termed "the buffer hypothesis" (p. 261). In the context of mental health, Gonzales (n.d.) defines the buffer hypothesis as "a theory holding that the presence of a social support system helps buffer, or shield, an individual from the negative impact of stressful events" (p. 1).

Today, Asian Americans still experience issues with racial stereotyping and institutional racism in various forms and in every walk of life. Asian Americans are presumed to excel in school, achieve high incomes, be submissive, and work hard, which is all a part of what's called the "model minority myth." However, Asian American students who do well in school may have this reputation backfire on them. In 2016, Abigail Fisher filed a lawsuit against The University of Texas at Austin, arguing that the university denied her admission based on her race at the Supreme Court. Even though the Supreme Court managed to uphold the affirmative action program at the University of

Texas at Austin (Liptakjune, 2016), the future of affirmative action is very shaky, and this lawsuit case served as “a warning to other universities that not all affirmative action programs will pass constitutional muster” (para. 2). Should uniform admission standards apply at the Ivy League institutions of higher learning, then Asian American students would be overrepresented. Currently, there are some cases of discrimination in college admissions, where some Ivy League universities impose more stringent selection standards on Asian applicants with higher entrance qualifications. Wong (2017) stated that “The Justice Department plans to investigate whether Harvard [University] discriminates against applicants because of their race” (p. 1). Wong (2017) commented in another article that “the way members of the ‘model minority’ are treated in elite-college admissions could affect race-based standards moving forward” (p. 1) and [Asian American students] may need “to distort their identities solely for the sake of getting in” (para. 2). Should reverse affirmative action take place, it would certainly affect the college admissions of underrepresented Asian American ethnic minority students in the future. To prevent a lawsuit in California, California passed Proposition 209 (an initiative Constitution Amendment) in 2006 to prohibit discrimination or preferential treatment by state and other public entities. In other words, “an affirmative action program cannot be implemented [in California] unless state law is changed” (Chinoy, 2016). Otherwise, reverse affirmation action may take place for college and university admissions in the future.

Logan and Zhang (2013) did a study on Asian Americans for the Advisory Board of the US2010 Project that was based on the 2000 US Census data. They found that “Asians have often been thought of uniformly as a single ‘model minority,’ but their ‘very large differences that exist between the Chinese, Filipinos, Indians, and other major Asian groups’ to lump them as a ‘single model minority’ is ‘misleading’” (p. 1) due to “their heterogeneity in social background and economic achievement, and their pattern of neighborhood settlement” (p. 1). In fact, a typical Asian American immigrant group that would have arrived in the USA prior to 1975, such as the Chinese, Japanese, Korean, Filipino, and South Indians, “was generally on a par with non-Hispanic whites” (Logan & Zhang, 2013, p. 1) and often exceeded other racial minority groups on a variety of social, academic, and economic indicators. This “model minority myth,” however, has become a double-edged sword for Asian Americans because, on one end, it raises higher expectations and pressures for Asian American children to succeed, while on the other end, it leads them to being victims of systemic racism, oppression, ostracism, and depression.

On the positive side, all Asian Americans have been lumped together into the model minority stereotype theory (Gordon, 1996; Lee, 1996), which profiles them as successful and high-achieving minorities. As previously discussed, this generalization about Asian Americans is misleading. In fact, more data is available for the “six distinct Asian national origin groups with more than a million residents” (Logan & Zhang, 2013, p. 1). Logan and Zhang (2013) used the term “Asian nationalities” or “Asian national origins” to identify them, which consisted of 4 million Chinese, 3.4 million Filipinos, 3.2 million Asian Indians, 1.7 million Vietnamese, 1.7 million Korean, and 1.3 Japanese, but failed to provide the disaggregate data on the populations of other smaller “Asian national origin” groups in their report.

As discussed previously, the earlier Asian American immigrant groups (e.g., the Chinese, Japanese, Korean, Filipino, Asian Indians) tend to do well and fit the model minority myth, whereas the Asian refugee group (e.g., the Cambodians, Mong, Iu Mien, Laotians, and Vietnamese) do not compare with their earlier Asian American immigrant counterpart. It is important to point out that there is [a great] diversity among Asian Americans. Feng (1994) asserted that Asian Americans in the USA represent more than 29 distinct groups with different languages, religions, and customs. However, the US discourses of race relations are still framed within the context of “black versus white” even though certain Asian American groups have been in the USA for more than 150 years, according to Kitano (1997).

On the negative side, Chou and Feagin (2015) argued that "Asian Americans are typically viewed and labeled as 'model minorities' by outsiders, especially Whites with power over them, but this high stereotyped labeling creates great pressure to certain Asian American ethnic groups [e.g. the Mong, Iu Mien, Cambodian, Laotians, and Vietnamese] to conform to the White-dominated culture, usually, in one direction" (p. 3). Lim (2015) also commented that the "'model minority myth' seems like a compliment, but it does great harm" (para. 3). This label, in fact, fails to recognize the diversity of Asian American "nationality" groups and to acknowledge the fact that there are disparities in socioeconomics and education among them.

This "model minority stereotype" also harms individual Asian Americans who seek psychological and mental health services. Noh, Beiser, Kaspar, Hou, and Rummens (1999) did a study of refugees in Canada and found that Korean refugees were anxious and unlikely to seek help from mental health professionals. Moreover, there are deleterious consequences for certain Asian Americans coming from intense pressures to achieve to live up to the "model minority myth." The American Psychological Association (APA) (2012) reported that "the suicide rate for Asian-Americans (6.10 per 10,000) is about half that of the national rate (11.5 per 10,000)" (p. 1) and that "Asian-American college students had a higher rate of suicidal thoughts than White college students but there is no national data about their rate of suicide deaths" (p. 1). APA (2012) further asserted that "Among all Asian Americans, those aged 20 -24 had the highest suicide rate (12.44 per 100,000)" (p. 1). Seligson (2015) reported that a "[Chinese] Yale University mathematics major Luchang Wang jumped to her death from San Francisco's Golden Gate Bridge [on January 27, 2016], leaving behind a Facebook post saying that while she was in deep emotional pain, she feared that if she left school to get treatment she would not be allowed back" (p. 1). In California, Dudley Ellis (2002) of The Fresno Bee reported that, from 1998 to 2002, eight (8) Mong/Hmong teenagers committed suicide in Fresno during their "struggle to balance their American lifestyle with the Hmong traditions" (p. 1). In this case, mental health intervention was too late for those Mong/Hmong youngsters. Ly (2016) did a review of literature on the barriers to accessing mental health services by the Hmong and concluded that the obstacles that discouraged them from seeking mental health services included cultural practices and beliefs, mental health literacy, language barriers, stigma, accessibility and affordability, and trust.

Prejudice and Discrimination Against Asian Groups in the USA

Experience of the Asian Americans

No matter how long Asian Americans have resided within the USA, they have shared similar experiences involving stereotyping and discrimination, e.g., relating back to the conceptualization of the *Yellow Peril*, name-calling like Chin or Jap, institutional racism, and anti-miscegenation laws for earlier Asian American group, and they have been treated like second-class citizenship and model minority myth (just like a double-edged sword) throughout their immigration experiences as they struggled to cope and adjust to the American culture. They encountered some of the most challenging and salient issues with mental health and education during their cultural adjustment. The following material discusses some of the major problems faced by earlier Asian American group:

1. *Anti-Asian sentiment and victims of hate crimes*. Tewari and Alvarez (2009) indicated that "The National Asian Pacific American Legal Consortium (NAPALC, 2009) has found that Asian Americans continue to be the target of hate crime that spanned the range from vandalism and robbery to physical attacks, rape, murder" (p. 404). Examples of anti-Asian sentiment and hate crime include the murder of Vincent Chin in Detroit in 1982 by two disgruntled autoworkers who thought that Vincent Chin was a Japanese (p. 404).

In another event involving hate crime against the Hmong, Mueller of *USA Today Network* (2017) reported that "an 80 year-old Junction City man in Wisconsin [Kaminski] accused of aiming and firing a gun near his neighbor could be the first person ever charged with a hate crime against a Hmong person in Wisconsin" (para. 1). "Kaminski told nurses he 'had problems with the Hmongs,' that he thought Hmong people were criminals and that Hmong residents of Junction City were poaching animals, according to a criminal complaint filed March 24 in Portage County" (para. 7). Furthermore, the Unrepresented Nations and Peoples Organization (UNPO) (2017, Mar 14) reported that "Democratic Representative Katrina Shankland urges Wisconsin residents to respect the Hmong community and to denounce any action or speech that incites hate" (para. 1).

Another incident of hate crime happened to a Vietnamese in Oregon. It was reported (Angry Asian Man, 2012) that on June 22, 2012, "In Grants Pass, a Vietnamese American man says his family is being harassed and bullied by community members, and the police haven't done a damn thing. The last straw came when someone tried to bomb his family's home. Yeah, people apparently still do that: Hate Crime Against Vietnamese Family in Grants Pass" (para. 1). Thus, these are just a few examples of hate crimes taken place with Asian Americans. From these recent examples, certain Asian Americans continue to be singled out for hate crime, and they fall victims of hate crime. In sum, anti-Asian sentiment continues to exist as exemplified by these events.

2. *Institutional racism.* Institutional racism has no place in the US Constitution. However, it still exists in the American society today. Ball and Hartlep (2017) commented that the Immigration Reform and Control Act (IRCA) of 1986 has a provision for employers to verify the immigration status of new employees. This is a by-product of IRCA to screen Asian American and Latino applications or face sanction (p. 16). In addition, the Immigration Act of 1990 put a limitation on legal immigration overall. This has negatively impacted Asian Americans' entries into the USA. In California, another form of institutional racism took place with the passage of Proposition 187 in 1994 that put a stop to undocumented immigrants to have access to education, healthcare, and social services. This has disproportionally affected Asian and Latino immigrants since the passage of Proposition 187. For more detail on institutional racism for Asian Americans, readers are encouraged to consult more in *Asian/Americans, education, and crime: The model minority as victim and perpetrator* (Ball & Hartlep, 2017).
3. *Anti-miscegenation laws against Asian Americans.* The earlier anti-miscegenation law prohibited the marriage between earlier Asian Americans with Whites. Wu (1995) eloquently referred to Asian Americans to honorary whites (as quoted in Zhou & Ocampo, 2016, p. 249). Zhou and Ocampo (2016) also noted that "Asian Americans have been racialized according to the black/white paradigm and can be found in the case of People vs. Hall" (p. 340) that banned "a Chinese to testify under a law that prohibited Blacks, Mulattos, and Indians from testifying in trials involving White defendants" (p. 340). Even though this law is no longer in effect today, Vo and Bonus (2002) observed that "social pressure [still] prevented relationships between Asians and White" (p. 12).

   Given this Black/White paradigm, Zhou and Ocampo (2016) stated that "Asian Americans have stood on unstable ground between 'blacks' and 'white,' falling under the honorary white category in anti-affirmative action arguments, but considered constructive blacks for purpose of school segregation or anti-miscegenation" (p. 340). Wu (1995) eloquently referred Asian Americans to honorary Whites and noted that "racial groups are conceived of as white, black, honorary whites, or constructive blacks" as quoted in Zhou and Ocampo (2016, p. 249). Another researcher Dong (2016) discussed the contemporary forms of anti-misce-

genation laws that have evolved into "social norms regarding the expression of anti-Asian prejudice. White racial supremacists and other extremists continue to target Asian Americans in blatant, public, and direct manners, many every day acts of discrimination have been more subtle, covert, and insidious. For example, some people explain that they like Asian Americans but prefer to spend time with or date people from other racial groups" (p. 256). For a more detailed summary of the contemporary forms of anti-miscegenation laws, readers are encouraged to consult *Contemporary Asian America: A multidisciplinary reader* (Zhou & Ocampo, 2016), *Contemporary Asian American Communities: Intersections and Divergences* (Vo & Bonus, 2002), and *Asian American culture: From Anime to Tiger Mom* (Dong, 2016).

4. *Violation of human rights and civil liberties – Case of racial profiling*. The American Civil Liberties Union (ACLU) (n.d.) documented that Asians have been victims of racial profiling. The examples are many:
   1. "Wen Ho Lee, a Taiwanese American was targeted and suspected of espionage on the basis of his race" (p. 1).
   2. "In Seattle, Washington, in July 2001, a group of 14 Asian American youth were stopped by police for jaywalking, claiming that they were kept against the wall for about an hour."
   3. "In 2001, the Asian Freedom Project of Wisconsin issued a report that found the racial profiling of Hmong communities there, and included the testimony of adults, as well as boys and girls."
   4. "The Garden Grove (CA) Police Department settled a 'gang' database racial profiling lawsuit by a group of young Asian Americans who said their civil rights were violated when officers photographed them as suspected gang members based merely on their ethnicity and clothing" (para. 18).

   The assimilation theories. With regard to race relations, Kraus (1999) made a reference to a drama produced by Israel Zanwill in 1909 called *The Melting Pot*, which emerged into his theory of "the melting pot." The USA wanted to assimilate, or Americanize, and "melt" European immigrants into the American society (Kitano, 1997, p. 30). However, earlier Asian immigrants, e.g., the Chinese, Japanese, Korean, Filipino, and Asian Indians, were not meltable into the American society because the color of their skin denied them the opportunity to blend in. Diaz-Rico and Weed (2006) commented that other ethnic groups, e.g., the Hassidic Jews, the Amish, the Hopi, and the Navajo, resisted assimilation and chose to cling to their religious rites, lifestyles, and property without any compromise (p. 208). Given that some groups are not "meltable," two additional metaphorical theories emerged: the "kaleidoscope theory" and "the salad bowl theory." With regard to the "kaleidoscope theory," Diaz-Rico and Weed (2006) mentioned that race relations involving "the shifting patterns of culture, language, and race combine and recombine ceaselessly, yet bond together by an idea: that in the United States, diverse peoples are held together through common ideals" (p. 208).

   Today, there is a new shift to multiculturalism where diverse ethnic groups could also be described as a *salad bowl*. Each food source has a distinct flavor, but once it is covered with dressing or spices, each separate piece of ingredient takes on the flavor of the dressing. When thinking about being a pluralistic society, we think of a "quilt." Each material square is different in color, texture, and design, but together they are in harmony and create something unique and beautiful without subsuming sameness (Bynoe, 2004). A pluralistic society is made up of many cultures like a mosaic (Diaz-Rico & Weed, 2006, p. 208; Millet, 1999–2014) that could transform America into the US motto "*e pluribus unum*" or "out of many, one."

5. *Asian Americans continue to face discrimination and racism*. The Asian American immigrant group (e.g., Chinese, Japanese, Asian Indians, Filipinos, and Koreans) has "experience[d] with

racial hostility and discrimination over a long history of immigration" (Chou & Feagin, 2015, p. 6). The recent Asian refugee group (e.g., the Khmers or Cambodians, Laotians, Mong, and Vietnamese and other minority groups arriving from Asia) has also had countless of experiences of cultural hostility and discrimination in almost every walk of life as well. One recent case took place with a Vietnamese American doctor Dr. David Dao at the Chicago O'Hare International Airport in April 2017. In an article, *The Associated Press* (2017) reported that "A [69-year old] Kentucky doctor [Dr. David Dao, a Vietnamese American doctor] who was dragged off a United flight [by Airport Police on April 9, 2017] after he refused to give up his seat to employees of a partner airline" (recorded on video that went viral worldwide) (*The Guardian*, 2017, April 27, para. 1). Contacted reporters Martin and Raab of *The Los Angeles Times* further reported that "Dr. Dao suffered a broken nose and a concussion and lost two front teeth" (*The Los Angeles Times*, 2017, April 27, para. 2). Since this case was settled out of court, it is not possible to know what the lawsuit was based upon. However, this case is clearly a discrimination case of preferential treatment and/or racial profiling against Asian Americans from the privilege group.

6. *The impact of the model minority myth on Asian American high school dropout rates.* The model minority myth has a negative impact on the high school dropout rates among Asian American students. The perception that all Asian Americans as a group exceed other minority groups on a variety of social, academic, and economic indicators is not a fair assessment of the entire Asian group. The National Center for Education Statistics (NCES) (2017) examined the status of the high school dropout rates among all groups in the USA based on the 2000 Census and reported that the dropout rate for Asian was 2.4%, 4.5% for White, 7.2% for African American, 13.2% for Native American/Alaskan Native, and 5.4% for Hispanic. In California, Olsen (1988) found that the highest dropout rate (48%) was found among SEAs along with 46.1% among the Filipino students. Rumbaut and Ima (1988) revealed that the Pacific Islanders had the highest dropout rate (17%) in San Diego followed by Latinos (14%), Cambodians (14%), Vietnamese (11%), and White (10%). Trueba, Cheng, and Ima (1993) identified 12 characteristics that contributed to their educational risks, which were "disrupted schooling, disrupted family support, experience of trauma, long duration at refugee camps, poor health, lack of prior schooling, poor school attendance, lack of participation in class, lack of supervision at home, lack of progress in English, lack of participation in extracurricular activities, and lack of guidance and counseling for career/life goals" (Siu, 1996, pp. 14–15; Trueba, Cheng, & Ima, 1993, p. 123).

As a consequence of the high school dropout rates of Asian American students, despite the dropout rate being low in some geographical locations, some of these dropouts have organized Asian gangs and roamed the streets in several metropolitan cities or in the suburban communities that Li (2009) referred to as "ethnoburbs." These gangs include the Tongs and the Hong Kong-centered triads in the metropolitan Chinatowns around the world, the Wo Hop To triad, Wah Ching Gang, Joe Boys gang, Hop Sing Boys, and the Jackson Street Boys in San Francisco Chinatown, London, New York, Sydney, Australia, Vancouver, British Columbia, and Canada. Cambodian gangs operate in Southern California and in Boston (Willwerth, 2001). Mien gangs are concentrated in East Bay (Johnson, 2004). Several Hmong gangs operate throughout communities in the Midwest (Vielmetti, 2010) and in California. Vietnamese gangs operate in San Jose, California (Salonga, 2016), and throughout much of the other areas where the Vietnamese populations are clustered. All in all, these are just a few examples of the prominence of gangs in the Asian American communities. They usually prey upon their communities and victimize their very own nationality (News Ticker, 2017).

In sum, Asian Americans as a group will continue to "face subtle, blatant and protuberant

prejudice, discrimination, and institutional racism which cause suffering, intense pressures to adapt to values and belief systems that are typically part of the white way of thinking and living" (Feagin & Feagin, 2008, p. 166). Much of the systemic racism occurs with housing and employment which affects one's socioeconomic status and ability to live successfully in the USA. Schaefer (2006) referred to the term "the door half open" (p. 312) for Asian Americans to express the notion that they have hit a "glass ceiling" in employment opportunities (Schaefer, 2004, pp. 95–97, 2006, p. 86, 2012, p. 78).

Mental Health Problems Among Asian Americans

With regard to the issue of utilization and treatment, Sue, Ivey, and Pedersen (1996a, b) published a study on the use and treatment of mental health services and found that Asian Americans underutilized mental health facilities, no matter what specific ethnic group they belonged to. Leong (1986) indicated that there are some cultural factors that have caused Chinese Americans not to seek help from mental health services. Some Chinese believe that diseases are caused by an imbalance of the cosmic forces (e.g., yin and yang). Meanwhile, some (animistic) cultures from Southeast Asia, such as the Laotian, Mong, Iu Mien, and Khmu, believe that illnesses are the result of offenses one may have committed against the spirits (Leong, 1986). Thao (1999) discussed the spirit of supernatural forces as being known as the "*dlaab*" (spirits) in Mong and "*phi*" (spirits) in Lao. Individuals are not allowed to offend the "*dlaab*" and "*phi*" since they are able to inflict harm on one's physical body through nightmares, which might even lead to death.

Nishi (2016) reported that the University of Maryland School of Public Health research in 2007 examined the mental health of 174 young Asian American adults from 8 Asian American communities, consisting of Asian Indians, Cambodians, Chinese, Indonesians, Koreans, Taiwanese, Thai, and Vietnamese. Nishi's (2016) findings revealed that all the young Asian American adults participating in the study shared several common sources of stress that affected their overall mental health (listed below). More research and studies have been done and added to support their common sources of stress:

- Parental pressure from parents for children to succeed in academics (Childtrends Databank, 2015; Groves, 2016; Hong & Lee, 2003; Nishi, 2016; Vuong, 2015; Yamamoto & Holloway, 2010)
- Discussion of mental health concerns considered as taboo (Bhat, n.d.; Bilkhu, 2016; Jun, 2017; Kramer, Kwong, Lee, & Chung, 2002; Lee et al., 2009a, b; Mental Health America, 2006; Nishi, 2016)
- Denial or neglect of mental health symptoms (Mental Health America, 2006; Meyers, 2006; Nishi, 2016; U.S. Department of Health and Human Services, 2001).
- The pressure to live up to the "model minority" stereotype (Cheng, 2015; Lee et al., 2009a, 2009b; Wingfield, 2016; Woo, n.d.)
- Familial obligations based on strong traditional and cultural values (Choi, Kim, Kim, & Park, 2013; Kramer et al., 2002; Liu et al., n.d.; Pierce & Sarason, 2013; Nishi, 2016; Xia, Do, & Xi, 2013)
- Discrimination because of racial or cultural histories (Chow, 2017; Iwamoto and Liu 2010; Economist News Briefing, 2015; Eikenburg, n.d.; Guo, 2016a, b; Kiang, n.d.)
- The difficulties in balancing two different cultures (Chang, 2007; Hall, Hong, Zane, & Meyer, 2011; Lee et al., 2009a, 2009b; Leong, Juang, Qin, & Fitzgerald, 2011; Nishi, 2016; Tewari & Alvarez, 2009; Xia et al., 2013)
- Development of a bicultural sense of self (Dennis, 2008; Organista, Chun, & Marin, 1998; Scheunemann, 2011; Schwartza & Ungerb, 2010; Yamaguchi, Kim, Oshio, & Akutsu, 2016; Zhang, Noels, Lalonde, & Salas, 2017)

With regard to the cultural adjustment, Tummala-Narra, Sathasivam-Rueckert, and Sundaram (2013) study on the mental health implications for a group of elderly Asian Indians found that they had problems with acculturation. Their stress was related to adjustment of cultural values, family relationships, food, socialization, communication styles, as well as spiritual or religious practices. However, they received social support from their family, ethnic, and religious communities that played a very important role in helping them cope with the stress of acculturation. Lee (2009) identified the common stressors for Asian Indian individuals consisting of family obligations, difficulties in balancing two different cultures, and racial discrimination. Tummala-Narra et al. (2013) further asserted that the difficulty in balancing two different cultures seemed to be the primary stressor when dealing with issues, such as language barriers, changes in the societal and family structure, and isolation.

Kwok (2013) did a 10-year review of literature on factors that influence the diagnoses of Asian Americans and concluded that they have widespread domestic violence, alcohol abuse, and significant distress. However, they underutilized mental health services due to stigma, misconceptions of Western treatment, and cultural interpretations of mental health problems. With regard to the ethnic groups, Kuo (1984) did a study on the Chinese, Japanese, Filipino, and Korean Americans and found that they are on average slightly more depressed than Caucasians. Another study done by Hurh and Kim (1990) indicated that Koreans living in the Chicago area were more depressed when compared with the Chinese, Japanese, and Filipino residents in the same area. In a similar study done for Korean Americans, Han and her colleagues (2017) noted that there was an urgent need to destigmatize the beliefs associated with mental illness and called for the development of anti-stigma educational programs for the Korean Americans. But Ying's (1988) study on the Chinese in San Francisco discovered that the Chinese were even more depressed when compared to the subject participants in Kuo's (1984) study.

Shibusawa (n.d.) examined the mental health status of the Japanese American elderly for the Center for the Study of Social Work Practice and National Institute of Mental Health (NIMH) and found that Japanese and Chinese American senior citizens with mental health problems were on the rise and had the highest suicidal rate among all other US senior citizens (Baker, 1994; Lester, 1994). Cheng and her colleagues' (2010) study revealed that "the lifetime prevalence of suicidal ideation and attempts was 8.8% and 2.5%, respectively. Female gender, family conflict, perceived discrimination, and the presence of lifetime depressive or anxiety disorders were positively correlated with suicidal ideation and attempts" (p. 1). A study by Chu, Hsieh, and Tokars (2011) found that:

> Asian Americans with suicidal ideation were no more likely to perceive a need for help or seek help than Asian Americans with a mental disorder without history of suicide and were less likely to seek and perceive a need for help than Latinos with suicidal ideation…and that [they] prefer seeking help from nonprofessional rather than professional sources for help, other than medical professionals. (p. 1)

Duldulao, Takeuchi, and Hong (2009) reviewed the correlation of suicidal behaviors among Asian Americans and found that there was "little empirical epidemiological evidence about the correlates of suicide in this population" (p. 1). Kessler, Borges, and Walters (1999) and Kessler, Berglund, Borges, Nock, and Wang (2005) indicated that "prior studies have either omitted Asian Americans from the analyses, have included very small samples of Asian Americans, or have failed to disaggregate Asian Americans by socio-demographic factors, especially nativity" (p. 1) as reported by Kessler et al. (1999, 2005). Despite these findings, the elderly Asian American population received very little attention from researchers in the field of social work.

Given all the problems facing Asian Americans, there is a need to search for a model for counseling Asian Americans. Meyer and Zane (2013) pointed out that culturally sensitive mental health interventions were needed since "cultural elements affect the way mental health

clients experience services" (p. 1). A report of the Surgeon General on Mental Health, Culture, Race, and Ethnicity (2001) recognized that racial and ethnic minority persons are underserved by mental health professionals. A study done by Zane, Enomoto, and Chun (1994) revealed that Asian Americans were less satisfied in their service providers due to their lack of cultural sensitivity in their approach in treatment.

Mental Health Problems Facing the Asian Refugee Groups

The Asian refugee group encountered many issues, including disproportionate high school dropout rates (as previously discussed) and cultural, social, and educational problems. These, in turn, have contributed to the overall mental health of their entire families. Sue (1993, 2002) alluded to the fact that Asian refugee groups, such as the Cambodians, Laotians, Mong [Hmong], and Vietnamese, are considered high-risk groups due to the consequences of political events that took place back in their homelands. In *Mental Health: Culture, Race, and Ethnicity (Supplement to Mental Health: A report of the Surgeon General)*, the Surgeon General (2001) revealed that there are:

> Striking disparities for minorities in mental health services in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality. (excerpt, para. 1)

Lee et al. (2009a, 2009b) examined the needs of 17 young Asian mental adults (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese) in Montgomery County, Maryland, and found that the biggest challenge associated with mental health was the taboo in discussing their problems openly in many Asian communities. Asian mental health clients tended to "hide, neglect, or deny symptoms rather than to seek help. The most common conditions mentioned were stress, anxiety, and depression" (Lee et al., 2009a, 2009b, p. 147). Sack and Clark (1996) studied 170 Cambodian adolescent refugees in 80 families and found multiple forms of stress in Cambodian adolescent refugees (i.e., resettlement stressors and recent stressful life events). Their findings revealed that there was a consistent relationship between early war trauma, resettlement stress, and symptoms of post-traumatic stress disorder (PTSD). This study indicates that [Cambodian] "children who survive a war of terror, such as that of Pol Pot regime from 1975 to 1979, carry rather specific symptoms of that experience that affected the beginnings of their adult lives" (Sack & Clark, 1996, p. 114). Berthold (1999) supported Sack and Clark's (1996) findings and confirmed that "PTSD was strongly related to previous war trauma" but objected to the notion that PTSD "was not a manifestation of many forms of stress" (p. 456). This study is similar in nature to the kinds of content needed as previously studied, albeit somewhat dated (over 20 years old).

Critical Cultural, Social and Educational Problems Faced by the Asian Refugee Group The Cambodians, Laotians, and Mong have encountered some of the critical cultural, social, and educational problems during their adjustment in the USA. The refugees have gone through a period of cultural, social, educational, vocational, and gender role adjustment. In Cambodia and Laos, an individual's professional and vocational status determined their identity, social respect, and self-esteem. In the USA, adjustment to the new culture for the refugees meant an adjustment to a new self-identity. Many former high-ranking military officers who were illiterate in the English language had difficulty coping with vocational adjustment by accepting minimal-paying jobs, e.g., custodians and blue-collar jobs. Several Southeast Asian males also experienced the evolving gender role adjustment as well. Men were traditionally the breadwinners for the families, but this was no longer true in the USA. Financial circumstances now required two or more incomes to support a family. In several cases, Cambodian, Laotian, and Mong

women became the main breadwinners for the families (Thao, 1999). This adjustment of vocational and gender role for several Southeast Asian males was not easy in their acculturation process, and these challenges with acculturation had far-reaching effects on them that contributed to their mental health problems.

Challenges Faced by the Asian Refugee Student Group Asian refugee students (e.g., Cambodians, Laotian, Mong, and Vietnamese) have faced many challenges:

The lack of formal education received by their parents in their homelands (e.g., Cambodia, Laos, and Vietnam) has hindered progress in their education and further led to a lack of opportunities.

The unexpected migration from Cambodia and Laos to the refugee camps in Thailand and to the USA that subjected them to the stresses of uncertainty.

The experience of tremendous changes in almost every aspect of their lives that continues to this today.

The pressures to change their way of life as they are forced to adapt quickly to the American culture and social norms.

For these refugees, the acquisition of knowledge through whatever means needed to be accelerated at an unprecedented rate as they began their new lives in this "Information Age" and a highly technological US society (Thao, 1999). These are some of the challenges that they have had to struggle with for three or four decades.

Today, students from Southeast Asian refugee groups have made a lot of progress in education. However, they still fall behind their Asian immigrant counterparts and the average US student. Tang and Kao (2012) did a study on Cambodian high school students living in Southern California and found that "[they] were often mistaken for other Asian groups and due to stereotypes, expected to excel academically" (Abstract, p. 1). Their findings also revealed that gender and familial expectations still played prominent roles in their academic progress (Tang & Kao, 2012). Vang (2015) wrote a literature review on the barriers that impacted Hmong students in their postsecondary education in Minnesota and revealed that their barriers included family expectations, gender roles, cultural identity, racial prejudice, learning environment, language, financial struggles, academic perception, and separation or divorce in the family. Krupnick (2015) discussed the education and college admission rates of Southeast Asian American students and reported that, according to the Center for American Progress, 38% of the Hmong in the USA had less than a high school degree (which was 25% lower than the averages for both Asian Americans and the average US citizen) and only 14% had a bachelor's degree (which was less than half the national average). Despite the stereotype that most Asian American students typically attend college, Hmong, Laotians, and Vietnamese students, however, have had low rates of college attendance as compared to Chinese, Japanese, and Korean American students. Jaschik (2013) tabulated data on Asians and reported that the educational attainment was 14.7% for Hmong adults, 14.1% for Cambodian adults, 12.4% for Laotian adults, and 25.8% for Vietnamese adults. Jaschik (2013) further has asserted for colleges, universities, and organizations involved in education to disaggregate the numbers of Asian American students since the current practices to aggregate data on Asian Americans have only hidden many of the social inequities that they face.

In relation with the perception of the Southeast Asian community (SEA) on children with disabilities and special education, Rodriguez's (1995) study of 100 SEA parents and 31 bilingual SEA teachers found that half of these parents were unsure whether children with disabilities should go to school whereas only a quarter were unsure whether they could learn. Collignon, Men, and Tan (2001) researched SEA families that were involved in their children's education in New England and found that SEA community leaders lacked sufficient information about the educational system in the USA, attention to issues of language proficiency, cultural competency in ser-

vice provision to members of the SEA communities, and high expectations for their SEA community members.

The following material will discuss some of the more salient mental health issues among the recent high-risk Asian American communities in the following order: Cambodian, Mong, Laotians, and Vietnamese and mental health.

Cambodians and Mental Health For several cases of Cambodians with mental health problems, they normally complained about recurrent and multiple medical symptoms that had no visible or apparent discernible causes (Hinton & Otto, 2009). Lin's (1996) research findings acknowledged that somatization was a factor related to mental health. Hansen's (2014) anthropological study on the mental health of the Cambodian refugees who came to the USA after the Khmer Rouge era revealed that these refugees experienced "mental health trauma" that had long-term effects. Furthermore, Hansen asserted that Cambodians do not separate trauma from cultural practices, beliefs, and rituals; while Western cultures normally distinguished between the mind and body, many Asian cultures do not.

Cambodian families used education and gang avoidance as positive strategies to counter their difficulties with adjustment in America (Reiboldt & Goldstein, 2000). As a result, truancy and dropping out of school are major problems among Cambodian high school students in the USA. Goldberg's study (1999) indicated that truancy occurred primarily as a group activity among Cambodian students and none of these students reported parental support or tolerance for their truant behavior. The main reasons given for truancy were either boredom or the desire to socialize with friends. In addition, earning money and taking care of a spouse and children were major considerations for dropping out, but not truancy.

Mong and Mental Health Westermeyer et al (1984) discovered that there was a high rate of psychological stress among the Mong [Hmong]. The rate of depression was two to four times greater than that of the general US population. The Mong continued to sustain a high rate of depression sympthoms for even 3.5 years following their migration to the USA. Furthermore, Kinzie and Mason (1985) found striking cases of depression of 48% of Southeast Asians, as compared to 23% for American patient. In addition, Thao's (1999) study revealed that Mong American families encountered many problems, including "secondary migration" (p. 77), the lack of knowledge and access to jobs (p. 78), family reunification (pp. 78–79), vocational adjustment, and gender role adjustment (p. 80). Secondary migration was used as a way to get out of the problems.

Thao (1994) conducted a study in Chicago and found that the Mong who came to the Chicago area between 1978 and 1987 experienced tremendous frustration. This frustration was attributed to numerous problems including "adjustment to the new educational system," "language barrier," "native language and cultural loss," "intergenerational gap," "cultural differences between the Mong and the United States," "the issue of Over-Americanization," "gang related issues," "role shift," "misconceptions about the role of teachers," and "the lack of similar experiences to assist their children in the United States" (p. 86). These factors combine to create crisis in Mong American education (Thao, 1999). For a deeper insight into issues affecting Mong education, readers are encouraged to read *Mong Education at the Crossroads* (Thao, 1999).

Mueller et al. (1996) did a study on the early school performance of first and second grade Mong children while comparing them to their classmates and other ethnic groups and found that most of the children lived with both of their biological parents, had more siblings, moved less often, had lower mathematic achievement scores in kindergarten, and were rated by teachers as more cooperative, more self-controlled, having fewer classroom behavioral problems, and a higher school attendance rate than other ethnic groups. Liu and Li (1996) suggested that school psychologists, counselors, and other professionals use an ecological approach to effectively serve SEAs because it allowed for a more

accurate assessment of the students' psychological state and a broader understanding of crucial issues affecting them and their families within the context of a mesosystem (their immediate family, extended family, neighborhood, school, and other networks), macro-system (community or culture), and exosystem (society/social structures).

Bosher (1997) examined the relationship between language and cultural identity by interviewing 100 Mong students at the postsecondary level in Minnesota and Wisconsin. Bosher's findings suggested that Mong students who are academically successful are typically those who are bilingual and "have been able to adapt to the American culture without giving up their native culture or ethnic affiliation" (p. 601). Nevertheless, former California Secretary for Education Kerry Mazzoni echoed the severity of the low academic achievement of Mong students in a letter addressed to local school districts in California. The letter urged districts to attend a conference convened by the Office of the Secretary for Education (OSE), in collaboration with the Central Valley Mong/Hmong leadership and the Pacific Institute for Community Organization (PICO) on May 28, 2002. She brought it to their attention that "Mong/Hmong students are among the lowest performing students in many of our schools." For this section, the two spellings "Mong" and "Hmong" are used for inclusivity purposes of the two groups in the Mong/Hmong community (Bottomly, 2013).

Furthermore, former California Secretary for Education Kerry Mazzoni appealed to 150 Mong/Hmong educators and community leaders on May 28, 2002, at the State Capital in Sacramento, California, to bring up the crisis in Mong/Hmong education in America. Given the situation, there was a need to increase the efforts to increasing parental involvement, home-to-school communications, and the use of better teaching practices to improve the educational achievement of Mong students in California. The conference discussed the educational status of the Mong/Hmong students in California that resulted in the formation of the Advisory Committee for the Success of Mong/Hmong Students. Moreover, due to both Mong and Hmong students being among the lowest in academic achievement in California, the Advisory Committee then submitted 12 recommendations for improvement to Secretary Mazzoni, the California Department of Education (CDE), and several local school districts for consideration. For deeper insight into these recommendations, readers are encouraged to read Thao's cultural variation within Southeast Asian American families in *Comprehensive Handbook of Multicultural School Psychology* (Frisby & Reynolds, 2005, pp. 198–199).

Among the many problems associated with the Mong mental health emerged a horrific phenomenon called "*tuag tsaugzug*" (or sleeping death) (Thao, 1999, p. 79). The phenomenon involved Mong males between the ages of 22 and 55 who were perfectly healthy but died in their sleep. Sherman (1978) reported that 115 Mong males in the USA had died mysteriously in their sleep. Thao (1999) estimated that over 200 Mong males may have died from this sudden unexplained death syndrome (SUDS) alone. Several other experts linked the sudden unexplained death syndrome to nightmare frights due to the stress of cultural assimilation (Bliatout, 1982; Thao, 1999). Due to cultural differences between the Mong and the USA, Ugland Cerhan (1990) asserted that Mong had a difficult time adjusting to life in the USA and, therefore, were unlikely to seek help and counseling services from Western mental health professionals. Another Asian group that had similar problems was the Filipinos. Munger (1982) and Munger and Booton (1998) documented 45 Filipino males in Manila around the age of 33 between the years 1948 and 1983 who experienced some form of sudden death syndrome similar to the Mong cases. The Filipinos called this phenomenon *bangungut* (Aponte, 1960), as quoted in Munger and Booton's (1998) article. The cause of death for these Filipino males was related to "ventricular fibrillation" (Munger & Booton, 1998, p. 677), whereas the cause of death for the Mong cases was speculated to be related to "cardiac instability" (Munger & Booton, 1998, p. 677). Young, Xiong, Finn, and Young (2013) did a study on the sleep disorder cases of 747 Hmong immigrants in Wisconsin and found:

> a unique Hmong sleep disorder profile of a high prevalence of sleep apnea, sleep paralysis, and other [rapid eye movement] REM-related sleep abnormalities as well the interaction of culturally related nighttime stressors with these sleep problems. For example, experiences of *dab tsog* (a frightening night spirit pressing on one's chest) was prevalent and related to sleep apnea indicators, sleep paralysis, nightmares, hypnogogic hallucinations, and insomnia. (abstract)

Chen (2014) reported that "Scientists are just beginning to understand how cultural beliefs can lead to psychological stress, illness, and even death" (para. 4).

In Ramsey County, St. Paul, Minnesota, Thao, Leite, and Attela (2010) examined the mental health needs and services of the Mong community and reported that the Mong community experienced twice the level of mental health issues of the general US population, e.g., "major depression, post-traumatic stress disorder, and other anxiety disorder(s)" (p. 2). Rather than seeking help from mental health professionals, the Mong were more likely to seek help from their own community members, such as clan leaders and spiritual leaders (pastors for Christians and shamans for traditional Mong) (pp. 3–8).

Laotians and Mental Health After conducting research on the Laotian mental health, there seemed to be almost no information on this group. The only available source was some collaborative work between the Lao Studies Center and the Mental Health Association of San Francisco. However, three research projects are currently still underway: Lao Idiom Project, Know the Signs: Suicide Prevention Campaign, and a project titled "Our Story: Recovery and Mental Wellness" (Center for Lao Studies (CLS), 2006–2014). These research projects are still in progress and no report is yet available.

Vietnamese and Mental Health There is not much information on the mental health of the Vietnamese. Nauert (2008) conducted a study on the mental health of Vietnamese Americans and found that there were more mental health issues among older Vietnamese Americans over the age of 55, especially the individuals who came to the USA as political refugees. The report further indicated that Vietnamese people have more mental health issues than non-Hispanic Whites. DePaul (2013) examined the root of the trauma for mental health issues among Vietnamese people and reported that post-traumatic stress disorder (PTSD) has been widespread among the Vietnamese population with links to depression, gambling problems, and habits of domestic abuse.

Challenges in Working with Asian American Clients

Psychologists, social workers, and mental health professionals need to be aware that there are several challenges when working with Asian American clients:

1. The first challenge is the usage of the term "mental illness" itself which is a new and Western term for most Asian American people that also tends to carry a negative cultural connotation in some Asian cultures. There are no technical terms available yet in any of Asian languages that may be equivalent to the term "mental health," except its transliteration into the various Asian languages.

   Several researchers (Castillo & Phoummarath, n.d.; Chu & Sue, 2011; Sue, 1994) commented that there are cultural implications associated with the concept of mental illness as well as the cultural conceptions of shame and stigma. There are no technical terms equivalent to mental health since it only involves the concept of "shame" or the "saving of face." In the various languages that involve concepts of "shame" and the "saving of face", there is "*haji*" for the Japanese, "*hiya*" for Filipinos, "*mentz*" (*mian zi*) for Chinese, and "*chaemyun*" for the Koreans. In certain Asian cultures, some people may avoid associating themselves with mental health problems altogether once they are diagnosed with symptoms of mental illness. As a result, fewer Asian Americans may hesitate to seek help from Western mental health service providers, which in turn would affect their utilization of

Western mental health services due to the fear of shame and embarrassment in the community (p. 1). In some Southeast Asian languages, there are no equivalent technical terms that can capture the term "mental health" holistically. For example, in the Mong language, mental health only translates to "*mobhlwb* or *mobvwm*" (head disease or crazy disease, respectively). In Lao and Thai, it translates to "*lok/rok chit*" (psycho disease) and "*lok/rok prasart*" (nervous system disease). Although an acculturated Asian American today may not typically take the negative connotation surrounding the term quite seriously, "mental illness" is still considered taboo in the older and more traditional-minded Asian American generations, as previously discussed in this section. Due to the fact that several generations (e.g., grandparents, baby boomers, generation X, generation Y or millennials, and generation Z) of Asian Americans still live together in tight-knit families, the older Asian American generations still have a lot of influence over the younger generations when it comes to mental health issues.

It has been established that the stigmatization of the term "mental health" in several Asian communities only makes people feel reluctant to seek mental health services. Furthermore, the consequences of this reluctance to seek mental health services become detrimental to those who really need it. Therefore, mental health professionals and applied psychologists need to be aware and recognizant of the negative connotation of the term "mental illness" at all times, particularly when counseling the Asian American clients of a specific ethnicity that might have a mother tongue with some negative connotations associated with the term "mental health." With some prior knowledge of the culturally specific Asian American groups, mental health professionals would be better able to diffuse, demystify, and debunk the negative connotation of mental health services ahead of time. Things to keep in mind include:

1. Avoiding the translation of the term "mental health services" into certain specific Asian languages that have some negative connotations associated with the term. Instead, keep using the term "mental health services" in English to dispel the negative connotation of the term "mental health."
2. Avoiding identifying oneself as a mental health professional or applied psychologist and instead referring to oneself as a "social worker." Through personal and professional experience, the term "social worker" carries some positive connotation in the minds of Asian American clients as a "helper" who could help them with their psychosomatic symptoms as well as make them feel better. A professional must be mindful of some Asian American clients who may already have sought help from family and community members and consulted with spiritual leaders while resorting to traditional healing methods before seeking help from Western mental health services as a last resort (Gensheimer, 2006; Ly, 2016). Another suggestion is for mental health professionals to learn to be good listeners who will listen and empathize to the stories that their Asian American clients tell them, which would help them tremendously. Perhaps some form of vitamin prescription from mental health professionals or applied psychiatrists may be deemed necessary as it would help the psyche of the clients. Be aware that some Asian American clients will expect their mental health professionals to be experts, so mental health professionals need to present, dress, and conduct themselves professionally. Some Asian American clients may already have some familiarity with certain forms of treatment for relieving physical ailments, such as somatic symptoms. Due to some misunderstanding of mental health symptoms, some Asian American clients will tend to misunderstand mental health symptoms while they seek for certain medication from their mental health professionals. Perhaps mental health professionals will

want to suggest to their clients certain types of alternative therapies and culturally relevant activities within the Western mental health system that might get rid of their somatic ailments (including some suggestions for multivitamins that their clients might need). According to Thao, Leite, and Atella, these suggestions might even treat a client's mental illness symptoms as well.

2. Combined with the negative connotations of the term, some myths and misunderstandings about mental illness have also been cited as reasons for why fewer Asian Americans may not seek the help of mental health services (Brooke & Myers, 2015). The US Census Bureau (2010) reported that the Asian American population was 18.4 million and is projected to reach 40.6 million by 2050. If that is true, the proportion of Asian Americans in America would increase from 4.8% to 9.6% (Hoeffel, Rastogi, Kim, & Shahid, 2012). Of the Asian Americans who were diagnosed with some depressive disorders, "two out of three (69%) did not seek mental health treatment as compared to 64% for Hispanics, 59% for African Americans, and 40% for White Americans" (Alegria et al., 2008; Augsberger, Yeung, Dougher, & Hahm, 2015, p. 1). Furthermore, Le Meyer, Zane, Cho, and Takeuchi (2009) reported that "only 28% [of Asian Americans] used specialty mental health services" (Augsberger et al., 2015, p. 1; Le Meyer et al., 2009).

3. Asian Americans may have cultural and linguistic barriers. This has been a factor contributing to their underutilization of mental health services (Le Meyer et al., 2009). Several studies (Appel, Huang, Ai, & Lin, 2014; Kawahara & Fu, 2007) indicated that "cultural barriers and the lack of perceived access" (p. 241), public stigma, shame, and the need to "save face" (Kawahara & Fu, 2007) were also reasons for seeking help from mental health specialists and for their underutilization of mental health services. In addition, Sue (1993) stated that the cause of underutilization of mental health services involved several factors, e.g., "accessibility, availability, cultural and linguistic appropriateness of services, knowledge of available services, and willingness to use services" (p. 87).

Asian Americans failed to use mental health facilities with the same frequency as the greater American population, but "their rates of mental disorders are not extraordinarily low. Thus, public portrayals of Asian Americans as a well-adjusted group do not reflect reality" (Sue, Sue, Sue, & Takeuchi, 1995, Abstract, para. 1). In the meantime, Okazaki, Kassem, and Tu (2014) did a literature review on mental health disparities for Asian Americans and suggested that these disparities have continued to exist for certain Asian American populations relating to the rate of mental illness and access to care and treatment. Okazaki et al. (2014) advocated for the community-based participatory research (CBPR) approach to work with Asian American clients. Saw and Song (2014) discussed the physical and mental health disparities within the Asian American community, including health, "psychotropic medication, quality of life, occupational health, and inpatient psychiatric care, and to sociocultural factors that may influence disparities, such as cultural competency, face concerns, and the model minority myth" (p. 1).

While Fung and Wong (2007) admitted that younger, educated Asian Americans have more positive attitudes toward mental health, on the contrary, Augsberger, Yeung, Dougher, and Hahm (2015) mentioned that young Asian American women between ages 18 and 24 were considered to be the highest at risk for mental illness and the second highest suicide rate in the USA. Ting and Hwang (2009) observed that their rate of suicide from 2000 to 2009 increased by 100%. In addition, a number of researchers, Kopala and Keitel (2017) and Kawahara and Fu (2007), further commented that "[Asian] women who are undocumented may also hesitate to seek counseling for fear of being

reported to immigration service and later deported" (Kopala & Keitel, 2017, p. 241).

4. The Asian American population cannot be easily lumped together due to its huge heterogeneity in terms of their ethnicity, language, culture, education, income level, English proficiency, and sociopolitical experience (e.g., Bangladeshi to Korean) (Lee & Zhou, 2015). Psychology Research Reference (n.d.) documented that Asian Americans comprise of 43 different ethnic groups with over 100 languages and dialects. Given the heterogeneity and exponential growth in population, Iwamasa (n.d.) pointed out that "there is an increased need for culturally competent mental health services and providers with expertise in working with this population" (p. 1). Although counselors have been trained in the Western models of psychotherapy, their way of assumptions and approaches to counseling Asian Americans may not be compatible with the specific cultural background of Asian Americans.

   Instead of helping their Asian American clients, the efforts of counselors may even end up becoming a disservice to these clients. Counselors need to adapt their training and knowledge base to be both culturally appropriate and responsive to the needs of the specific culture of their Asian American clients. Due to the increase in interethnic population and the manifestation of mental health disorders of various specific cultural groups, coupled with cultural values, intergenerational gaps, and levels of acculturation, there is a growing need for cultural appropriate mental health services for the Asian American population in the years to come.

5. Sue (1993) noticed one major problem related to funding. There have not been large-scale studies conducted on issues of mental health disorders among Asian American groups. Furthermore, no funding has been provided or made available for such studies (p. 82). The Surgeon General (2001) and Eisenberg et al. (1998) concurred with Sue's (1993) point for the lack of large studies documenting the rates of psychiatric disorders among Asian American youth groups. Sue, Nakamura, Chung, and Yee-Bradbury (1994) found this out when they conducted a literature review on mental health research and pointed out that no serious mental health research for these youth groups has been undertaken until two decades ago. Moreover, mental health research for Asian Americans "is a [relatively] young and expanding field, diverse in its theoretical focus and methods" (p. 66). In addition, Asian Americans and Pacific Islanders in the past have not been included in national studies on the use of alternative and complementary healthcare sources (Eisenberg et al., 1998; The Surgeon General, 2001).

6. Finally, given the cultural and linguistic variations and differences in the Asian American populations, coupled with the stigma and shame against the term "mental health" itself, Asian American college students are reluctant to pursue training in mental health professions and social work and to participate in the necessary licensing procedures required to treat mental health patients in the USA.

In sum, the aforementioned problems discussed in these paragraphs are some of the most prevalent issues of mental health faced by the Asian American communities in the USA today. The point is that no matter how long Asian Americans have been in the USA, whether they have been naturalized by the US Immigration and Naturalization Service as citizens or were born in the USA, they still have not been regarded as truly "Americans." Furthermore, Ogbu (1987 & 1991) indicated that Asian Americans have been perceived as immigrants as opposed to minorities. At the bottom line, Takaki (1989) pointed out in his book that Asian Americans have continued to be regarded as strangers from a different shore. Furthermore, Lee (1996) commented that Americans believed that Asian Americans "do not have any problems" (p. 5), therefore, perpetuating that Asian

Americans do not need any mental health services, which is not true.

Discussion of Mental Health Problems in Asian American Communities

Given the demographic shift in the diversity of the US population, coupled with the cultural and mental health problems in the Asian American community, it is imperative to note that the cultural and psychological problems facing Asian Americans today have plagued their communities for a long time and deserve much needed attention. Mental health services must be culturally relevant, appropriate, and responsive to the needs of the various Asian American ethnic groups. Mental health professionals and applied psychologists currently serving Asian Americans need to equip themselves with the cultural knowledge base of various specific Asian American cultures, including their historical struggle as well as their immigration and religious backgrounds. They should be aware that Western models of counseling and therapy may not work for or be compatible with Asian Americans. Thus, mental healthcare and services should strike a balance between the community-based and individualistic approaches to life rather than meeting the demands of the Western culture (Durvasula & Mylvaganam, 1994). They should become culturally competent to provide the services that are culturally appropriate and sensitive to the clients that they serve (National Association of Social Work [NASW] (2000, p. 9).

Within the disciplines of cultural studies and education, two models of cultural competence will be discussed. The first model that Cross, Bazron, Dennis, and Isaacs (1989) put together is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Cross's model further consists of two components: (1) a set of basic assumptions involving the acquisition of knowledge of culture and (2) the development of individual cultural competence skills (pp. 13–17). Another model of cultural competence was introduced by Banks and Banks (2001). Banks's model is a set of professional standards centered on the principles of cultural competence in teaching and educational delivery. This model is referred to a "multicultural education," as quoted in the article "Diversity within unity" (p. 18) which was introduced by Patterson (1996) as a multicultural counseling model that later fully developed into a comprehensive model of multicultural counseling by Hays and Erford (2017). For more detailed information on the multicultural counseling model, readers are encouraged to consult *Developing Multicultural Counseling Competence: A Systems Approach* (Hays & Erford, 2017).

Due to the cultural stigma associated with the term "mental health" and "mental illness" in several Asian languages, Asian American families often refuse to seek professional help until they reach a state of crisis. During the period of crisis, service providers should take certain precautions when providing mental health services to their Asian American clients. Service providers should understand the shame that is involved and felt by the clients and their families (Shapiro, 2003). Before considering the use of service providers, some important factors are also involved in making the thorough assessment of treatment plans:

1. Adapting their knowledge in counseling, psychotherapy theories, and their approaches (Grohol, n.d.), such as psychoanalysis/psychodynamic theory (Shelder, 2011), behavioral theory, cognitive theory (Bandura, 1989), humanistic approach (Goldstein, 1986), and holistic/integrative therapy, in their treatment plan as they see appropriate. Service providers may already have in their repertoire a framework to work with their clients' feelings, thoughts, and behaviors from the diagnostic stage to treatment. However, they may need to consider adapting their approaches to meet the needs of their clients. Mental health professionals

may further want to consult the following resources: *Developing Cross-Cultural Competence: A Guide for Working with Children and Their Families* (Lynch & Hanson, 2011), *Handbook of Adult Psychopathology in Asians: Theory, Diagnosis, and Treatment* (Chang, 2012), and *Culturally Responsive Counseling with Asian American Men* (Liu, Iwamoto, & Chae, 2010) when working with Asian American clients.

2. Familiarizing oneself with the specific cultural characteristics of their clients, including their "history, experiences, cultural values, and their life style," is a must (Ugland Cerhan, 1990, p. 88). Learning and deepening one's knowledge of specific cultural norms of each Asian American ethnic group may also be necessary to provide cultural appropriate mental health services to them. Furthermore, service providers may need to consult and incorporate some of the new multicultural counseling and therapy approaches in their work. There is a plethora of resources available on multicultural counseling and therapy that they could include in their practices. Mental health professionals may consult the model for the theoretical basis of cultural competence to guide psychotherapy proposed by Chu, Leino, Pflum, and Sue (2016) as well. Chu et al. (2016) proposed three theoretical principles on how the mechanisms of cultural competence works, which involves "(a) a contextual match with clients' external realities; (b) an experiential match in the microsystem of the therapeutic relationship or framework; and (c) an intrapersonal feeling of being understood and empowered within the client" (p. 1). Involving family or extended family members and, to a certain extent, some community leaders may also be necessary (Kim-Goh, Choi, & Yoon, 2014; Thao, 1999). Wang and Kim (2010) suggested the therapist multicultural competence may be implemented where "four elements" of counseling are involved: (1) self-awareness, (2) cultural knowledge, (3) the ability to communicate understanding through empathy, and (4) the ability to apply the previous three in the appropriate context. These four elements are essential for counseling minority clients" (p. 141)—a conceptual framework for cultural competence developed by Balcazar, Suarez-Balcazar, and Taylor-Ritzler (2009).

   The role of the nuclear and extended family plays a central role in the mental health counseling of Asian Americans. Besides serving as potential mental health stressors, nuclear and extended family members could also serve as potential intermediary and/or gatekeepers and facilitate mental health counseling intervention, especially when the acculturation process is involved (e.g., social isolation, adjustment difficulties, and cultural and language barriers) (Psychology Research Reference, n.d.). Abe (2012) did a study on the community ecology approach to cultural competence in the delivery of mental health services of Asian Americans, and Ansary and Salloum (2016) researched on the community-based programs that utilize the ethnic-specific approaches to optimizing wellness of Arab Americans. Both studies (Abe, 2012; Ansary & Salloum, 2016) found the community-based programs that utilize the ethnic-specific approaches were very effective and concluded that there was a "high degree of commonality across the five Arab/Asian programs." Abe (2012) and Ansary and Salloum (2016) noted that community-based programs better met the needs of ethnic minority groups if they were adapted to the clients' ethnic culture.

3. Implementing effective methods for counseling Asian American clients require the considerable amount of adjustment of a professional's communication style and counseling style, and professional conduct, understanding of client expectations, and avoidance of biases. Culturally responsive approaches may need to be used by professionals to provide the effective delivery of cross-cultural services and counseling to their clients. Zhang and Dixon (2001) conducted a study to examine the difference between two approaches of counseling—culturally responsive and culturally neutral counseling—to 60

Asian international students and found that the students rated counselors in the culturally responsive approach to be "more expert, attractive, and trustworthy than those in the culturally neutral condition" (abstract, p. 1). Furthermore, these students preferred to be counseled by counselors with similar ethnicity. With regard to counseling styles, Kim et al (2001) commented that counselors who observe ethnic traditional values make their Asian American clients feel more comfortable and advised counselor to use a directive approach in counseling. In addition, Zhang and Dixon (2001) suggested that counselors need to present themselves as culturally responsive by exhibiting pictures or crafts from various Asian countries and, perhaps, a map of Asia in their offices when communicating with clients, including a show of interest in the cultures of their clients.

Service providers may want to consult Paniagua's (2014) practical guidelines for the assessment and treatment of Asian clients in his new book *Assessing and Treating Culturally Diverse Clients*. Paniagua (2014) cautioned therapists about the indirect way of communication of Asian Americans. Leong (1982) pointed out that Asian Americans use indirect ways of communication when they are "polite even when they don't understand the questions," "quiet and passive," and "tend to avoid eye contact" (Paniagua, 2014, p. 5). This could, in turn, hinder "problems for assessment and treatment" (p. 5). Regarding the relationship between therapist and client, Paniagua (2014) advised that formalism and maintaining of distance should be observed at all times. In the meantime, Park, Chesla, Rehm, and Chun (2011) suggested three methods for how mental health professionals might be able to adapt their practices to meet the unique needs of Asian American clients: (a) the implementation of cultural brokering, (b) the offering of support for families in transition, and (c) the use of cultural knowledge to enhance competent care to be culturally appropriate to work with Asian American clients.

4. Professionals need to learn to observe the Asian American way of expressing their psychological disorders in somatic terms. Paniagua (2014) discussed some examples of somatic symptoms (e.g., chest pains, headaches, and fatigue) as well as psychiatric symptoms (e.g., hallucinations and delusions). Mental health professionals should be mindful that, instead of seeking help from counselors and therapists, some traditional Asian Americans might choose alternative forms of home remedies—e.g., herbal medicine, acupuncture, moxibustion, coin rubbing, and cupping (Carteret, n.d.)—before seeking help of mental health services. Others may turn to the spirituality and religious practices—e.g., meeting with religious leaders, community leaders, or older family members (Iwamasa, n.d.); for example, a Christian pastor or Catholic priest may be called upon to counsel Mong Christians or Catholics; a shaman for the traditional non-Christian Mong [Hmong]; and a Buddhist monk for Cambodians, Laotians, and Thai (Thao, 2005). Spirituality and religious practices have served "as protective factors for the development of psychological distress among Asian Americans and Pacific Islanders" (Iwamasa, n.d., p. 1). For deeper insight into the Asian American psychological disorders expressed through somatic terms, readers are encouraged to read Chapter 5 Guidelines for the Assessment and Treatment of Asians in Paniagua's *Assessing and Treating Culturally Diverse Clients: A Practical Guide* (Paniagua, 2014).

Recommendations

As pointed out by the Surgeon General (2001), our knowledge of the mental health needs of the Asian American population is very limited because no large-scale studies have been conducted on the issues of mental health disorders of Asian Americans and serious mental health research has not been done for the last two decades. Kalibatseva and Leong (2011), in their study, cautioned mental health professionals and

researchers of "the complexity of depression among Asian Americans, as the disorder seems to be more multifaceted, and the population is more heterogeneous compared to previous conceptualizations of depression among Asian Americans in research and clinical practice" (p. 1). Therefore, future research and practices must take into consideration "the heterogeneity of Asian Americans, the multidimensionality of depression, and intersectionality of various factors that may affect the experience of depression" (p. 1).

Kim and her colleagues (2015) did an annual review of Asian American Journal of Psychology in 2014 and included 316 articles for the review. Most of these articles were primarily about the health and health-related behaviors of youths and emerging adults (18–25 years). In 2015, Kiang and her colleagues (2016) did the following annual review of Asian American Psychology in 2015 and included 332 articles in the review. Kiang et al. (2016) pointed out that "[Asian American Psychology] continues to grow in breadth, depth, and rigor" (p. 234) and "existing research spanned over 25 topic areas with empirical work on health and related issues representing the most popular field of study" (p. 234). Even though there is more evidence of studies on culturally relevant areas of research (e.g., acculturation, identity, and racism) as well as studies on family and school contexts, she opined that topics such as adoption, media, politics, spirituality, and LGBTQ are still lacking. In addition, Yoon and colleagues (2013) used a meta-analysis to examine the relationship between the process of acculturation, enculturation and acculturation strategies, only to find that "acculturation was favorably with both Negative Mental health (NM) and Positive Mental Health (PM); whereas enculturation was favorably related only to PM (positively). In fact, enculturation was positively related to anxiety" (p. 1). In the meantime, Sun and colleagues' (2016) study suggested that acculturation and enculturation are to affect minorities' attitudes toward seeking psychological services. Systemic reviews and meta-analysis should be used to examine the three methods to assess acculturation and enculturation—unidimensional acculturation, bidimensional acculturation, and bidimensional enculturation—serving as predictors of help-seeking attitudes (HSAs), both positive and negative attitudes, among racial and ethnic minorities when examining research reports. For more detailed information on acculturation in Asian American families, readers are encouraged to consult the *Handbook of Mental Health and Acculturation in Asian American Families* (Trinh, Rho, Lu, & Sanders, 2009).

Indeed, there is a need for research into the mental health issues of Asian American communities at the micro- and macrolevel. Ongoing longitudinal research on issues of mental health disorders for Asian Americans should be undertaken as a priority and on a large scale. Moreover, sufficient funding from the federal, state, and local governments as well as private sectors should be available to investigate issues of access, equity, resources, and the ongoing search for effective counseling and therapy models.

Jussim's (2012) study indicated that "history of research led social scientists to conclude that people's perceptions are often biased and inaccurate" (p. 18). Personal stereotyping when growing up and personal experience with Asian Americans may have influenced mental health professionals to develop some biases against their Asian American clients. One should be aware of personal bias toward certain Asian American ethnic groups. One final suggestion is that establishing trust is very important for counseling and working with Asian American clients and must be earned. When trust is earned, Asian American clients will start to open up more, and at the end, mental health professionals and their Asian American clients could develop a good relationship and perhaps forge a long-lasting friendship in the years to come.

In addition, bilingual, bicultural, multilingual, and multicultural mental health professionals need to be trained to serve the specific Asian American populations that are increasing in number. To improve Asian American clients' satisfaction, mental healthcare and healthcare facilities should hire "culturally diverse staff to bridge the cultural gaps and to improve the overall quality

of care" (Ubogaya, Alfred, Chen, Wint, & Worral, 2014, Abstract).

Furthermore, colleges and universities should take extra efforts to recruit and attract potential bilingual, bicultural, multilingual, and multicultural students to enter the mental health professions. In doing so, our nation could truly prepare future competent professionals in the field to deliver an efficient mental health system that is truly culturally responsive and sensitive to the needs of the diverse American population, which includes Asian Americans as well.

Suggestions for Further Study

As several researchers pointed out, there is a need to search for a culturally sensitive mental health model for counseling Asian Americans (Meyer and Zane, 2013; The Surgeon General's report, 2001; Zane, Enomoto, & Chun, 1994). Therefore, "the 3H principle using the head, hands, and heart" model is proposed in this chapter for mental health professionals to consider. Furthermore, after reviewing countless literature of various disciplines and accumulating years of personal and professional experiences in the refugee human services, immigration services, and education, I suggest more research should be done on the 3H principles to further develop them into the 3H model [FCL1] for practicing and delivering mental health services for Asian Americans.

Plumb (n.d.) alluded that Steven C. Hayes, Nevada Foundation professor at the Department of Psychology at the University of Nevada, Reno, and former president of the Association for Contextual Behavior Science (ACBS), introduced the phrase "head, heart, and hands" at the Third World Conference on ACT, RFT, and Contextual Behavioral Science in Enschede, Netherlands, in July 2009. To explain the model, "head" involves the cognition, education, and training in one or more disciplines of mental health professionals; "hands" refers to the implementation stage where the mental health professionals apply the knowledge and training to perform and deliver professional mental health services; and "heart" refers to the social-affective side where the mental health professionals develop empathy, mutual respect, and a connection with the clients' cultural aspects while wanting to go the extra mile beyond just their occupational duties. The 3H principle has been used in various disciplines:

- In education, "hand, head, and heart" techniques in the development and cooperative education (Gazibara, 2013)
- In sustainability education, as "head, heart and hand model"
- In religion, as "heart, head, and hand" (Sillis, 2016, 2017)
- In evaluation, as "head, heart, hand" (Ghate & McDemid, 2016[FCL2])

Conclusion

As the demographics in the USA have become more diverse, complex, and multicultural, so does the Asian American population. Even though Asian Americans may look similar, they are different in terms of language, culture, history, patterns of migration, socioeconomics, and level of education. Asian Americans consist of two main groups: the first group, also called the Asian immigrant group, which came to the USA prior to 1975, namely, the Chinese, Japanese, Koreans, Filipinos, Asian Indians, Malaysians, and Thai, and the second group, also called the Asian refugee group, which came to the USA after the fall of Cambodia, Laos, and Vietnam to the Communists in 1975 and consists of the Cambodians, Laotians, Vietnamese, Mongs [Hmongs], and Iu Miens. In fact, the Asian immigrant group has reputedly done better than the Asian refugee group, in terms of economics, education, and employment. Therefore, because both groups have striking differences, lumping all Asian Americans together into the same category—like some people do with an imprecise application of the model minority myth—can be a huge mistake.

As discussed previously, Asian Americans as a whole have had to and will continue to face prejudice, discrimination, and institutional racism (Feagin & Feagin, 2008) not just in housing and employment (Schaefer, 2006) but also in other areas of their lives as well. Not to mention, the negative experiences in their past histories of these Asian communities will continue to haunt them and hinder their ability to move up the ladder of social mobility. This chapter discussed in detail the contemporary mental health and educational problems that Asian Americans often encounter. With regard to mental health services, the Surgeon General on Mental Health, Culture, Race, and Ethnicity (2001) recognized that racial and ethnic minority people are underserved as well as ineffectively served by mental health professionals. There is an obvious need to then develop a new model for counseling Asian Americans today that would also need to be culturally sensitive and responsive to the needs of Asian American clients (Meyer & Zane, 2013) since there is a lack of cultural sensitivity in the current approach today (Zane et al., 1994).

Mental health service providers should recognize that Asian Americans are one of the most diverse groups of people and their numbers only continue to rise. As the number of Asian American population increases, the need for mental health services will also increase. Sue (1991) stressed the importance of counseling Asian Americans whose cultures are unique and different from the rest of the US population. Mental health professionals need to acquire a different set of knowledge and skills, be culturally and multiculturally competent, and approach Asian American clients with an open mind. It is important to recognize that providing mental health services with a Western-oriented model to Asian American clients may not be as effective as mental health professionals might expect and that "one size does not fit all." Nguyen and Bornheimer (2014) suggested that "the perception of mental health needs [of Asian American clients] increased the likelihood of using mental health specialist care. Social and systemic barriers together hinder mental health service use" (p. 1). Therefore, it is essential for a mental health professional to have an open mind and adjust his or her counseling skills and practices to be culturally relevant and responsive to the needs of the Asian American clients.

With additional cultural training for mental health professionals, Asian American clients may be better served by service providers who are knowledgeable about the cultural values of specific Asian ethnic groups. It is also imperative to be aware that providing mental health services to Asian Americans will become more and more challenging, but this also does not mean that mental health professionals cannot work with Asian American clients. They need to build bridges and establish trust in their clients as the first step. By increasing their knowledge base, however, in the cultures of their Asian American clients, these professionals will be able reduce the biases of their clients while being able to continue to deepen their knowledge and skills to serve the Asian American communities altogether more effectively.

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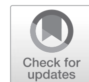

22 Cultural Competence in Therapy with African Americans

Eduardo Jones, Stanley J. Huey Jr., and Miriam Rubenson

African Americans face unique challenges in the mental health-care system. For instance, African Americans with mental health problems are more likely than European Americans to be misdiagnosed or undiagnosed (Schwartz & Feisthamel, 2009). They are less likely to receive specialty mental health care (e.g., psychologist, psychiatrist; Alegría et al., 2002; Alegría, Carson, Goncalves, & Keefe, 2011) and are more likely to be treated in primary care or community clinic settings (Noël & Whaley, 2012), where outcomes are sometimes worse for ethnic minority clients (Borowsky et al., 2000; Weersing & Weisz, 2002). When they do receive treatment, they are less likely to receive adequate care (Hahm, Cook, Ault-Brutus, & Alegría, 2015) and are more likely to end treatment prematurely (Fortuna, Alegria, & Gao, 2010; Smith & Trimble, 2016). The US Department of Health and Human Services (2001) concluded that African Americans and Whites tend to have similar rates of psychiatric disorders but that African Americans experience a greater burden of disease as a result of some of the disparities mentioned above.

The causes for these disparities are multifaceted and cannot be readily distilled to any single cause (Smedley, Stith, & Nelson, 2003). Disproportionate experiences of poverty, incarceration, racism, and exclusion likely intersect with the mental health needs of African Americans and may contribute to disparities (R. Williams & Williams-Morris, 2000; Roberts, 2003; Simons et al., 2002; Skiba et al., 2011; Snowden, 2014). At the same time, clinical factors and considerations such as clinical bias in assessment and treatment, misdiagnosis, lower rates of treatment engagement, and lower quality of services also likely contribute to observed disparities (DHHS, 2001; Snowden, 2003, 2012). Further highlighting the complexity of these disparities is research showing that even when relevant sociodemographic variables are controlled for (e.g., socioeconomic status, insurance status), racial disparities in treatment utilization and dropout persist (Alegría et al., 2002; Fortuna et al., 2010; Snowden, 1999).

Regardless of the exact causes, the consistent documentation of such disparities has led many mental health experts to conclude that culturally sensitive interventions – treatments that account for values, norms, attitudes, beliefs, and practices of a racial or ethnic group (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999) – are necessary to increase engagement (e.g., utilization, treatment adherence) among African Americans in therapy and improve treatment outcomes. The increased emphasis on culturally responsive interventions has primarily focused on primary care and outpatient community treatment settings where African Americans are more likely to receive treatment and disparities have been observed.

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In this chapter we critically assess the assumption that culturally tailored interventions are necessary to enhance treatment effects with African Americans. Specifically, we address three primary questions regarding the nexus between cultural competence and psychotherapy outcomes with African American youth and adults. First, is psychotherapy effective at reducing mental health problems with African Americans, and are there ethnic and racial differences in treatment outcomes? Second, what approaches to cultural tailoring are used with African Americans, and is there evidence that African Americans benefit from such approaches? Third, given the current evidence base, what are promising ways to think about improving treatment, including culturally tailored approaches, for African Americans?

Because we favor research that incorporates strong methodological rigor (i.e., internal validity) and robust patterns across the literature, we rely heavily on randomized controlled trials (RCTs) and meta-analytic reviews when possible. RCTs are considered the "gold standard" for assessing clinical efficacy because they involve random assignment of participants to treatment conditions and allow researchers to make causal inferences regarding treatment effects (American Psychological Association [APA], 2002). Meta-analyses involve synthesizing treatment outcomes across multiple studies with heterogeneous designs while controlling for specific study characteristics and provide more precise and reliable measures of treatment effects than individual studies alone (Cohn & Becker, 2003; Westen, Novotny, & Thompson-Brenner, 2004).

Overview of Psychotherapy Effects with African Americans

Psychotherapy is a form of treatment for mental health problems that typically involves a therapeutic relationship between a clinician and client in which the clinician attempts to reduce the distress of the client through inducing changes in the client's feelings, attitudes, and behavior (Frank & Frank, 1993). The clinician may do this through verbal dialogue or prescribed written (e.g., thought record, trauma narrative, expressive writing) or behavioral assignments (e.g., deep breathing, exposure exercises). Many therapies involve a variety of treatment techniques, and one of the most common types of therapy, cognitive-behavioral therapy, includes a focus on both in-session dialogue between the therapist and client and prescribes between-session homework assignments (Beck, 2011). Therapy can occur in a variety of settings including primary care, community-based clinics, university-based research clinics, college counseling centers, inpatient or hospital settings, addiction treatment centers, private practice settings, clients' homes, and prisons, among others. Most of the literature on psychotherapy has focused on treatment delivered in university- and community-based settings.

Literature reviews of psychotherapy outcomes for African Americans are cautiously positive, particularly those focused on youth. Huey and Polo (2008) found numerous evidence-based treatments (EBTs) for African American youth with conduct problems (e.g., cognitive-behavioral treatment, multisystemic therapy [MST]) and fewer for other psychosocial problems including test anxiety (e.g., anxiety management training), ADHD (e.g., behavioral therapy combined with stimulant medications), suicidality (e.g., MST), and trauma-related problems (e.g., resilient peer training). Effects sizes were in the low-medium range on average for studies using African American samples ($d = 0.35$).[1]

Reviews of psychotherapy outcomes for African American adults generally support its effectiveness. Carter, Mitchell, and Sbrocco (2012) reviewed 14 studies of psychosocial treatments for African Americans with anxiety disorders including panic disorder with agoraphobia, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and social phobia. Although only three RCTs were included in their review, each found positive treatment effects.

[1]Cohen's d is the most common effect size estimate used for clinical trials. It represents the standardized mean difference in outcomes between treatment and comparison conditions. Cohen (1988) considered a d of 0.2 as small effect, 0.5 as medium effect, and 0.8 as a large effect.

Horrell's (2008) review focused broadly on cognitive-behavioral therapy (CBT) for ethnic minority adults and summarized four RCTs addressing outcomes specifically for Africans Americans. Those four trials provide support that CBT is effective for African Americans with depression, PTSD, panic disorder with agoraphobia, and substance abuse.

Taken together, the available literature indicates that psychosocial interventions, including those without explicit cultural tailoring, work with African American adolescents and adults (see Table 22.1 for list of some EBTs with African Americans). However, gaps in the literature remain (Huey, Tilley, Jones, & Smith, 2014), including the near absence of African American clients in some treatment areas (e.g., Williams, Powers, Yun, & Foa, 2010). Additionally, questions remain regarding whether there are racial/ethnic disparities in treatment outcomes. In other words, is psychotherapy as effective for African Americans as European Americans?

Are Treatment Effects Similar Across Ethnic Groups? To assess whether treatment is equally effective (i.e., ethnic invariance) or less effective (i.e., ethnic disparity) for African Americans compared with European Americans, we summarized reviews that compared treatment outcomes for these two ethnic groups. Research on youth-focused treatments (i.e., those aimed at clients 18 years old or younger or their parents) generally found that there are no reliable differences in treatment outcomes by ethnicity, with a few caveats. Huey and Jones (2013) summarized findings from five meta-analyses of treatment outcomes with youth and adolescents and found no consistent differences by ethnicity; however, these studies examined treatment outcomes for European American youth compared with ethnic minority youth and did not explore effects for African Americans specifically. Huey and Polo's (2008) review reflected a similar finding – three studies showed superior treatment outcomes for African Americans compared with European Americans, one study found superior outcomes for European Americans compared with African Americans, and seven found no significant ethnic differences.

Table 22.1 Examples of EBTs for African Americans with behavioral health problems

Target problem	Age group	Representative EBTs
ADHD	Youth	Behavioral treatment + stimulant medication (Arnold et al. 2003)
Anxiety-related problems	Youth	Group CBT (Ginsburg & Drake 2002)
	Adult	Panic control therapy (Carter, Sbrocco, Gore, Marin, & Lewis 2003)
Antisocial behavior	Youth	MST (Borduin et al. 1995)
Depression	Youth	Attachment-based family therapy (Diamond, Reis, Diamond, Siqueland, & Isaacs 2002)
	Adults	Collaborative care for depression (Areán et al. 2005)
Schizophrenia	Adults	Assertive community treatment (Kenny et al. 2004)
Smoking	Adults	CBT plus nicotine replacement therapy (Murray, Connett, Buist, Gerald, & Eichenhom 2001) Group CBT (Webb, de Ybarra, Baker, Reis, & Carey 2010)
Substance use problems	Youth	Multidimensional family therapy (Liddle, Dakof, Turner, Henderson, & Greenbaum 2008)
	Adults	Contingency management (Milby et al. 1996)
Suicidal behavior	Youth	MST (Huey et al. 2004)
	Adults	Nia empowerment intervention (Kaslow et al. 2010)
Trauma-related problems	Youth	Prolonged exposure (Foa, McLean, Capaldi, & Rosenfield 2013)
	Adults	Prolonged exposure (Feske 2008)
Mixed/ comorbid problems	Youth	RECAP intervention (Weiss, Harris, Catron, & Han 2003)
	Adults	Seeking safety (Boden et al. 2011)

Note: ADHD, attention-deficit/hyperactivity disorder; CBT, cognitive-behavioral therapy; EBT, evidence-based treatment; MST, multisystemic therapy; RECAP, Reaching Educators, Children, and Parents

For adults, the picture is also mixed, with most studies finding no significant differences in treatment outcomes by ethnicity. Of the RCTs in the Horrell (2008) review that involved comparisons of multiple ethnic groups, two studies found no differences in outcomes by ethnicity, while one found weaker effects for African Americans receiving CBT compared to European Americans. Analyses of ethnic differences in the two relevant RCTs in the Carter et al. (2012) review found equal benefit for both European Americans and African Americans. Reviews of adult treatments in Huey et al. (2014) also suggest that treatment effects are fairly robust across ethnic groups and that, on average, psychotherapy is as effective with European Americans as ethnic minorities. In other words, there was no consistent evidence that European Americans benefited more from treatment compared with ethnic minorities, and treatment was effective with minorities for the most common types of mental health problems (e.g., depression, anxiety, and substance use).

In summary, the results of treatment outcome studies generally support ethnic invariance in psychotherapy outcomes, with three noteworthy limitations. First, there still exist areas for which positive psychotherapy effects with African Americans have not been sufficiently documented (e.g., OCD). Second, many studies lacked large enough samples of African American clients to adequately test whether treatment was as effective for African Americans specifically and instead compared treatment effects between European Americans and ethnically mixed samples (i.e., treatment outcomes for all ethnic minority participants were combined into one comparison group). Third, the reviewed literature mostly involves clinical "efficacy studies" as opposed to "effectiveness studies." Efficacy studies generally take place in well-controlled research environments (e.g., university clinics), and do not necessarily reflect outcomes in real-world practice settings (e.g., community mental health clinics) where African Americans are disproportionately likely to be treated (Snowden, 2014). Although it seems reasonable to conclude that African Americans stand to benefit as much from psychotherapy as European Americans, persistent evidence of disparities in treatment utilization and dropout continues to raise questions about how psychotherapy might be improved for this population and whether culturally tailored treatments are necessary to reduce these disparities.

Cultural Competence Approaches, Models, and Evidence

Proponents of cultural competence differ in how they define this term but tend to agree that it involves having a broad awareness of culture and the knowledge and skills to effectively treat racially and ethnically diverse clients (Sue, Zane, Hall, & Berger, 2009). Calls for increased attention to cultural diversity in the design, evaluation, and provision of mental health treatments began in the mid-1980s and culminated in the publication of the APA's *Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). The guidelines assert that all individuals have a cultural heritage that influences their worldview and that psychologists should strive to increase their knowledge and awareness of their own cultural heritage, assumptions, and biases. Psychologists are also encouraged to become knowledgeable about other cultures and to use culturally sensitive approaches in treatment (APA, 2003). The rationale for increased attention to culture in the delivery of mental health services is due to four primary concerns: (1) rapid sociodemographic changes in the US population toward more ethnic diversity (Rastogi, Johnson, Hoeffel, & Drewery, 2011); (2) a historical lack of inclusion of ethnically diverse participants in research studies that constituted the empirical foundation of evidence-based treatments (Mak, Law, Alvidrez, & Pérez-Stable, 2007); (3) evidence of ethnic/racial disparities in treatment utilization and dropout (DHHS, 2001; Snowden, 2012); and (4) concerns that traditional evidence-based approaches were Eurocentric, based on Western values and assumptions, and not attentive to the worldviews of culturally diverse clients (Gone, 2011; Kirmayer, 2012; Wendt & Gone, 2012).

Despite the rationale for increased emphasis on cultural competence, scholars continue to debate how this elusive concept should be understood and practiced, as there are no established standards to determine whether a provider, intervention, or treatment facility is culturally competent. Critics of cultural competence have warned that it may lead to overly simplistic attributions and stereotypical assumptions of cultural differences based on race and ethnicity, and risks viewing these as the most salient and important factors in clients' treatment (Satel & Forster, 1999; Weinrach & Thomas, 2004). In theory, a focus on cultural competence involves considering numerous facets of client diversity including gender identity, age, sexual orientation/identity, socioeconomic status, disability, language, religious/spiritual beliefs, national origin, immigration status, level of acculturation, educational attainment, and historical life experiences (Whaley & Davis, 2007). However, in practice, researchers continue to struggle with how to account for and integrate the multitude of client diversity factors in treatment, and many have used ethnicity/race as the primary factor around which to organize the development of culturally sensitive approaches. Overall, it appears that cultural competence advocates and researchers continue to grapple with how best to broaden providers' awareness and attention to cultural differences in treatment while minimizing the likelihood of providers inadvertently stereotyping clients or making treatment recommendations based solely on client race/ethnicity.

Some Oft-Recommended Strategies When Treating African Americans Because there has been limited empirical attention to treatment strategies specific to African Americans, many clinicians refer to recommendations of scholars who treat African Americans to increase their own cultural competence. There appears to be general agreement regarding the importance of several key themes in working with African American clients including openness to addressing experiences of racism, supporting positive racial/ethnic identity development, and incorporating clients' spiritual and/or religious values into treatment (Bean, Perry, & Bedell, 2002). Racism continues to be a particularly salient issue for African Americans, who report greater experiences of discrimination than other ethnic minority groups (Pieterse, Todd, Neville, & Carter, 2012). Such experiences are associated with increased psychological distress and poorer psychological functioning (Pieterse et al., 2012) and thus could be an important area for clinicians to develop competency in discussing with African American clients (APA, 2003; Boyd-Franklin, 1989). Similarly, working to support a positive racial/ethnic identity may also be valuable with some African American clients, who, in addition to reporting more perceived racism, are regularly confronted with negative stereotypes about their race (Johnson-Ahorlu, 2013). Indeed, research shows that a positive racial/ethnic identity is associated with several important outcomes for African Americans including improved self-esteem, well-being, psychological functioning, and academic adjustment (Rivas-Drake et al., 2014; Smith & Silva, 2011). Lastly, African Americans endorse greater levels of religious and spiritual engagement compared with other ethnic groups, and many African Americans turn to religious leaders and institutions (e.g., church homes) for support regarding mental health concerns (Boyd-Franklin, 2010). Carefully assessing and incorporating African Americans' religious and spiritual values into treatment where appropriate could serve to make treatment more relevant and engaging for some African American clients.

It is important to note that although evidence exists supporting the relevance of these issues with African Americans, findings are largely correlational, and empirical support demonstrating that treatment outcomes of providers who explicitly target these issues are superior to those who do not is still forthcoming. Hence, we recommend that clinicians use caution when implementing these recommendations and that treatment approaches with African Americans avoid overgeneralizing and assuming these themes are relevant to all African American clients.

Culturally Adapted Treatment Effects Much of the empirical literature on improving mental health services for African Americans has involved culturally adapting or tailoring treatment (Huey et al., 2014). Typically, cultural adaptations involve systematic modifications to preexisting treatments aimed at making them more congruent with the cultural values, beliefs, attitudes, and practices of African Americans (Huey et al., 2014; Metzger, Cooper, Zarrett, & Flory, 2013). In a recent review of culturally adapted interventions, Huey and colleagues (2014) summarized outcomes from five meta-analyses that reported treatment outcomes specific to African Americans (Griner & Smith, 2006; Hodge, Jackson, & Vaughn, 2012; Huey & Polo, 2008; Jackson, Hodge, & Vaughn, 2010; Smith, Rodríguez, & Bernal, 2011). For African Americans, interventions generally yielded effects in the small-to-medium range relative to control conditions, which were comparable to those of culturally adapted treatments for other ethnic groups.

Although not specific to African Americans per se, there is some evidence to suggest that culturally adapted treatment may be beneficial relative to standard treatment approaches. First, a meta-analysis by Benish, Quintana, & Wampold, (2011) included only those studies comparing adapted treatments to other bona fide treatments (i.e., established treatment approaches) and found that adapted treatment was superior ($d = 0.32$). Second, in a recent meta-analysis of culturally adapted prevention and intervention studies, Hall, Ibaraki, Huang, Marti, and Stice (2016) found that adapted treatment was superior to unadapted versions of the same intervention ($g = 0.52$). Two limitations to these meta-analytic findings are (1) they included culturally adapted treatment studies directed mostly toward other ethnic minority groups and (2) they did not control for therapist allegiance effects, a phenomenon in which the treatment condition that the researcher favors (i.e., the culturally adapted treatment condition) may result in better outcomes due to researcher bias (Munder, Gerger, Trelle, & Barth, 2011).

Overall, meta-analytic results support the claim that culturally tailored approaches are more effective than control conditions (e.g., no treatment) at helping African Americans with a wide array of mental health concerns (e.g., depression, anxiety, trauma, substance use problems). Moreover, two meta-analyses with predominantly Asian American and Latino clients suggest that culturally tailored approaches may be more effective than alternative treatments at ameliorating mental health symptoms (Benish et al., 2011; Hall et al., 2016).

Types of Cultural Tailoring with African Americans Two common approaches for tailoring treatment for African Americans involve the use of Afrocentric models and client-therapist ethnic matching. Afrocentric frameworks seek to infuse intervention curricula with Afrocentric values (Cokley, 2005) and often include didactics that draw on the shared cultural history and experiences of African Americans (Belgrave, Chase-Vaughn, Gray, Addison, & Cherry, 2000). These models often aim to empower African Americans by addressing experiences of internalized racism, supporting a positive racial identity, fostering social cohesion and support among group members, and incorporating spiritual and faith-based coping strategies (Banks, Hogue, Timberlake, & Liddle, 1996; Davis et al., 2009). Treatments that utilize Afrocentric approaches are typically group-based, gender-specific, and limited to clients of African American heritage (Belgrave et al., 2000; Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002).

One exemplar of the Afrocentric approach is the Claiming Your Connections (CYC) intervention. CYC is a strength-based, group intervention for Black women aimed at decreasing symptoms of depression while enhancing psychosocial competence (Jones, 2009). Intervention didactics focus on building healthy relationships, increasing social support, and fostering a positive Black female identity. The program is unique in its inclusion of literary works by Black women (e.g., bell hooks) as a tool to address issues specific to these women's psychosocial environment. The literary works are believed to augment group pro-

cesses by allowing Black women to identify and discuss important themes relevant to their own lives, identify positive role models, and promote a positive Black female concept. In a randomized trial, CYC was found to be effective at decreasing depressive symptoms and perceived stress compared to wait-list control (Jones & Warner, 2011). However, an important limitation is that CYC was not compared to a standard EBT or to a culturally "inert" but otherwise equivalent treatment, so it is unclear whether the cultural elements per se contribute to treatment efficacy.

Perhaps the most common approach to cultural tailoring involves the use of client-therapist ethnic matching. Some argue that this approach may be particularly useful with African Americans because of their shared history of discrimination, marginalization, and abuse, including by health service providers (Washington, 2006). Indeed, research shows that many African Americans report a cultural mistrust of European Americans (Benkert, Peters, Clark, & Keves-Foster, 2006; Townes, Chavez-Korell, & Cunningham, 2009; Whaley, 2001). For these reasons, use of client-therapist ethnic matching has been advocated as a way to increase rapport with African American clients, reduce attrition, and improve outcomes. In a meta-analysis of ethnic matching effects, Cabral and Smith (2011) found that, compared to other ethnic groups (i.e., Asian Americans, Latinos, and European Americans), African Americans indicated the strongest preference for seeing a provider of their same race ($d = 0.88$). Moreover, those who were ethnically matched viewed their therapists more positively than those matched with a therapist of a different ethnicity ($d = 0.59$) and experienced significantly better outcomes compared with those who were not ethnically matched, although the effect was small ($d = 0.19$). The finding that ethnic matching was associated with improved treatment outcomes (e.g., reduced symptoms of anxiety/depression) was unique to African American clients and was not found for Asian Americans, Latinos, or European Americans.

Why might ethnic matching be associated with better outcomes for African American clients? Some research suggests that African American clients who are ethnically matched may be more inclined to disclose information that they might not otherwise disclose if seeing a provider of a different ethnicity. Ibaraki and Hall (2014) found that African American clients who were ethnically matched were ten times more likely than unmatched clients to discuss substance use problems and also more likely to attend three more treatment sessions. Samples et al. (2014) found that African American women who were interviewed by a same race provider, as opposed to a European American provider, reported higher levels of daily stressors and were more likely to disclose experiences of intimate partner violence. These findings suggest that for some African American clients, ethnic matching may increase client-therapist rapport and lead to discussion of more vulnerable content that they might not otherwise share, perhaps due to cultural mistrust, experiences of discrimination, or stereotype threat (Abdou & Fingerhut, 2014; Whaley, 2001).

However, a major limitation is that nearly all ethnic matching studies are correlational in design, leaving open the possibility that ethnic matching effects might be spurious or accounted for by other factors. Indeed, the one experimental study we know of with symptomatic African Americans found ethnic matching effects that were counterintuitive in nature. Genshaft and Hirt (1979) assigned impulsive African American and European American youth to self-control training led by either a Black or White peer model. Unexpectedly, both European American *and* African American youth showed the greatest improvement in self-control responses when assigned to White models. This rare experimental study of ethnic matching suggests that ethnic matching may not always be beneficial for African Americans. One possibility is that ethnic matching more often benefits those African Americans who report a cultural mistrust of European Americans or who express a strong preference for an African American therapist (Townes et al., 2009).

Can Cultural Tailoring Be Harmful? Many cultural adaptations reported in the literature are

theoretically grounded, but most lack the rigorous empirical testing needed to validate their efficacy relative to culturally unadapted treatments (Huey et al., 2014). This can present a challenge to improving treatments for African Americans because adaptations that are intuitively appealing may not in fact be more effective; some may even yield poorer outcomes for African Americans. In contrast, some standard EBTs that appear minimally relevant to culture may result in better outcomes. Three recent studies evaluating culturally adapted interventions for African Americans illustrate these concerns. First, Kliewer et al. (2011) conducted an RCT comparing the effects of a standard expressive writing intervention and culturally adapted intervention on emotional lability and aggressive behaviors in violence-exposed, African American youth. In the standard condition, youth were instructed to write about their deepest thoughts and feelings regarding violence they had witnessed or experienced. In the culturally adapted treatment, youth were instead allowed to express themselves using rap, spoken word, poetry, songs, or skits about violence and were encouraged to share their work with their classroom peers. The researchers assumed that such an adaptation would fit with the oral tradition of African American culture and be more engaging for Black youth. Surprisingly, the culturally adapted version was significantly *less effective* than the standard writing intervention at reducing youth aggression and mood lability at 2-month post-intervention.

Second, Webb (2009) compared the efficacy of a culturally adapted self-help smoking cessation guide for African Americans with a standard, unadapted guide. The culturally adapted guide highlighted race-based smoking statistics (e.g., 47,000 *Black* deaths per year), used religious and spiritual quotations (e.g., Bible verses), and used culturally specific examples. In contrast, the standard guide provided general smoking statistics (e.g., 400,000 *American* deaths per year) and made no explicit reference to race or culture. Although African American smokers reported a preference for the culturally adapted guide, the standard guide was rated as more credible. In addition, those receiving the standard guide reported greater readiness to quit smoking and more 24-h quit attempts compared to those receiving the culturally adapted guide. When considering client-specific factors, Webb (2008a) hypothesized that the culturally adapted materials would be particularly efficacious for African Americans with lower levels of acculturation - i.e., those reporting more traditional African American beliefs and values (e.g., religious/spiritual beliefs, preference for African American artists, music, or TV shows; Klonoff & Landrine, 2000). Unexpectedly, results revealed the opposite pattern – less acculturated Blacks were *less* likely to report 24-h quit attempts when receiving the culturally specific materials than when receiving the standard materials (Webb, 2008a). The standard, unadapted treatment proved more effective for African Americans overall and for those who were least acculturated.

Finally, in a meta-analysis on the efficacy of smoking cessation interventions with African Americans, Webb (2008b) evaluated the effects of standard interventions and culturally specific interventions (CSIs). CSIs used a diverse set of strategies assumed to make the interventions more culturally relevant to African Americans. These approaches included ethnic matching, using race-relevant epidemiological data, featuring materials with African Americans, delivering interventions in churches, and addressing experiences of racism, among others (Webb, 2008b). The researcher found that both standard interventions and CSIs were effective; however, CSIs were more effective in the short term (i.e., resulted in greater odds of smoking cessation at post-treatment), whereas standard interventions were more effective in the long term. Webb (2008b) speculated that culturally tailored approaches may be more effective at engaging African Americans in treatment and reducing attrition but that these benefits may decline with time, whereas standard approaches may remain more robust over longer periods.

Why might some cultural adaptations result in poorer outcomes for African Americans? Some theorists speculate that excessive or unstructured use of cultural adaptations might replace or dilute

core intervention components and thus lead to inefficiencies in treatment implementation (Castro & Alarcón, 2002; Kumpfer, Alvarado, Smith, & Bellamy, 2002). Others argue that for some ethnic minority clients, the inclusion of explicit cultural adaptations may inadvertently lead to stigma or reactance (Huey et al., 2014). In the next section, we provide recommendations for tailoring treatment aimed at increasing the likelihood of improving treatment outcomes with African Americans while minimizing the likelihood of attenuating treatment effects.

Recommendations and Future Directions

Base Adaptations on Culturally Salient Risks and Strengths One approach for enhancing mental health treatment for African Americans is to focus interventions on culturally salient risks and strengths. Rather than develop methods that are presumed applicable across most African American clients, intervention developers can organize treatments around the specific underlying culturally relevant factors that contribute to mental health concerns of African American clients. We provide two examples of interventions that do this, with each utilizing a unique approach.

African American women are at higher risk of intimate partner violence (IPV), and those with IPV experiences are at greater risk for suicidal behavior (Kaslow et al., 1998). Recognizing this disproportionate risk, Kaslow et al. (2010) designed Nia (meaning "purpose" in Swahili) to reduce depression and suicidal behavior among low-income Black women with a history of abuse. The intervention targets culturally relevant risk factors for these women (e.g., relationship power imbalances, unemployment) while seeking to simultaneously enhance culturally relevant strengths. To address relationship power imbalances, Nia includes intervention didactics that directly address stereotypes of Black women's coping strategies and teach women adaptive coping skills to improve the balance of power in their relationships. Additionally, because unemployment and financial dependence were identified as barriers to Black women ending relationships with abusers, the intervention focuses on connecting participants with affordable housing and employment opportunities. Lastly, Nia builds on culturally relevant protective factors through its emphasis on increasing indigenous social supports (i.e., religious communities), spiritual well-being, and positive ethnic identification (Davis et al., 2009). In a randomized controlled trial with suicidal, African American women, Nia led to greater reductions in depressive symptoms at post-intervention and 12-month follow-up (Kaslow et al., 2010). Moreover, among those with higher levels of IPV, Nia women reported lower levels of suicidal ideation than those receiving standard care.

Multisystemic therapy (MST) is a well-established treatment for reducing criminal reoffending and conduct problems among high-risk youth (van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014). This community-based, family-driven intervention uses a social-ecological approach (Bronfenbrenner, 1979) for contextualizing youth problems and targets risk factors specific to the development of youth conduct problems (e.g., deviant peer groups, school failure). MST providers intervene at multiple levels (e.g., home, school, and community) and use a diverse set of evidence-based treatments to empower caregivers and meet the individualized needs of youth and their families (Henggeler, 2011). This flexible approach allows MST to incorporate cultural strengths of African American families (e.g., extended kinship, family interdependence), which may help explain why MST is effective for African American youth, who are at greater risk of incarceration (Brondino et al., 1997). Indeed, RCTs consistently find that African American and European American youth benefit equally from MST (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler, Pickrel, Brondino, & Crouch, 1996).

Nia and MST are two examples of culturally responsive, theoretically grounded, and empirically validated interventions that address problems relevant to African American communities.

Although both treatments address culturally salient strengths and risks, a limitation is that none of the studies evaluating these interventions showed that targeting these factors led to improvements in treatment outcomes.

Reverse-Engineer Cultural Competence Another possible path to improving treatment effects with African Americans involves reverse engineering the cultural competence construct as it relates to African Americans (Huey et al., 2014). Rather than assuming a priori that particular therapeutic styles or approaches are optimal for African Americans (e.g., the inclusion of Afrocentric values), one could construct cultural competence empirically by (1) dismantling existing practices and identifying components that appear to optimize outcomes for African Americans, (2) embedding such components into preexisting interventions, and (3) evaluating whether enhanced practices improve outcomes beyond standard treatment.

There are at least three ways for investigators to pursue this initial dismantling step. First, within the context of existing practice, investigators could explore which therapeutic processes are correlated with better outcomes with African Americans. For example, Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) examined whether culture-related treatment processes predicted treatment engagement and symptom reduction for African Americans receiving Multidimensional Family Therapy. Participants were 18 African American youth and their families referred for substance abuse and conduct disorders. They found that in-session discussions concerning some culture-related themes (e.g., anger/rage, journey from boyhood to manhood) were positively associated with greater alliance and engagement, whereas treatment focused on other cultural themes (e.g., trust and mistrust) was negatively associated with alliance (Jackson-Gilfort et al., 2001). Thus, this study suggests that eliciting cultural themes of a particular nature could enhance engagement for African American youth, whereas discussing other themes could be counterproductive.

A second approach involves discerning which therapeutic practices or processes are differentially impactful for African Americans compared to European Americans. For example, Sayegh et al. (2016) examined how patterns of treatment resistance led to differential outcomes for African American and European American juvenile drug offenders in a randomized trial of MST. They found racial differences in the trajectory of resistance during treatment and in the predictive relationship between resistance and criminal desistance. Specifically, European Americans who desisted from crime showed a negative quadratic pattern of resistance (i.e., inverted U-shaped), characterized by low resistance at the beginning and end of treatment, yet high levels of “struggle” at mid-treatment; on the other hand, African American desisters more often showed a positive quadratic pattern of resistance (i.e., U-shaped), characterized by low levels of mid-treatment “struggle” (Sayegh et al., 2016). One implication for therapists is that, as a forerunner to successful therapy outcomes, *low* levels of mid-treatment resistance and challenge might be expected of (or perhaps encouraged with) African American clients, whereas the opposite might be true for European Americans.

Using a different methodology for identifying therapeutic approaches that may be relatively more beneficial for African Americans, Imel et al. (2011) tested whether client ethnicity predicted variability in therapist efficacy in the context of a randomized trial for cannabis use. They found that some therapists were comparatively more effective at treating White clients, whereas others were more effective at treating ethnic minority (76% African American) clients. However, given methodological limitations, they were unable to determine what characteristics differentiated those who were competent vs. “incompetent” when treating ethnic minorities. These findings indicate that some therapists may be significantly more skilled in treating African American clients than others, although the specific qualities characterizing such therapists are unclear as yet.

A third approach would use meta-analysis to identify culturally salient predictors or modera-

tors of treatment success across multiple studies. Although we could find no examples specific to African American mental health problems, two meta-analyses addressed this issue with diverse samples of ethnic minority clients (Huey, 2013; Smith et al., 2011). Smith et al. (2011) assessed which elements of Bernal's cultural adaptation model[2] were associated with improved treatment outcomes in a meta-analysis of 65 controlled trials. Overall, the number of cultural adaptations (based on Bernal's model) was positively associated with treatment effects. Moreover, in terms of specific cultural elements, they found that interventions that solicited outcome goals from the client and utilized metaphors/objects from client cultures were associated with better outcomes. In an unpublished meta-analysis of culturally adapted versus nonadapted mental health treatments, Huey (2013) found a somewhat different pattern. Interventions were generally ineffective when they "explicitly" addressed ethnocultural factors, whereas interventions that were more "implicit" in nature (i.e., no apparent mention was made in treatment of the client's ethnicity/race, *or* clients were unaware that treatment was culturally tailored) were generally more effective. The author speculated that some explicit adaptations may elicit negative responses from clients or reactance. In the context of psychotherapy, African Americans who feel that clinicians are making assumptions about them based on their race/ethnicity may become agitated or try to belie these assumptions by behaving in ways counter to the stereotype.

However, dismantling effective approaches is only the first step in this reverse-engineering process. To our knowledge, no published studies have proceeded to the next two stages of embedding effective components into standard interventions and then evaluating the effectiveness of the presumed enhancements for African Americans.

Use "Generic" Strategies with Implicit Cultural Elements A third recommendation when treating African Americans is to utilize evidence-based strategies that are ostensibly "generic" or universal but also implicitly culturally sensitive in that they adopt styles or address themes that might be particularly salient for African Americans. We know of at least two intervention strategies that fit this mold – role induction (Katz et al., 2004, 2007) and motivational interviewing (Miller & Rollnick, 2012). Although sometimes used as stand-alone interventions, more often these serve as brief, add-on strategies to conventional therapies.

Role induction is a brief, engagement technique that involves clarifying client and therapist roles, identifying and correcting misperceptions about treatment, and problem-solving barriers to treatment (Katz et al., 2004; Walitzer, Dermen, & Connors, 1999). Because African Americans perceive more stigma with regard to seeking treatment and are less trusting of mental health professionals (Whaley, 2001), some experts recommend role induction as an engagement strategy for African Americans that strengthens the therapeutic relationship by clarifying the treatment process. In fact, several published studies strongly argue for the effectiveness of role induction with this population. Katz et al. (2004) randomly assigned treatment-seeking drug abusers (98% African American) to receive either a brief role induction session or standard group orientation. Those receiving role induction were significantly more likely to attend an initial counseling session and remain in treatment, and marginally more likely to abstain from drugs during treatment. In a subsequent trial, African American (96%) drug abusers were randomly assigned to individual role induction or standard orientation (Katz et al., 2007). Compared to controls, role induction participants were significantly more likely to attend at least one post-orientation

[2]Bernal's eight elements of cultural adapted treatments include (1) providing therapy in the clients' preferred language, (2) matching clients with therapists of similar ethnic/racial backgrounds, (3) utilizing metaphors/objects from client cultures, (4) including explicit mention of cultural content/values, (5) adhering to the client's conceptualization of the presenting problem, (6) soliciting outcome goals from the client, (7) modifying the methods of delivering therapy based on cultural considerations, and (8) addressing clients' contextual issues (Bernal & Sáez-Santiago, 2006).

session and showed significantly larger reductions in substance use at 6-month follow-up. Thus, brief role induction appears to be a promising approach to engaging and treating African Americans.

Motivational interviewing (MI) is another evidence-based, conventional treatment with potential relevance for African Americans. MI is a brief counseling approach that promotes behavior change by resolving client ambivalence; it utilizes empathy building, "rolling with resistance," and elicitation of change talk, among other strategies (Miller & Rollnick, 2012). Given its approach to client resistance, MI may be a natural fit for African Americans and other populations that experience disparities in treatment seeking and engagement (Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010; Miller et al., 2008). MI encourages clinicians to work within the patient's values, and this might be conducive to cultural humility (a therapeutic stance characterized by respect for and a lack of superiority toward the client's cultural background or experiences; Hook, Davis, Owen, Worthington, & Utsey, 2013) and understanding by clinicians. Indeed, multiple MI trials with predominantly African American samples demonstrate its effectiveness in terms of treatment engagement (e.g., Longshore, Grills, & Annon, 1999; Montgomery, Burlew, Kosinski, & Forcehimes, 2011) and reducing drug use problems (e.g., Bernstein et al., 2005; Longshore & Grills, 2000; Stotts, Schmitz, Rhoades, & Grabowski, 2001). Moreover, a meta-analysis by Hettema, Steele, and Miller (2005) indicates that MI may actually be more effective with ethnic minority samples than with European American samples.

Although "culture-neutral" at face and universal in practice, these two strategies include design features that implicitly increase their potential relevance for African Americans. Thus, some standard approaches that subtly address culturally salient risk or relationship factors might be particularly effective with African Americans, without requiring specialized adaptation or tailoring.

Conclusion

In the preceding sections, we highlighted clinical issues pertinent to African Americans, summarized treatment outcomes with African Americans, outlined approaches to cultural competence and cultural tailoring, evaluated empirical support for culturally adapted treatments, and made recommendations for those interested in improving the quality of treatment for African Americans. Clear and persistent disparities in treatment utilization, access to care, and treatment quality suggest that a focus on improving mental health services for African Americans is warranted. At the same time, treatment outcome research shows that psychotherapy is generally effective with African American youth and adults and that, on average, treatment is as beneficial for African Americans as it is for other ethnic groups, including European Americans. With respect to culturally tailored interventions, the available evidence indicates that they are effective with African Americans, but few studies utilize designs that allow us to isolate specific types of cultural tailoring that improve outcomes for African Americans or to determine whether culturally tailored interventions yield outcomes that are superior to unadapted EBTs. Research demonstrating the enhanced efficacy of adapted treatments compared with other treatment approaches is promising, but few methodologically rigorous studies have focused specifically on African Americans. Importantly, we question whether all forms of cultural tailoring are uniformly beneficial for African Americans and provide examples of cultural tailoring that yielded poorer outcomes compared with standard unadapted interventions. To reduce disparities and improve treatment outcomes with African Americans, we suggest that researchers continue to rigorously evaluate culturally adapted interventions, with emphasis on whether specific cultural tailoring improves treatment utilization and engagement, the area where disparities are most consistently observed.

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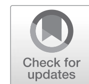

23 The Complexities of Multicultural Competence with LGBT+ Populations

Mark A. Yarhouse, Justin Sides, and Cassandra Page

This chapter focuses on some of the existing challenges in describing how one achieves multicultural competence with lesbian, gay, bisexual, transgender (LGBT+), and related populations. In other words, what it specifically means to be multiculturally competent with this population has not been precisely defined. The definition of this level of competence is still evolving and faces several unique challenges. Our intention is to discuss some of those concerns as well as point in a direction that may help the field identify sound aspirations.

Multicultural competence has historically emphasized work with racial and ethnic minorities or persons of color. Many resources exist today with recommendations for working competently with African-Americans, American Indians, Asian Americans, Alaska Natives, Pacific Islanders, Hispanic Americans, Arab Americans, and persons of multiracial descent, among others (Sue & Sue, 2013). More recently, multicultural competence has expanded to include other populations, including those of lower socioeconomic status, older adults, persons with disabilities, persons of immigrant status, and LGBT+ persons. Discussions of multicultural competence often assume implicitly that the person providing services belongs to a group that is different from the client receiving services.

In the context of ethical and professional practice, a multicultural approach emphasizes understanding and appreciating ways in which clients' unique differences (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) inform clinical considerations, including case conceptualization, treatment planning, and interpretation of results from assessment data. The field of psychology has also witnessed a corresponding emphasis on training to achieve multicultural competency for practitioners; and, more recently, a shift for practitioners to advocate for and participate in social justice initiatives regarding all marginalized clients is not typically represented (Arfken & Yen, 2014; Wendt, Gone, & Nagata, 2015).

As many chapters in this handbook can attest, there are several issues that arise when we turn to the construct of multicultural competence even when considering topics that have been under discussion for much longer than discussions on LGBT+ concerns. There are numerous conceptual, scientific, and applied challenges. For example, Sue (2013) recalls that in early stages of attempting to develop multicultural competence, well-meaning professors often taught modalities to well-meaning students that either insults a person's dignity or mischaracterizes them in one way or another. Cultural competence is not a construct

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with conceptual and practical consensus; nor is it always explicitly grounded in psychological theory or principles. There are various approaches each discipline is encouraged to take; yet not one defined pathway to follow toward teaching multicultural competence effectively (Mallinckrodt, Miles, & Levy, 2014).

As we survey the literature on multicultural competence and cultural awareness as it pertains to LGBT+ studies, we see several challenges. The first and most prominent challenge is actually a larger philosophical or worldview consideration. We refer to the different worldviews as frameworks through which people approach LGBT+ concerns within psychology's current societal context.

Once consideration is given to these different frameworks, a more nuanced discussion can be had regarding several other challenges: identifying the parameters of the culture, accuracy and humility around dissimilarities from prototypical topics of cultural competency, prejudice and bias against conventional religious beliefs and values, and measurement of multicultural competence for clinical practice. We turn our attention first to three contrasting frameworks.

Contrasting Frameworks

In this section we introduce the reader to three frameworks through which people in US society view LGBT+ issues: the diversity framework, the disability framework, and the sacred framework (Yarhouse, 2015).

The Diversity Framework The first framework for discussing LGBT+ issues in the broader society is a *diversity* framework that conceptualizes "gay" (as an umbrella term) as an identity and LGBT+ persons as part of an LGBT+ community—a unique culture to be recognized, celebrated, and honored. This is by far the most widely recognized framework in our culture today. Mental health communities, such as the American Psychological Association, have been at the forefront of advancing this framework often in sharp contrast to prior models that have been informed by conventional religious perspectives and deemed moral models in the literature. The reader will recall that homosexuality was removed as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders* that reflected social trends and advocacy within APA (Bayer, 1981). Indeed, a chapter on cultural competence with LGBT+ persons is possible as a result of this framework.

The sociocultural context in which we live in the West has been rapidly moving toward the direction of celebrating diversity in areas of sexuality and gender identity. Thus, we refer to this as a diversity framework because it highlights LGBT+ issues as reflecting an identity and a people group to be celebrated as a culture. Guidelines for practice that come from the major mental health organizations reflect this conceptualization. Proponents of this framework frequently cite historical examples in which gender variant expressions, for example, have been documented and held in higher esteem, such as the Fa'afafine of Samoan Polynesian culture and the Two-Spirit people identified in some Native American tribes.[1]

In discussions of whether and to what extent sexual identity and gender identity differences constitute a people group and a culture, it may be important to recognize that these are discussions tied primarily to how people make meaning out of same-sex sexuality and the variations in experiences of gender identity. Put differently, this meaning-making is at least to some degree socially constructed and can function as a distinct narrative intended to inform a vision for cultural competence worthy of further refining and reflection.

This narrative begins with a discussion of what comprises a culture. The Office of Minority Health (2013) defines culture as "…integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial,

[1]Lynn Conway has a helpful summary that includes historical and current global perspectives. See http://ai.eecs.umich.edu/people/conway/TS/TG-TS%20World.html#Hijra

ethnic, religious, or social groups." An alternative definition is offered by Kagawa-Singer, Dressler, George, and Elwood (2014):

> Culture consists of dynamic and ecologically based inter-related elements that function together as a living, adapting system. To delineate culture begins with a perspective that contextualizes population groups within a multi-level, multi-dimensional, biopsychosocial, ecological framework and explicitly recognizes and incorporates the geographic, historical, social, and political realities of diverse communities. All of these elements constitute the cultural framework its members use to 'see' the world and attribute meaning to their daily lives. (p. 12)

Difficulties in defining culture have also been identified insofar as definitions include what is "transmitted across generations." As O'Donohue and Benuto (2010) observed, such definitions may preclude the LGBT+ community as a culture to meet such definitions (p. 35). Baldwin, Faulkner, and Hecht (2006) begin to identify some of the challenges associated with defining culture. They offer: "The definition of culture is a moving target, and those who choose to define it should ground their definitions in a fuller, multidisciplinary and historicized accounting of the word" (p. 24).

For example, in many instances, those who adhere to the diversity framework support the deconstruction of norms related to sex and gender. For example, the International Human Rights Commission represents the diversity framework in calling for the deconstruction of sex and gender binaries:

> We believe it is indispensable to deconstruct the binary sex/gender system that shapes the Western world so absolutely that in most cases it goes unnoticed. For 'other sexualities to be possible' it is indispensable and urgent that we stop governing ourselves by the absurd notion that only two possible body types exist, male and female, with only two genders inextricably linked to them, man and woman. We make trans and intersex issues our priority because their presence, activism and theoretical contributions show us the path to a new paradigm that will allow as many bodies, sexualities and identities to exist as those living in this world might wish to have, with each one of them respected, desired, celebrated. (International Gay and Lesbian Human Rights Commission [IGLHRC], 2005, pp. 7–8)

Whereas the biological distinction between male and female had been considered rather immutable, as we can see, there are those who wish to recast sex as *just as socially constructed* as gender.

This call for the deconstruction of sex/gender binaries might be thought of as the *strong* form of the diversity framework. We do think there is also a *weak* form of the diversity framework that simply places emphasis on LGBT+ identity and community without the corresponding emphasis on deconstructing norms associated with sex and gender (see Yarhouse, 2015).

For our purposes, we are going to focus in on one facet of a definition of culture offered by Carpenter-Song, Schwallie, and Longhofer (2007). Citing Jenkins and Barrett (2004), Carpenter-Song et al. define culture in relation to what is symbolically shared and what is created by people in the context of their social relationships.

As we have suggested, a larger critique of these various definitions of culture may be warranted (see Chaps 4, 5 and 6), but for now we are simply exploring the idea that what is shared and created as meaning guides and shapes people's thoughts, feelings, and way of experiencing the world (Carpenter-Song et al., 2007, p. 1362). This is what Yarhouse (2013) referred to as a "gay script" and elsewhere as a transgender script (Yarhouse, 2015). Thus, if a script reflects social expectations for behavior, relationships, and identity, a gay script is a reflection of contemporary meaning-making associated with same-sex sexuality:

> - Same-sex attractions reflect categorical distinctions between types of people (gay, lesbian, bisexual, and heterosexual).
> - Sexual attractions accurately signal who you are as a person.
> - Sexual attractions reside at the core of your identity, your sense of self.
> - Sexual behavior no longer resides in a category of behavior that can be evaluated as right or wrong in and of itself; rather, it is an expression of identity insofar as you express and enjoy who you really are. (Yarhouse, 2013)

A gay script also rests on at least two assumptions:

- You are born gay, lesbian, or bisexual—it is just a matter of discovering this about yourself.
- Your attractions are a defining element of identity in part because they are enduring or immutable.

This script also leads to a sometimes critical view of other conclusions people might draw about one's identity or behavior:

- If you experience same-sex attractions but do not identify as gay, lesbian, or bisexual, you are in denial or not yet ready to be honest with yourself about who you really are as a person.
- If you experience same-sex attractions but choose to abstain from sexual expression, you are either in denial or not yet ready to be honest with yourself about who you really are as a person. (Yarhouse, 2013, p. 70)

Elsewhere, Yarhouse (2015) suggests there is a comparable meaning-making script or cultural expectation for meaning associated with being transgender:

- Gender dysphoria reflects a naturally occurring difference among types of people (transgender rather than cisgender).
- Your gender dysphoria as gender incongruence suggests who you are ("who I am") rather than how you are ("how I am").
- Gender dysphoria points to a community of others who experience a similar phenomenon ("I am part of the transgender community.").
- Your gender incongruence points to something at the core of who you are, something that is central to your identity (p. 132).

We are not particularly critical of any of these scripts or of the idea that there are commonly shared ways in which different scripts have informed meaning and purpose and significance in the lives of people navigating sexual and gender identity questions. However, when discussing cultural competence for a people group, it is important to recognize the social construction and assumptions associated with the development and claim to a culture, as well as the potential intended and unintended consequences of such developments, including any counter-narrative of exclusion for those for whom the preferred narrative does not resonate.

For many proponents of the strong form of the diversity framework, the sex/gender binary is one more source of authority that needs to be deconstructed in order to create room for the various exceptions to the sex/gender binary (Butler, 1990). These exceptions reflect a unique culture—a new vista for the range of ways in which people experience their sexuality and gender. Such claims challenge not only gender norms that have been widely understood to be socially constructed but also a sex binary as something fixed and stable, tied to an essentialist view with biological foundations.

- **Gay**: a contemporary designation of identity among biological males who experience predominant or exclusive same-sex sexual attraction.
- **Lesbian**: a contemporary designation of identity among biological females who experience predominant or exclusive same-sex sexual attraction.
- **Bisexual** or **bi**: a contemporary designation of identity and sexual orientation among biological males or females who experience attraction to both the same sex and to the opposite sex.
- **Biological sex**: typically a reference to the physical, biological, and anatomical dimensions of being male or female (including chromosomes, gonads, sexual anatomy, and secondary sex characteristics).
- **Gender identity**: how people experience themselves (or think of themselves) as male or female, including how masculine or feminine they feel.

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- **Gender dysphoria**: the experience of distress related to having a psychological and emotional gender identity that does not match one's biological sex.
- **Transgender**: an umbrella term for the many ways in which people may experience or present or express their gender identity differently than those for whom gender identity is congruent with their biological sex.
- **Transsexual**: a person who believes he or she was born in the "wrong" body (of the other sex) and wishes to transition (or has transitioned) through hormonal treatment and sex reassignment surgery.
- **Intersex**: a term to describe conditions in which a person is born with sex characteristics or anatomy that does not allow them to be identified clearly as male or female. This can be chromosomal, gonadal, or genital (e.g., congenital adrenal hyperplasia). Also referred to as disorders of sex development or disorders of sex differentiation.

A recent article in *Nature* titled "Sex Redefined" asserted that "the idea of two sexes is simplistic" (Ainsworth, 2015, p. 288). After an accurate account of normative male/female development, the author proceeds to present the "sex spectrum" by identifying a range of disorders by identifying a range of deviations from what has been considered to be normative development (sometimes referred to as disorders of sexual development, DSD). This is followed by a generous prevalence estimate of 1% of the population; the more widely recognized estimate is 1 in 4500 people, which the author acknowledges. Some view the recognition of DSD as challenging the sex/gender binary, while others view these rare exceptions as confirming the male/female norm (Yarhouse, 2015).

However, not everyone who adheres to the diversity framework is actively attempting to deconstruct norms related to sex and gender. Others adopt it simply because it offers answers to questions about identity ("Who am I?") and community ("Of which community am I a part?"). There is a tendency here to discuss diversity not so much as an identity and culture but as natural variations. Emphasis here is on viewing differences in sexual attraction, gender identity, or sexual development as variations that simply occur in nature. These occurrences would not necessarily be celebrated as such, but they would also not be pathologized or viewed from any kind of moral/ethical framework.

For example, it is not known what causes transsexualism. One theory proposed by Diamond (2013) is that transsexuality is "a form of brain intersex." In describing his theory—the biased-interaction theory of psychosexual development—Diamond reflects the natural variation lens when he writes:

> In general, biological factors starting from XY chromosomes produce males that develop into boys and then men with whatever characteristics are appropriately seen as masculine for society and females develop into girls and then women with whatever characteristics are appropriately seen as feminine for the same society. Differences from the usual course of development are not seen as 'things gone wrong' or errors of development but as to-be-expected occasional variations due to chance interactions of all the variables involved. http://www.hawaii.edu/PCSS/biblio/articles/2005to2009/2006-biased-interaction.html

Therefore, experiences of differences by attraction, gender identity, or sexual development reflect nonmoral realities that occur as normal variations that one would expect to see over time.

While you can hold this view of nonmoral realities and be a proponent of the diversity framework, it is also possible that such a view can inform other frameworks through which people see sexual and gender identity concerns.

The limitations to a diversity framework come to the foreground when proponents overlook or marginalize other aspects of diversity, or single out models of care, as the sole expression of cultural competence when working with the LGBT+ community. We turn now to two other frameworks for consideration to address these concerns.

The Disability Framework A second, more descriptive, way people in contemporary society think about matters of same-sex sexuality and gender incongruence has been referred to as a disability framework (Yarhouse, 2015). Adherents often use what is referred to as person-first language (see Dunn & Andrews, 2015, who discuss person-first language with reference to disability rather than LGBT+ issues). For example, rather than reference people as "gay" or "transgender," those who adopt this framework may refer to themselves as "a person who is navigating sexual identity questions" and "a person who experiences gender identity concerns or who experiences gender incongruence" (see Yarhouse & Tan, 2004; Yarhouse, 2013, 2015).

This language allows the person and others who engage them to reflect on the meaning of one's same-sex sexuality to oneself and to others. It is also possible for someone to prefer identity-first language over person-first language but to also experience their same-sex sexuality as more like a disability than a culture to be celebrated. This language parallels the shift in how we describe individuals diagnosed with mental disorders: We view a person as one with Schizophrenia rather than "a schizophrenic" (Keeley, Morton, & Blashfield, 2015). The celibate gay Christian above does adopt identity-first language, while others would prefer descriptive language or person-first language (e.g., "I am a woman who experiences same-sex attraction"), and this is often for personal and religious reasons in which an LGBT+ identity is just not as helpful to their meaning-making structures (Yarhouse & Tan, 2004).[2] Someone from a religious faith tradition might view their same-sex sexuality as a "disability" likely due to a normative view of sexuality and sexual functioning in which attraction to the opposite sex is viewed as intended from creation; variations would be departures from that norm that would be the result of "fallenness" (of the creation order) (see Yarhouse & Nowacki, 2007).

For example, a celibate gay Christian who is also deaf once shared with us why she prefers identity-first language ("celibate gay Christian") over person-first language ("A person who experiences same-sex attraction") (Yarhouse, Morgan, Anthony & Sadusky, 2015). She indicated that describing her sexual attractions in isolation seemed to reduce them to just the desire to be genitally sexually active; in her experience, "being gay" was a broader "way of being in the world" than just identifying to whom she was sexually attracted.

Additionally, some celibate gay Christians may be drawn to a disability lens and cite the example of the deaf/Deaf debates as rationale:

> In the world of hearing loss, you have those who are Deaf and those who are deaf. These two groups are well-distinguished and identified. Anyone who uses capital 'D' Deaf knows she is referring to something more than small 'd' deaf. People who are Deaf comprise a culture; they do not see themselves as having a disability. Instead they see themselves as a people group with their own language and culture. On the other hand those who are deaf do not see their hearing loss as an identity; instead, they see it as a disability or medical condition. This group is more likely to be 'oral.' That is, they often undergo intensive training to lip-read and use their voice to communicate instead of using sign language. Some might also seek a cochlear implant. When they say 'I am deaf' they are *not* saying 'I am Deaf.' At times there is contention between the groups because of a conflict in how each group understands its experience of hearing loss. For example those who are Deaf see cochlear implants as threatening and an extreme offense. They don't believe anything needs to be 'fixed.' They celebrate their identity as Deaf. (Yarhouse, 2013, p. 28)

Additionally, because historically the disability lens draws on assumptions about normative sexual and gender experiences, it offers a storyline for thinking about sexual identity and gender identity concerns, too. This storyline is based on

[2] The mainstream LGBT+ community did not follow the Deaf/deaf community in distinguishing between Deaf (as a culture) and deaf (as a disability). In other words, there is no formal homosexual/homosexual distinction. Rather, the LGBT+ community took other pejorative labels, such as gay and queer, and reclaimed them in the face of what has been understood to be an oppressive majority that held out normative claims about sexual identity and behavior (heterosexual) and a gender identity that corresponds with one's biological or birth sex (cisgender). However, there are members of the LGBT+ community who do experience their same-sex sexuality and gender incongruence as more akin to a disability than a mark of diversity as such.

a specific understanding of sex and gender norms, at least insofar as it makes assumptions about both ability and human flourishing.

There are people who are drawn to a disability lens in part because they do not adopt a diversity lens; that is, they do not experience their gender identity concerns as indicative of an identity to be celebrated or of a community of which they tend to identify. Their experiences do not point them to a culture in the same way it does for adherents of the diversity framework. Nor are proponents of a disability perspective necessarily drawn to more religious perspectives, what we refer to as the sacred framework, which we will discuss in a moment. Drawn to the disability lens, they reject both the celebration of identity from the diversity lens and the rejection of self-experienced when framed as a moral matter. It is perhaps easier to see past the disability if a phenomenon in some way reflects or is associated with mental health concerns. Here it may be more resonant to cite gender dysphoria as an example, as it is currently in the *DSM-5*. People adopt this framework and see the benefit in stating that the person has not chosen to experience same-sex attractions or gender incongruence, and the person-first language (e.g., "I am a person who is navigating sexual identity questions.") often associated with this framework evokes in some a greater sense of compassion and empathy.

This framework also reflects the perspectives of those who simply do not see their experience as optimal for human functioning or flourishing in quite the same way as those who adhere to the diversity model. A disability framework may be particularly appealing to those who wish to distinguish themselves from those who only discuss sexuality and gender in terms of morality, or of willful disobedience to standards for behavior or identity, particularly any claim that same-sex sexuality or gender incongruence is chosen as such. In other words, the disability lens may cultivate compassion from others who do not know what an experience is like (e.g., gender incongruence).

Although helpful and perhaps seen as more compassionate, challenges arise for those drawn to the disability model. First, supporters will be viewed by proponents of the sacred model as not sufficiently valuing the sacredness of matters that drive their own concerns. A critic of the disability model shared: "Another problem with his 'Disability' view is that for the most part people don't associate a disability with sinful conduct. When people think of disabilities they typically think of such things as physical impairments of mobility, hearing, or sight; intellectual disability or other learning impairments; or health impairments like asthma, epilepsy, or attention deficit disorder. Such nonmoral disabilities can be accommodated in all sorts of ways without violating any divine standards" (Gagnon, 2015). Second, for those who adopt a diversity approach, any deviation from diversity as the lens through which people are viewed is often experienced as marginalizing or insulting. In other words, adherents of the disability model are not where proponents of the diversity model will want them to be, even in cases in which they share many of the same characteristics (e.g., same-sex sexuality).

The Sacred Framework As we have suggested already, aspects of the diversity framework can at times be in conflict with conventional religiosity as practiced by many adherents throughout the United States and the world (particularly in Africa, Asia, and South America). Let us consider what we mean, then, by sacred. Pargament and Mahoney (2005) observe that "people can perceive virtually any aspect of their lives as having divine character and significance" (p. 179). To treat something as sacred is to sanctify that aspect of one's life. That is, it is to set apart a behavior or an aspect of personhood as having spiritual or religious significance. The human capacity to sanctify has been studied in a few areas, including sexuality and sexual behavior (Murray-Swank, Pargament, & Mahoney, 2005) and the perception of one's body (Mahoney et al., 2005). A related construct, sexual congruence, has also been studied empirically (e.g., Hook et al., 2015).

Other lines of research on the experiences of conventionally religious sexual minorities (e.g., Yarhouse & Tan, 2004; Yarhouse et al., 2009) suggest that some individuals draw on similar

considerations when navigating sexual and gender identity questions. The human capacity to imbue with significance various aspects of personhood, including one's sexuality and gender identity, is what we refer to as the sacred framework. This framework views sex and gender and, therefore, sexual identity and gender identity conflicts with reference to normative claims about sex and gender that are informed by religion or spirituality.

The reason that this framework is under discussion is that it reflects a widely agreed upon understanding of sex and gender that is held by many adherents of several major world religions. Adherents often experience the other lenses as problematic, as they can at times reflect a disrespectful or sacrilegious approach to distinctions that matter to them.

As one conventionally religious theologian put it, the reference point is "the sacred integrity of maleness or femaleness stamped on one's body" (Gagnon, 2007). This is primarily a religious and theological argument. Same-sex sexual behavior and cross-gender identification are concerns to those who adhere to this framework in large part because such behaviors are thought to threaten the integrity of male/female distinctions. Conventionally religious persons of the Abrahamic faiths, that is, Christians, Jews, and Muslims, cite passages from their sacred texts that they view as supporting this sacred integrity, including references to the importance of complimentary male/female differences from the creation narrative.

This is in part because of the role religion plays in informing views of morality in which homosexual behavior is morally impermissible. Religious communities essentially joined other social structures in condemning homosexuality, whether as pathology or crime. This history almost certainly makes it difficult for the mainstream LGBT+ community to protect and safeguard the existence of other frameworks, particularly those informed by religious doctrines. This is perhaps one of the greatest challenges to any discussion of cultural competence as it has many implications for training, professional development, and practice.

The religious or theological approach that is at the foundation of the sacred lens raises similar concerns about cross-gender identification as are raised about same-sex sexuality and behavior. In other words, from this perspective same-sex sexual behavior is a moral concern in part because it does not "merge or join two persons into an integrated sexual whole..."; the "essential maleness" and "essential femaleness" are not brought together as intended. When extended to the discussion of transsexuality and cross-gender identification, the theological concerns rest in the "denial of the integrity of one's own sex and an overt attempt at marring the sacred image of maleness or femaleness formed by God" (Gagnon, 2007, p. 3).

Some recent events highlight these different frameworks that are present among individuals and institutions. One example can be seen in the story of Kelvin Cochran (Riley, 2015), a former fire chief in Atlanta. According to the Wall Street Journal a, Cochran was a well-respected fire chief who had given 30 years of service to the department and who had helped improve performance and service in the department. In 2014, Cochran was suspended for 30 days without pay for an investigation into his conduct. At the conclusion of his suspension, the mayor of Atlanta, Kasim Reed, terminated him from his position for "publishing a book in violation of the city's ethics code and without permission from the mayor" (Riley, 2015, p. 1). Cochran's book consisted of lesson plans for a Bible class that he taught to help men change their lives. In this book, Cochran refers to homosexual conduct as "perversion." Though the original statement indicated that he was not fired for his religious views, later comments made by the mayor suggested that the beliefs in Cochran's book were not in line with the mayor's personal beliefs or the city's. We can readily see distinctive frameworks at play here. Cochran seems to be coming from the sacred framework. He views sexuality and gender from a conventionally religious perspective and wrote this in a book intended for the same audience. Mayor Reed and the city of Atlanta seem to be rooted in the diversity framework and see no place for this perspective among their employees, despite the fact that it

is not something that is directly related to their work. This example illustrates what was stated earlier: deviations from diversity as the lens is experienced as marginalizing or insulting, even if that is likely not the intention.

Other stories highlight similar disconnects between those of different frameworks. Dr. Robert Oscar Lopez, a tenured professor at California State Northridge University (CSNU), has been targeted by the Human Rights Campaign (HRC) and now his university for more conservative views on family and the rights of children (Siggins, 2015). Dr. Lopez, a bisexual man, feels that he has been targeted for believing that children have a right to a mother and father and disagreeing with redefining marriage. He was not raised by natural parents, and he, along with others raised by same-sex couples, filed a brief with the Supreme Court surrounding these beliefs. Dr. Lopez sees these issues through a disability lens, while those at his school utilize a diversity lens. The HRC and CSNU do not feel that Dr. Lopez's beliefs are compatible with what they would deem acceptable for his current position.

One other example is highlighted in an article written by Peter Smith (2015). Smith writes about Wesley Hill, an associate professor and author who identifies as a celibate gay Christian. Hill believes that gay Christians should be committed to celibacy while also affirming their sexual orientation. Smith states that this "stance runs counter to the growing American majority that supports legalized same-sex marriage among Americans, including religious progressives…" (2015, p. 1). Additionally, it runs counter to many Christian conservatives who do not affirm being gay as an identity. Hill's stance through a disability lens is seen by those in the diversity framework as not fully embracing who the individual is and by those in the sacred framework as covering up or avoiding a problem they may have. It is easy to see how misunderstandings based on different frameworks can cause many difficulties in this discussion.

Yet a challenge for a truly multicultural framework is recognizing the reality and place of these religious communities and the persons who are a part of these communities, even when adherents of a religion are part of the field of psychology or are students in training to become psychologists. A challenge also arises in recognizing that students in training may also represent the sacred framework and will need mentoring in how to navigate their own religious identity and beliefs and values while developing as a mental health professional.

Multicultural competence in LGBT+ issues should also find ways to navigate education and training that reflects the reality (historically and globally) of this framework. This involves representing this perspective accurately and respectfully, as well as providing an environment conducive to students in training who identify as conventionally religious.

We turn our attention now to several other topics in the cultural competence literature around which to develop clarification. As was mentioned previously, these include identifying the parameters of the culture, accuracy and humility around dissimilarities from prototypical topics of cultural competency, prejudice and bias against conventional religious beliefs and values, measurement of multicultural competence for clinical practice, and pinpointing issues for further clarification that have to do with identity, politics, and epistemology.

Identifying the Parameters of the Culture

When we turn to discussions of multiculturalism and multicultural competence and their applications to the LGBT+ community, part of the difficulties lay in what the construct of multicultural competence means in this context. We are referring to the heterogeneity within the LGBT+ community, which we have so far been discussing primarily with reference to lesbian, gay, bisexual, and transgender. Even if we add to that the rather modest extension of questioning, queer, and intersex persons (LGBTQQI), we are already discussing remarkably different experiences. Some resources include additional identity labels such as pansexual, pangender, gender fluid, gender queer, asexual, and many more. A person who

seeks care for an intersex condition is having a very different session from a same-sex couple having difficulties with communication or finances. Both of these cases are different from someone who experiences significant gender dysphoria.

Each of the previously mentioned identifiers point to a specific experience that warrants thoughtful discussion, but what we are asking is how does the mental health professional approach such diversity as though it were a culture around which to be competent? Is the LGBT+ community a culture? If so, what makes it a culture? For example, in contrast to the African-American community, which shares a unique cultural history in the United States, there are dimensions that are rather dissimilar when we think of the experience of sexual attraction as compared to the experience of gender dysphoria or cross-gender identification or intersex conditions or asexuality.

In some respects, it is a culture insofar as it distinguishes itself from those who are heterosexual and cisgender. It is a culture of *not being that*. The LGBT+ community *as culture* originated from the basis of experiencing a different pattern of sexual attraction that is conceptualized as a sexual orientation: homosexual or bisexual rather than heterosexual. It eventually expanded to note distinctions between male and female experiences (gay and lesbian). Today it includes discussions of pansexuality and asexuality. It expanded further to include those who are transgender or otherwise gender variant, which has subsequently expanded to include experiences of those who are gender queer and gender fluid. As authors who are exploring the challenges associated with cultural competence in this area, we are not particularly critical of this development, but we are asking if there are inherent limitations in creating a culture of contrasts with existing norms surrounding sexuality and gender.

Questions also come up within the LGBT+ community around race and socioeconomic status. According to Petchaur, Yarhouse, and Gallien, the LGBT+ community relied upon and was influenced significantly in its history by White, gay identity and its associations with the middle class. Fukuyama and Ferguson (2000) offer the following:

> Gay identity and the gay liberation movement have been associated with the White middle class.... [Thus] people of color may resist joining the gay liberation movement because it is perceived to be joining with the White oppressor and denying one's family ties. In some ways, a gay identity may be a function of acculturation into American society. (p. 99)

The emergence of LGBT+ persons as a culture is further delineated when referencing meaningful historical events (e.g., Stonewall Inn riots of 1969) and early organizations (e.g., the Mattachine Society) that hoped to end criminalization of homosexual behavior, as well as historical tragedies (e.g., the execution of an estimated 50,000 men under the Nazi's because they were believed to have a homosexual orientation). Criminalization of homosexuality also exists in some countries today (e.g., Iraq, Iran, Saudi Arabia).

As we mentioned above, one of the strides in the development in the emergence of the LGBT+ community as a culture was the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1973. Since that time, subsequent revisions have recognized that there may be a conflict between one's sexual orientation and one's personal beliefs and values. However, not being classified as a mental illness does not legitimize the creation of a culture. But, the removal of homosexuality from the *DSM* was as important as de-pathologizing and later decriminalizing same-sex sexual behavior in fostering a culture group one could positively ascribe to.

As a result, the LGBT+ community can now be described as a culture of patterns of sexual attraction, behavior, and diverse experiences of gender identity, including in some cases medical conditions (e.g., Klinefelter syndrome or the presence of XXY chromosomes rather than XY or XX). These patterns are argued to be natural, by which is often meant biological in origin, which was historically important and contrasted to the language of sexual preference, which reflected volition on the part of the subject.

Today, what is often pathologized are any views of homosexuality that are not affirmative, which is not clearly defined, but had typically involved (prior to the Supreme Court ruling in *Obergefell v. Hodges* in 2015) political endorsement of marriage equality and comparable political and ideological positions. Political and moral positions often show up on measures of competence, which is a further complication in light of the various frameworks discussed above. Presumably, such questions are warranted because psychologists and other mental health professionals are urged to examine their beliefs and values for any "heterosexual and cisgender privilege" (Sue & Sue, 2013, p. 484), which is an all too often ambiguous declaration that is becoming canonical in the cultural competence movement. Readers are often urged to examine one's beliefs for any cisgender privilege because failing to do so may perpetuate the cycle of microaggressions that can leave an individual feeling invalidated, misunderstood, and less than (American Psychological Association [APA], 2009; Hebard & Hebard, 2015). It is unclear, however, how each of these concepts (e.g., cisgenderism) is practically conceptualized when they are articulated from a diversity lens and how to incorporate other lenses (e.g., sacred, disability) that may be held by client and clinicians alike that view some of these distinctions not as signed of privilege but as normative claims regarding personhood with identifiable variations which can be responded to with understanding and compassion.

As we bring this section to a close, we want to reiterate the challenges associated with this remarkably heterogeneous population. Much of the history of meaning-making and culture development has been in reference to a negative—in regard to what a person is not and often tied to the deconstruction of social norms regarding sex and gender. At a practical level, we have to ask whether true cultural competence will be reflected in reviewing paperwork, policies, and procedures for privileges associated with gender congruency (to reflect the concerns of those who report gender dysphoria), heterosexuality (for clients who may be attracted to the same sex or both same and opposite sex), sexual desire (for those who may be asexual), gender constancy (for those who may be gender fluid), and nonmedical conditions related to disorders of sexual development (for those who may be intersex). Perhaps more thought can go into what constitutes good professional practice to those who may present with any number of clinical concerns and who may represent the different frameworks or lenses previously discussed.

Parallels Drawn to Skin Color

Another related difficulty has to do with attempts to pattern the LGBT+ community and corresponding multicultural competence after racial minority discussions. The questions that arise are: In what ways is the LGBT+ population a culture akin to that of an African-American culture or a Hispanic culture? In what ways are they similar? In what ways are they different? Is drawing a parallel to race or ethnicity an accurate analogy? If not, why not?

After all, we are not discussing a group of people who are a community of like-minded people. We are not discussing what it means to be a Republican or a Democrat (as though all within a political party agreed with one another). This is not a discussion of being an animal rights advocate. We are talking about presenting the LGBT+ community as a culture by virtue of being different wherein the difference is one that occurs in nature (a natural human kind of difference) and that is immutable.

Perhaps the most emotionally compelling analogy that been used in the past 40 years has been to connect patterns of sexual attraction to race to argue that just like racial minorities, sexual minorities are a people group whose very existence is tied to an innate and immutable characteristic (i.e., sexual orientation). It has been widely presented as though sexual orientation was an immutable characteristic. This argument is then extended to discussions about etiology and change, for the assumption is that if sexual orientation has biological markers in the way race has biological markers, then the LGBT+

community comprises a similar culture. Along the same lines, if it can be demonstrated that patterns of sexual attraction or orientation are immutable, then perhaps the reference to race is an apt analogy.

The larger argument has meant connecting LGBT+ personhood to the civil rights movement among African-Americans. This has been a compelling analogy that has captured the imagination of many younger Americans who see LGBT+ equality as the civil rights issue of their generation. In many ways, the celebration of marriage equality or gay marriage in the Supreme Court's 5–4 decision on *Obergefell v. Hodges* in 2015 reflected this connection.

The language of LGBT+ youth reflects this preference for a parallel to race. However, what is particularly difficult with this analogy as extended to youth is that a percentage of young people who report same-sex attraction, orientation, and/or identity may not continue to experience the same degree of same-sex sexuality into adulthood. The Adolescent Health Study data suggested a stable same-sex sexuality for a smaller percentage of adolescents and those in emerging adulthood; however, a higher percentage experienced more of an ebb and flow of attractions toward the same sex and the opposite sex, with greater fluidity in same-sex sexuality (e.g., those for whom bisexuality was a preferred designation in adolescence often reported greater heterosexual attraction in emerging adulthood; see Savin-Williams, Joyner, & Rieger, 2012; cf., Li, Katz-Wise, & Calzo, 2014; Savin-Williams & Joyner, 2014).

Jones's (2012) conclusion seems apt:

> So, is sexual orientation like skin color? At birth, or in the womb for that matter, we know whether a child is a boy or girl (except in those rare aberrant cases where the multivariate phenomenon of sex goes awry) and we know that the child will share the racial characteristics, in some creative mix, of his or her two biological parents. At this point, we know little with clarity about the etiology of homosexual orientation. Given the theoretical and empirical possibilities of genes interacting with environment, the clear evidence of postnatal, socio-cultural variables having an influence upon sexual orientation … and the clear evidence of the modest contribution of genetic and other biological factors that has emerged from studies of similar truly representative samples, it is safe to conclude that sexual orientation is disanalogous to skin color, and of mysterious origins indeed. (p. 12)

Etiology In our previous work (Jones & Yarhouse, 2012), the fundamental validity of the analogy as to whether sexual orientation is akin to skin color was discussed. Skin color is biological/genetically caused and is essentially immutable (aside from cosmetic, chemical, or surgical interventions or disease states, e.g., vitiligo). The biological hypothesis for the etiology of sexual orientation has been forcefully advanced since the early 1990s. Several studies have been published on genetic and prenatal hormonal hypotheses with mixed results. Resulting evidence appears to support biological contributions for a subset of persons. For example, the original genetic hypothesis studied by Dean Hamer and his colleagues (1993; Hu et al., 1995) indicated a significant concordance for the Xq28 subtelomeric region of the sex chromosome, which would suggest a genetic basis for male homosexuality. These study findings failed replication by Rice, Anderson, Risch, and Ebers (1999) and by Mustanski et al. (2005). A more recent report was able to replicate these findings and perhaps suggests a genetic basis for a certain type of homosexuality, that is, select males only (selected for higher occurrence among maternal relatives).

Twin studies have also been a point of focus on genetics. Some of the earliest studies (e.g., Bailey & Pilard, 1991) suffered from recruitment bias that contributed to a broader, public perception genetic causation that has not been able to be empirically sustained. Subsequent twin studies (e.g., Bailey, Dunn, & Martin, 2000) that drew upon a more representative sample significantly reduced the genetic factors, as only 3 of 27 identical twin pairs matched for homosexual orientation). A study that drew from the Swedish twin registry also reported a much lower concordance rate, as only 7 of 71 twin pairs matched on homosexual behavior (Langstrom, Rahman, Carlstrom, & Lichtenstein, 2010).

A third line of research implicating biological contributions to sexual orientation is referred to

as the fraternal birth order research. This line of research examines the influence of having an older brother on male sexual orientation, and it draws upon the "maternal immune hypothesis" as the primary rationale for the relationship between older brothers and increased rates of homosexual orientation. This hypothesis states that the mother's body develops anti-male antibodies in response to subsequent male fetuses, which prevent the full masculinization of the fetus's brain. The greater the number of older brothers, the greater the chance of subsequent males developing a homosexual orientation (Jones & Yarhouse, 2012).

There does appear to be a relationship between the number of brothers in a family and homosexuality. What is unclear from the data so far is the strength of that relationship and the causal pathway as well as other possible, often overlooked variables. However, even if the older brother hypothesis were confirmed across several research labs, it is estimated to only account for about 15% of male homosexuals. That leaves multiple other potential pathways for male homosexuality, not to mention female homosexuality.

A more accurate way to conceptualize homosexuality might be to think of their being multiple homosexualities and multiple pathways to the same endpoint (the principle of equifinality). Moreover, the endpoint of homosexuality is quite broad, as there appear to be significant differences between male experiences of homosexuality and female experiences of homosexuality, as well as differences among male experiences and female experiences.

Instability Evidence of sexual identity instability has been documented among sexual minority male and female adolescents and emerging adults (Kinnish, Strassberg, & Turner, 2005; Ott, Corliss, Wypij, Rosario, & Austin, 2011). That same-sex sexuality is fluid was unthinkable not too many years ago. It was a view challenged notably by a line of research by Diamond (2008) but perhaps thought of as a unique difference in fluidity among female sexual minorities. However, as more evidence is collected on male and female sexual minorities, from adolescence through emerging adulthood and into adulthood, it is unclear how the prior narrative of immutability upon which so much policy has been written will fare.

When we turn to the question of gender identity, most young people who are diagnosed with gender dysphoria do not meet criteria in adulthood. The DSM-5 estimates that about 75% of cases resolve on their own before a child enters late adolescence or adulthood. These children are referred to as desisters (rather than persisters). Here, the parallel to race breaks down, and the analogy does not inform competent practice as it was perhaps intended.

Among those whose gender dysphoria persists, the person now faces several pathways: living and forming a gender identity congruent with one's biological/birth sex, engaging in cross-gender behavior/presentation intermittently, or forming a cross-gender identity through various measures that may or may not include hormonal treatment and sex reassignment surgery (Carroll, 2007; Yarhouse, 2015). Again, as with lesbian, gay, and bisexual identity and value congruence, perhaps creating supportive avenues for a range of resolutions would be helpful in achieving a more nuanced cultural competence when managing gender dysphoria and identifying person-specific pathways for achieving congruence.

In addition to potential changes in attraction and gender dysphoria, we also note that just at the level of identity and behavior, many people choose not to identify themselves as LGB nor to engage in same-sex sexual behavior for personal, cultural, or religious reasons. In an effort to protect the LGBT community as a culture, this could be dismissed as a reflection of internalized homophobia or sexual self-stigma; however, while internalized negative messages may play a role for some people, any such declarations fail to grapple sufficiently with the full range of reasons why a person might choose to dis-identify with the gay community or might choose to refrain from sexual behavior. We have seen this in surveys of sexual minorities at religiously affiliated colleges and universities, for example

(Stratton et al., 2013; Yarhouse et al., 2009), as well as community samples (Yarhouse & Tan, 2004).

The more narrow the focus, the more likely we are to find similarities. For example, if we were to only discuss gay males, we might have more of a sense for gay males being like other groups that so often comprise discussions of multicultural competence. For example, there is more research suggesting biological contributions to homosexual orientation among males. There is a less a sense of choice in gay males who have been surveyed about such matters. In a recent survey, for example, gay, lesbian, and bisexual persons were asked the question, how much choice do you feel you had about being [lesbian/gay/bisexual/queer/homosexual; depending on the respondent's preferred term] (Herek, Norton, Allen, & Sims, 2010, p. 186)? While about 42% of bisexual men and women indicated having a fair amount or a great deal of choice and 16.4% of lesbian respondents reported having a fair amount or a great deal of choice in the matter, only 5.2% of gay men reported having a fair amount or a great amount of choice in being gay.

This may fit with other lines of research that suggest greater sexual fluidity among female sexual minorities (women who identify as lesbian or bisexual, for instance) than male sexual minorities (e.g., Diamond, 2008).

Perhaps a more helpful question for multicultural competence has to do with identifying the developmental pathways toward an LGBT identity as well as developmental pathways among those for whom an LGBT identity is not sought or realized (Yarhouse, 2001). Current research on identity models or pathways toward an LGBT identity (Worthington, Savoy, Dillon, & Vernagalia, 2002) follows a similar template to those of racial/ethnic identity development: one from self-hating to one that is self-accepting, in the attempt to capture this experience of grappling with and understanding one's own sexuality (Morgan, 2012).

We think the challenge for multicultural discussions is to consistently extend the discussion beyond those declarations that draw upon male experiences to the exclusion of other experiences. Further, the interpretation of such findings can at times occur with reference to political utility and a single lens (i.e., diversity) rather than humility, scientific accuracy, and a recognition of multiple lenses adopted by clients, clinicians, and researches alike.

Mutability Insofar as members of the LGBT+ community are said to be a culture analogous to racial groups distinguished by skin color, the question arises whether sexual orientation is an immutable characteristic. However, as we turn our attention from etiology to the question of mutability, we face similar complexities. At a time when sexual orientation was being discussed as absolutely immutable, we (Jones & Yarhouse, 2007) set out to conduct a longitudinal and prospective study to test that hypothesis. We studied the experiences of 98 adults who sought to change their sexual orientation through involvement in religious ministries. These participants were followed for a total of between 6 and 7 years (Jones & Yarhouse, 2011).

Here is a helpful summary of the findings at the conclusion of the study:

> Of the original 98 participants in the study (72 men, 26 women), 61 subjects completed the key measures of sexual orientation and psychological distress at the conclusion of the study, and were successfully categorized for general outcome. Of these 61 subjects, 53% were categorized as successful outcomes by the standards of Exodus Ministries. Specifically, 23% of the subjects reported success in the form of 'conversion' to heterosexual orientation and functioning, while an additional 30% reported stable behavioral chastity with substantive dis-identification with homosexual orientation. On the other hand, 20% of the subjects reported giving up on the change process and fully embracing gay identity. On the measures of sexual orientation, statistically significant changes on average were reported across the entire sample for decreases in homosexual orientation; some statistically significant change, but of smaller magnitude, was reported in increase of heterosexual attraction. These changes were less substantial and generally statistically non-significant for the average changes of those subjects assessed earliest in the change process, though some of these subjects still figured as 'Success: Conversion' cases. (Jones, 2012, p. 15)

In this study, "conversion" referred to a change in strength of attraction toward the same sex and a corresponding increase in attraction toward the opposite sex; "behavioral chastity" referred to the ability to refrain from same-sex behavior, which was made possible because of a sufficient decrease in the strength of same-sex attraction; and gay identity referred to a decision to discontinue all change efforts and to integrate same-sex attractions into a gay identity and view same-sex behavior as morally permissible (see Jones & Yarhouse, 2007, 2011).

We also measured psychological distress and reported that there was not an average increase in psychological distress associated with the attempt to change orientation through these religious ministries; if anything, there were, on average, slight improvements in reported psychological distress over time.

These findings should not be taken to mean that categorical changes from gay to straight are likely, but we did see meaningful shifts along a continuum for some people and not for others. It is unclear whether those shifts were due to involvement in a religious ministry; they may have also reflected a natural fluidity and may reflect to some extent a combination of changes in orientation and also behavior and identity as we discussed in our peer-reviewed journal publication (Jones & Yarhouse, 2011).

The question of natural fluidity is a more recent one. Recall that our study was launched at a time when it was the prevailing view that sexual orientation is immutable, which is the nod to skin color analogy. However, today there are increasing numbers of researchers who have documented shifts in sexuality over time—these shifts are sometimes referred to as a reflection of natural fluidity. One of the more well-known lines of research is by Diamond (2008) who reported shifts in self-reported sexual behavior, identity, and attractions among sexual minority women, including self-identified lesbians (in addition to bisexual women and women who eschewed a sexual identity label as such).

Perhaps we are seeing multiple homosexualities rather than any one phenomenon. With greater humility and honesty, perhaps it can be concluded for the time being that sexual orientation is in some cases mutable. As Jones (2012) states it, "'Homosexuality' is a multifaceted phenomenon; there are likely many homosexualities, with some perhaps more malleable than others" (p. 15). Such an observation, if increasingly demonstrated to be the case, further suggests we reconsider analogies to skin color and reflect greater humility about what we do and do not know.

Identity, Politics, and Epistemology As we bring our discussion of etiology, instability, and mutability to a close, we want to reiterate that the scientific work and associated debates occurred in the sociocultural context of what has been referred to as identity politics (Heyes, 2012). Much of the ground that has been gained in discussions centering on homosexuality has been due to an essentialist view of sexual orientation as something immutable and essential to who someone is (their identity) as a person.

> Nowhere have conceptual struggles over identity been more pronounced than in the lesbian and gay liberation movement. The notion that sexual object choice can define who a person is has been profoundly challenged by the advent of queer politics. Visible early lesbian and gay activists emphasized the immutable and essential natures of their sexual identities. For some, they were a distinctively different natural kind of person, with the same rights as heterosexuals (another natural kind) to find fulfillment in marriage, property ownership, and so on. This strand of gay organizing (perhaps associated more closely with white, middle-class gay men, at least until the radicalizing effects of the AIDS pandemic) with its complex simultaneous appeals to difference and to sameness has a genealogy going back to pre-Stonewall homophilic activism … (Heyes, 2012)

Discussions centering on people who experience gender dysphoria have moved in a similar direction. Adherents of the diversity framework often draw on (as their primary paradigm) an essentialism that distinguishes types of persons: transgender from cisgender. The biological essentialism that has been associated with sexual orientation (with an emphasis on neurobiological brain differences, markers on the X chromosome, twin studies, etc.) is being discussed with reference to a corresponding essentialism

associated with gender identity, particularly as it is conceptualized in the brain-sex theory mentioned above (see Yarhouse, 2015).

The challenge in discussions about multicultural competence, however, comes with how people may wish to use research in the context of broader political interests (of, say, liberation or civil rights or identity politics) while also demonstrating self-control and humility about the limitations of science and what can be known from science. What do we know about causation at this point from the research that has been conducted so far? What do we know about the mutability of sexual orientation or resolutions of gender identity conflicts?

Of course, the LGBT+ community may still be a culture, and discussions of what constitutes cultural competence will continue to be salient. However, the difference in discussions of and training toward cultural competence is that they would not use the prevailing analogy to skin color to advance that perspective. Such discussions and training may also be enhanced through the inclusion of multiple lenses through which people conduct and interpret such research, as well as how clients make meaning out of their own experiences of sexual and gender identity.

Humility Regarding What Is Known/Not Known with Respect to LGBT+ Families

Another area where there is some contention and confusion is the research on LGBT+ families. It seems that there is conflicting research on LGBT+ relationships, LGBT+ parenting, and the outcomes for children growing up with LGBT+ parents between the mainstream LGBT+ community and those on the other side of the debate. Both sides are asking the same questions, but there seems to be a lack of consensus on the definitions of key terms and the methodologies used. The current political realities only make it that much more difficult to identify points of consensus for serving those who identify as LGBT+.

Some of the arguments against LGBT+ families have been that LGBT+ relationships do not last as long as heterosexual ones because of higher frequencies of sex outside of the current relationship, indicating lower levels of commitment. For example, the National Lesbian Family Study (NLFS) conducted by Gartrell and colleagues (2011) found that 40 out of 73 lesbian-mother relationships dissolved by the time their child was 17 years old. Other research (Goldberg & Garcia, 2015) has shown that relationship dissolution of lesbian or gay couples is about as frequent as it is for heterosexual couples. Both studies have relatively small sample sizes, and each give their own reasoning for why the number is not higher or lower, depending on their point of view.

These assumptions have led individuals who likely view the topic through different lenses to research the effects of LGBT+ parents on the children that they raise. Part of the difficulty here is that each side is looking to prove a point or obtain certain findings, which may affect their ability to objectively perform research. The Witherspoon Institute put out a book entitled *No Differences? How Children in Same-Sex Households Fare: Studies from Social Sciences* (Samuel, 2014) which aims to give evidence that children who are raised by same-sex parents have significant differences from those raised by heterosexual parents. This book was a direct challenge to the APA's 2005 document that stated that there were no studies of children of LGBT individuals that showed any negative effect. Therefore, this line of research was conducted to directly prove this statement wrong, drawing into question whether or not it has been done objectively.

In this text, Marks (2012) argues that previous research that shows no effect is centered on small convenience samples and should be called into question. Regnerus's (2012) study that indicates significant differences on 25 out of 40 outcome measures for a large group of children is also highlighted. He found that children of same-sex parents scored suboptimally on measures of receiving welfare, needing therapy, STIs, sexual victimization, and lower educational attainment,

to name a few. Altogether, the text paints a picture that "…in a cross-section of children raised by parents in same-sex relationships, life outcomes tend to resemble those of children raised by single and divorced parents" (Londregan, 2014, p. 14).

On the other hand, those from the mainstream LGBT+ community have multiple problems with the research presented by the Witherspoon Institute. Cheng and Powell (2015) reexamined Regnerus's (2012) study based on the belief it was poor methodology and all too convenient for the researcher. They state that there was not a valid or reliable measure of family type, which may conflate some of the findings. Additionally, they state Regnerus may have overestimated the number of children with gay or lesbian parents, as his definition of a LGBT+ family was somewhat confusing. After reanalyzing the data, they believe that, had all the respondents been properly categorized, there would be no significant difference between those raised by same-sex parents and those raised by heterosexual parents.

Other research done by those in the mainstream LGBT community consistently find that children of same-sex parents have outcomes similar to or sometimes better than those raised by heterosexual parents. Some suggest that these children are better off because they must create new identities, examine what they believe, and think critically due to their different situation (Sasnett, 2015). Others suggest that the psychological well-being of children with same-gender parents is better than those of heterosexual parents (Fedewa, Black, & Ahn, 2015).

As clearly indicated, there is essentially no agreement between the two sides, and there seems to be no middle ground, suggesting that each side may be serving their own bias. Because of this, there are multiple things that we do not know. We do not know if having same-sex parents will increase the likelihood of an individual exploring same-sex sexuality or identifying as lesbian, gay, or bisexual (and on one "side" of the cultural debate, the very question is itself not a concern). We also do not know whether or not having same-sex parents has a universal effect on the psychological well-being of children or their development. Additionally, we do not know any mediating factors that may be influencing findings. In sum, what is uncertain is: If there are differences, are they a direct result of the parents themselves or other factors in the environment, such as relational strains with extended family, societal views, etc.? These are ample avenues to pursue in future research.

Despite the disagreements and the questions surrounding the research, there are a few things that we do know. We know that there will be an increase in LGBT+ families and that there are different views which may affect how the families operate and how they experience themselves. We also know that LGBT+ parents often times face more discrimination and more obstacles in parenting, specifically when adopting (Farr & Patterson, 2013). Furthermore, we know that there is no consensus on LGBT+ families and their effect on children and society as a whole. This can make it difficult when discussing measuring competence in working with this population as it is difficult to know of which research to base our work. Perhaps collaboration between the opposing sides would aide in a consensus being reached that is helpful and valuable to the discussion.

Cultural Competence in Training and Practice

As we consider the practical dimensions of obtaining cultural competence in work involving LGBT+ persons, we note two areas of primary concern: training and practice. As we enter into a discussion of these two areas for review, we invite the reader to consider whether the present way of understanding LGBT+ issues has become the preferred way of understanding to the potential exclusion of other perspectives, including other important expressions of diversity. If so, such a view may risk taking a narrow slice of recent history, speak of a LGBT+ rights movement following significant events and people that shape the contours of the LGBT+ movement as a whole, and establish a standard by which other worldviews and perspectives are rejected.

One of the interesting developments in training has been efforts to measure LGBT+ competence. At present, the empirical base for providing evidence-based training in LGBT+ cultural competence is "a relatively underdeveloped literature" (Pantalone, 2015, p. 147). As Pantalone and others have suggested, there is a need to identify core themes that constitute cultural competence in LGBT+ studies and to empirically test those core themes. Several suggestions have been offered as a potential line of research toward the end of establishing greater evidence-based training. These include whether the core themes that are being identified in the mainstream of LGBT+ studies (e.g., Matza, Sloan, Kauth, & DeBakey, 2015) are "the most important, impactful ones"; whether one "can train nonexperts to some standard of fidelity" for LGBT+ competence; and whether those training to be culturally competent providers can "achieve clinical outcomes similar to experts" (Pantalone, 2015, pp. 148–149).

Measuring LGBT+ Cultural Competence We see the mainstream approach toward LGBT+ persons in the multicultural movement as organized around attitudes, knowledge, and skills. We have not thoroughly critiqued whether competence is rightly established and measured by paying attention to these three areas. However, we are concerned by some of what is included under each heading, especially attitudes and knowledge. Attitudes (and measures associated with counselor competence) are affirming in ways that preclude a psychologist from holding views or reaching conclusions about sexual ethics/morality or marriage that are rational and historically significant. What counts as knowledge can include inflated prevalence estimates and limited theories about causation (e.g., the biological hypothesis that has been forcefully advanced since the early 1990s). Interest in other life trajectories (e.g., celibacy, chastity, or even attempts to change strength of attractions) is either not discussed or treated as akin to bleaching the skin of an African-American client who requests it. In any case, any non-affirming position is reduced to homophobia and internalized homophobia—both poorly defined constructs.

One scale for measuring attitudes toward the LGBT community is the attitudes toward lesbians and gay men scale (ATLG-R; Herek, 1998). Several problems have been noted, however, with bias toward conventionally religious persons (Rosik, 2007), such that a Christian, for example, could score high in homophobia by simply endorsing items that reflect historical doctrinal positions of Christianity vis-à-vis sexual morality (e.g., "Female homosexuality is a sin" and "Sex between two men is just plain wrong"; Rodriguez-Seijas, 2014). Other items ask about legal matters (e.g., marriage) where we might expect to see great variability in a diverse and pluralistic culture and democracy. Indeed, there is not even consensus among those in the LGBT+ community with respect to marriage equality.

Other measures of attitudes similarly include items that preclude the possibility of competence by students or clinicians who hold a conservative or more traditional sexual ethic. For example, in the field of counseling, Bidell's (2005) Sexual Orientation Counselor Competency Scale distinguishes attitudes, knowledge, and skills with no empirical support offered for the assumption that attitudes are a critical piece of competence. As mentioned elsewhere (Yarhouse, 2009), at least three scale items are problematic in this regard: "The lifestyle of a LGB client is unnatural or immoral"; "Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help."; and "When it comes to homosexuality, I agree with the statement: 'You should love the sinner but hate the sin'" (p. 273).

These three items are problematic for many reasons. The first item conflates "unnatural" and "immoral," which are two different topics. A person who adheres to a traditional view of sexuality and sexual behavior might recognize that homosexual behavior occurs in nature but might take issue with whether such behavior among humans is moral or immoral. The second item fuses psychopathology and sin. It compounds this concern by adding the question of clinical intervention and spiritual care. The third item reflects a statement many conventionally religious people use to organize their own thinking about morality and

respect for those who have reached different conclusions about sexual behavior. Its inclusion here, however, is as a measure of competence that simply begs the question: Are conventionally religious people less competent to provide mental health services to LGBT+ clients?

Related to questions about counselor competence scales, we also see measures of homophobia and sexual prejudice. The construct of homophobia is problematic in many ways. The term homophobia suggests a phobic reaction to anxiety-provoking stimuli. It is unclear that any evidence exists that supports this narrow use of the term. Yet the connotation is much broader than that, as the term is often used in response to any discussion or response to same-sex sexuality or behavior that is not fully affirming or advocacy-based. It just may not be the most accurate word to use in discussions of cultural competence. Further, to cite it as a measure of practice is also a concern. It is unclear whether any concern a client has about his or her sexual attractions, orientation, or behavior is deemed internalized homophobia and pathologized. Such measures seem to often overlook sincerely held personal beliefs and values regarding sexuality that may in some cases be tied to religious and/or spiritual beliefs, doctrinal positions regarding theological anthropology, sexual morality, and so on.

Similarly, the Sexual Prejudice Scale (Chonody, 2013) was designed to measure the construct of sexual prejudice. The researchers who developed the scale take as evidence of prejudice differing views of morality: "It's wrong for men to have sex with men." A prejudice is a prejudgment (by definition) and is irrational. However, a rational conclusion may be that one holds that specific actions are morally impermissible. That rational conclusion is not, by definition, a prejudice.

Other items get at political concerns, such as views on gay marriage, health care and retirement benefits for partners, and so on. It is unclear how differing views on these political matters constitutes evidence of prejudice. Such views could be held by a person who is prejudiced against LGBT+ persons; but to indicate that these items are foregone conclusions and evidence of prejudice moves beyond what we know and is poorly conceptualized. It is unclear how these scales are used in practice or in training, but insofar as they could be used to identify undesirable or potentially dangerous clinicians is problematic on many fronts.

One of the chief questions we are asking is this: Is there a relationship between affirmative practice or LGBT+ competence as measured by these scales and actual clinical practice outcomes? In an interesting study of affirmative training, Rock et al. (2010) ask the question "Does affirmative training matter?" and answer the question by collecting data about perceived self-competence from students in training. However, that is not a study that answers the question of treatment outcomes.

Perhaps more to the point for training, Hathaway (2014) asks the important question, "Are conservative religious convictions professional counter-indicators?" (p. 99). A few recent legal cases have been the impetus to this question. In one case (Ward v. Wilbanks, 2010) a graduate student, Julea Ward, brought a concern to her supervisor that had to do with whether she should refer a client as she was unable, for religious reasons, to affirm his same-sex behavior. The supervisor supported the referral option, but this led to an informal hearing that then followed with the decision to force Ward to either withdraw from the program or go through a formal review. Ward did not withdraw from the program, and the formal review was held. The decision was reached that Ward had violated the code of ethics of their professional association. Ward subsequently filed a suit against her program. Although a federal judge initially ruled in favor of the program, the appeals court determined that the claim should go to a jury and questions were raised regarding the programs' referral policy and the manner in which Ward's religious beliefs were addressed (Wise et al., 2015).

To return to Hathaway's (2014) question about whether conservative religious conviction can be properly identified as a counter-indicator to clinical practice, he offers the following:

> Psychologists and other mental health professionals with conservative religious views have worked with people form mixed faith marriages, couples cohabiting outside of marriage, atheists, those adhering to other faiths, secularists, couples going through divorces, and countless other areas of difference that might represent counternormative forms of life within those varieties of religious convictions. We simply do not have at present a scientific basis to warrant treating students (or applicants) with conventional religious convictions on these matters as ipso facto impaired in their potential to work with clients across value divides. (Hathaway, 2014, p. 99)

There has been an interesting line of research (e.g., Bassett et al., 2005) suggesting that those who are high on intrinsic religiosity demonstrate a regard for LGBT+ persons but may not support sexual behavior. This has been studied more recently by Rodriguez-Seijas (2014). It may be an interesting line of research to consider whether clinicians with a genuine and deeply help religious faith may be *more* likely to respect the human dignity of, and have heartfelt empathy for, all clients regardless of their presentation.

To return to the question of training, a potentially significant concern in training and mentoring of conventionally religious students is the need to recruit and retain conventionally religious faculty in training settings: It has been argued that "pedagogical foreclosure" (Hathaway, 2014, p. 99) may have contributed to Ward's posture and the subsequent polarization. Interestingly, the case was ultimately settled out of court after the 6th Circuit court ordered the district court to rehear it.

There have also been numerous opinion pieces published in response to this and other legal cases that could be read as rather dismissive of the place of sincerely held religious beliefs and values among students in training or professionals in general. For example, the language of "if you can't take the heat, stay out of the kitchen" (Plante, 2015, p. 96) is unlikely to be as productive in the discussions surrounding cultural competence, training, and inculcating professional identity among all students, including those for whom religious and spiritual considerations inform moral reasoning in ways that appear contrary to the current form of the diversity framework as it is being presented. We turn our attention now to challenges in achieving cultural competence in training and practice.

Cultural Competence in Training and Practice It was mentioned above that one potential challenge facing the mainstream LGBT+ multicultural movement is that it can function out of the strong form of the diversity framework without demonstrating sufficient regard for the other frameworks and the beliefs and values of the adherents of those frameworks. We can apply this to both clinical practice and training.

Culture is often multidimensional; we might discuss a female client who also self-identifies as African-American and Baptist. The current language for this is intersectionality. However, very little work has been done on the kinds of intersections that are most difficult to navigate, such as when a person is gay and intrinsically religious (Yarhouse & Tan, 2004). What if the client above was a devout Baptist whose faith informed her moral reasoning regarding sexuality and sexual behavior? What if the client identified as lesbian or bisexual? What do clinicians need to know to be either sensitive to or competent with such a client?

Most of the discussions of culture, competence, and cultural competence with reference to LGBT+ issues extend the discussion and definitions used in the broader racial minority literature and apply it to the LGBT+ community:

> Cultural competence with LGBT people therefore involves the sensitivity and understanding of individuals in the profession, from trainees to practicing clinicians, about the relevant issues that specifically and uniquely affect members of sexual and gender minority communities, and those psychological concerns that, while more universally applicable, differentially influence those within these communities. (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015, pp. 152–153)

For others, cultural competence includes honoring members of the LGBT+ community: "As professionals invested in multicultural competence, we also hope to train students to honor those who are different, rather than merely accepting differences or looking beyond differences" (Cochran & Robohm, 2015, p. 120). It is

unclear what "honoring" means in training and practice, although the statement was made in the context of a larger discussion of religious and spiritual beliefs and values which may be held by students in training. It also follows statements suggesting a biological basis for sexual orientation and the claim that efforts to change either sexual orientation or gender identity are "invalidating at best and iatrogenic at worst" (p. 120).

Many proponents introduce training and practice by referencing Sue and Sue's (2013) model emphasizing knowledge, attitudes, and skills and then applying that directly to the topic and interests of the LGBT+ community—frequently without defining other terms, such as the LGBT+ community as a culture per se and how the diversity within the LGBT+ community, including the existence of conventionally religious members, shapes the discussion of culture, and cultural competence, as well as how one experience of diversity intersects with other important expressions of diversity, specifically religion and spiritualty. These discussions become increasingly problematic in direct proportion to political considerations. For example, Hope and Chappell (2015) extend the discussion of knowledge, attitudes, and skills to include a fourth area of competence: advocacy. We do not disagree with the value of learning advocacy in psychology; however, the charge for mental health professionals to see themselves as advocates and social justice practitioners for those who are LGBT+ rarely reflects the nuances needed to demonstrate respect for multiple stakeholders in a discussion about LGBT+ concerns. In this context, it is unclear how to best define "social justice" in LGBT+ contexts and how to address the many divergent perspective represented.

It is one thing to lobby for access to mental health services or to advocate for safety in a local school system. It is another thing to advocate for legislation for/against a student trainee's right to abide by sincerely held religious beliefs regarding client services. Consider the recent discussions centering on training in which conventionally religious students experience a conflict with working with specific client presentations, such as a same-sex relationship. For some embroiled in the political debates, these are policies and debates about "convictions of conscience"; for the vast majority who have written about these matters in our field, however, these are clearly legislative efforts focused on "refusal of services." With few exceptions, this is the way the matter is framed with an almost "everybody knows" quality about which is the correct side in the debate.

So are these conflicts in training a matter of religious liberty or of prejudice and bigotry? Our position is that neither of these two dichotomies captures the nuance needed to adequately respond to the complexities inherent in balancing the interests of multiple stakeholders in areas of overlapping competence and diversity. Yet much of the mainstream LGBT+ discussion—often anchored in a vision of cultural competence—discusses these cases with the foregone conclusion that the proper frame is "refusal of services" steeped in a kind of religious prejudice and bigotry anathema to professional training and ethics.

One of the better and more tempered statements came from the APA Board of Education Affairs, which approved a statement developed by the Education Directorate's Working Group on Restrictions Affecting Diversity Training in Graduate Education. Part of that statement states:

> Training environments foster the ability of trainees to provide competent care to the general public, and trainees' competencies in professional practice are evaluated regularly. Some trainees possess worldviews, values, or religious beliefs that conflict with serving specific subgroups within the public. For example, they may experience strong negative reactions toward clients/patients who are of a particular sexual orientation, religious tradition, age, or disability status. Trainers take a *developmental approach* to trainee skill and competency acquisition, and support individual trainees in the process of developing competencies to work with diverse populations. *Trainers respect the right of trainees to maintain their personal belief systems while acquiring such professional competencies.* Trainers also *model the process* of personal introspection; the exploration of personal beliefs, attitudes, and values; and the development of cognitive flexibility required to serve a wide diversity of clients/patients. Training to work with diverse clients/patients is integral to the curriculum, and consists of both didactic coursework and practical training. http://www.apa.org/pi/lgbt/resources/policy/diversity-preparation.aspx

The emphasis in the document is on core competencies to practice psychology and the "pedagogical support and time" needed to train students:

> Training programs, trainers, and trainees cannot be selective about the core competencies needed for the practice of psychology because these competencies are determined by the profession for the benefit of the public. Further, training programs are accountable for ensuring that trainees exhibit the ability to work effectively with clients/patients whose group membership, demographic characteristics, or worldviews create conflict with their own. Trainers respectfully work with trainees to beneficially navigate value- or belief- related tensions. At times, training programs may wish to consider client/patient re-assignment so trainees have time to work to develop their competence to work with client/patients who challenge trainees' sincerely held beliefs. Trainers utilize professional judgment in determining when client/patient re-assignment may be indicated in this situation as in all other possible situations in which client/patient re-assignment may be considered. *The overriding consideration in such cases must always be the welfare of the client/patient*. In such cases, trainers focus on the trainees' development, recognizing that tensions arising from *sincerely held beliefs or values* require pedagogical support and time to understand and integrate with standards for professional conduct. Thus trainees entering professional psychology training programs should have no reasonable expectation of being exempted from having any particular category of potential clients/patients assigned to them for the duration of training. http://www.apa.org/pi/lgbt/resources/policy/diversity-preparation.aspx

The APA (2011) has offered more detail on content areas for clinicians to be aware of when looking at competence, and we see these as promising. They are more descriptive and allow for nuance in discussing a range of stakeholders and intersecting identities, beliefs, and values:

> Key areas for psychologists to be familiar with include, but are not limited to, an understanding of: (1) human sexuality across the lifespan; (2) the impact of social stigma on sexual orientation and identity development; (3) the 'coming out' process and how such variables as age, gender, ethnicity, race, disability, religion, and socioeconomic status may influence this process; (4) same-sex relationship dynamics; (5) family-of-origin relationships; (6) the struggles with spirituality and religious group membership; (7) career issues and workplace discrimination; and (8) the coping strategies for successful functioning. (APA, 2011)

We see these as promising insofar as they describe basic lines of research with which a clinician can become aware. At the same time, we encourage familiarity with how these content areas may be discussed with reference to the different frameworks mentioned throughout this chapter: diversity, disability, and sacred. We are not suggesting these are equally weighted; however, insofar as such content areas set the parameters for training and clinical practice out of a diversity lens to the exclusion of the other frameworks, we want to at least raise the concern that current training and practice approaches may be incomplete.

As we bring this chapter to a close, we want to return to some of the observations made by O'Donohue and Benuto (2010) on what needs to be clarified in the cultural sensitivity/competence movement. We have adapted their suggestions and added language relevant to the three frameworks we have presented in this chapter and applied them to LGBT+ studies with the intention of developing a more integrated, multicultural framework for professional training and practice.

- Identify the framework or lens through which persons see themselves and their experiences of sexual identity or gender identity-related matters.
- Identify the cultures to which an individual LGBT+ client belongs and the broader regional and contemporary social and cultural context in which the person resides, including the person's religious and/or spiritual identity, beliefs, and values as relevant.
- Recognize when lenses or frameworks associated with LGBT+ issues and cultural experiences and convergences across cultural experiences are salient to the professional services being offered.
- Navigate salient frameworks or lenses relevant to LGBT+ issues and the cultural experiences and potential points of conflict in a professional and ethical manner, recognizing that the mental health professions cannot adjudicate religious doctrinal positions, including questions of morality.
- Provide interventions in a way that is competent and sensitive to the identified frameworks or lenses through which the client views

LGBT+ issues and the cultures and potential points of convergence and conflict therein.

- Recognize the many variations among relevant lenses or frameworks through which people view LGBT+ concerns and the cultures that may be present in any clinical scenario.
- Understand how the clinician's own preferred framework or lens through which he or she views LGBT+ issues, including how his or her culture, values, and beliefs interact with the salient issues presented by the client's culture.

Each of these points is worthy of further empirical study. While it may be helpful to distinguish between cultural competence practiced at the level of the individual and at the level of the institution (see Carpenter-Song et al., 2007), it is even more foundational to recognize the frameworks people use to "see" LGBT+ issues and how underlying assumptions may inform the present cultural competence movement in LGBT+ studies.[3]

[3]Cultural competence is understood by Carpenter-Song et al. (2007) to be practiced at the level of the individual "in the application of specific techniques and skills in the context of clinical encounters" and at the level of the institution "in the promotion of organizational practices to meet the needs of diverse populations" (p. 1363).

Along these lines, when we look at institutional considerations, we want to recognize areas for potential improvement in serving different groups. However, there is a long-standing practice in which one division in the American Psychological Association regularly reviews reaccreditation of religiously affiliated doctoral programs in clinical psychology and provides public comment on these programs and expresses concerns for whether and how religiously affiliated programs provide for the training and care for LGBT+ students, faculty, and staff, as well as how they conduct education and training in regard to LGBT+ client services. It is not so much that such actions are inappropriate; however, there is no documented attempt by this division to contact the psychologists in those programs directly about their professional and/or ethical concerns as directed by the APA ethics code, nor is there a sense of self-awareness for how those raising concerns address cultural competence insofar as it intersects with conventional religiosity in the lives of students training at their own institutions and practice settings. The assumption that potential bias is only in one direction is remarkable given prior evidence suggesting bias against conventionally religious applicants to psychology programs (e.g., Gartner 1986). Such practices are unlikely to produce the kind of professional discourse necessary to improve training and competence in multiple areas of diversity across varying training sites.

What does cultural adaptation of services mean for treatment of LGBT+ persons? This question primarily discussed under the umbrella of gay affirmative therapy. However, gay affirmative therapy functions more like a lens through which professionals see people rather than a protocol for treatment. In that sense, adapting services functions more like choosing feminist therapy rather than cognitive behavioral therapy. Therein lies a pragmatic applicability of cultural competence. That is, it is quite unclear how to operationalize in-session behaviors associated with multicultural competence with LGBT+ clients.

We saw a promising development in the APA Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009) in which the task force recognized the distinction between types of congruence. That is, the task force distinguished between organismic congruence, in which a person resolves sexual identity concerns in keeping with their impulses and sensate self, and telic congruence, in which a person pursues congruence in keeping with a view of their ideal self and transcendent interests. These are philosophical differences in which organismic congruence is often associated with what we refer to as a diversity framework and telic congruence is likely associated with a sacred framework. What we appreciated about the report was an awareness that either type of congruence could be viable in the life of the person seeking clinical services in light of a conflict between their sexual identity and religious identity. From the report:

> This difference in worldviews can impact psychotherapy. For instance, individuals who have strong religious beliefs can experience tensions and conflicts between their ideal self and beliefs and their sexual and affectional needs and desires (Beckstead & Morrow, 2004; D. F. Morrow, 2003). The different worldviews would approach psychotherapy for these individuals from dissimilar perspectives: The telic strategy would prioritize values (Rosik, 2003; Yarhouse & Burkett, 2002), whereas the organismic approach would give priority to the development of self-awareness and identity (Beckstead & Israel, 2007; Gonsiorek, 2004; Haldeman, 2004). It is important to note that the organismic worldview can be congruent with and respectful of religion (Beckstead & Israel, 2007; Glassgold, 2008; Gonsiorek, 2004; Haldeman, 2004; Mark, 2008), and the telic worldview can be aware of sexual stigma and respectful of sexual orientation (Throckmorton &

> Yarhouse, 2006; Tan, 2008; Yarhouse, 2008). Understanding this philosophical difference may improve the dialogue between these two perspectives represented in the literature, as it refocuses the debate not on one group's perceived rejection of homosexuals or the other group's perceived minimization of religious viewpoints but on philosophical differences that extend beyond this particular subject matter. However, some of the differences between these philosophical assumptions may be difficult to bridge. (p. 18)

The task force then identified a few published accounts of approaches to clinical services with conventionally religious persons that seem promising insofar as they reflect an awareness of these different worldviews and philosophical differences (e.g., Throckmorton & Yarhouse, 2006; Yarhouse, 2008).

In addition to this specific and promising account, it may be helpful to identity additional suggestions. As O'Donohue and Benuto (2010) observe, suggestions include identifying the cultures to which an individual client belongs, recognizing when cultural experiences and convergences across cultural experiences is salient to the professional services being offered, navigating salient cultural experiences and potential points of conflict in a professional and ethical manner, obtaining knowledge for how to provide interventions in a way that is competent and sensitive to the identified cultures and potential points of convergence and conflict therein, developing an expanded appreciation for the many variations in among relevant cultures that may be present in any clinical scenario, and having an understanding of how the clinician's own culture, values, and beliefs interact with the salient issues presented by the client's culture. A concern has also been raised as to whether cultural sensitivity and cultural competency as a movement are more of a political consideration than a scientific consideration (O'Donohue & Benuto, 2010). As the authors observe, there are entire groups and cultures (e.g., Italian-Americans) omitted from the discussion of cultural sensitivity and competence; this may be because "these are the traditional political categories used in a certain political narrative and…these standard political categories have been imported into these scientific questions" (p. 37).

To the extent that cultural competence *as a movement* may be more political than scientific, is it possible that such a movement is in some ways a reflection of a more homogenous liberal/progressive sociopolitical orientation of those drawn to both academia and the field of clinical psychology? In the language we have used in this chapter, are those who are shaping the contours of the field committed to a diversity lens with little awareness of other lenses through which their colleagues and their clients experience these phenomena? Does a true cultural competence by definition require a broader view of the landscape and a shared humility around various ways in which people navigate these experiences? If so, such trends warrant further study so we are increasingly aware of our own biases that may inadvertently shape training and service provision in the years to come.

Conclusion

What we have suggested throughout this chapter is that there are different frameworks in use by practitioners, clients, students, and other stakeholders when approaching LGBT+ populations, clients, and concerns in a culturally competent manner. These frameworks represent a range of diverse ways to understand sexual and gender identity concerns. However, the prevailing or dominant narrative of diversity that currently informs training and practice in LGBT+ concerns is weighted toward one framework that can at times exclude a more robust engagement of those who adhere to or draw upon other frameworks. By shedding light on other existing frameworks, we aim to enhance the reader's culturally competent approach to working with the LGBT+ community.

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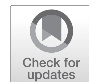

24 Racial and Ethnic Diagnostic Patterns in Schizophrenia Spectrum Disorders

Kayla Gurak, Jessica Maura, Amy Weisman de Mamani, Ana Martinez de Andino, and Irwin Rosenfarb

Introduction

Schizophrenia is a debilitating mental illness that occurs in approximately 1 in every 100 individuals (Comer, 2015; Silverstein, Moghaddam, & Wykes, 2013) and consists of positive symptoms known as behavioral excesses (e.g., hallucinations, delusions), negative symptoms or behavioral deficits (e.g., lack of motivation, flat affect), and disorganized symptoms (e.g., disorganized behavior or speech). According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), to meet diagnostic criteria for schizophrenia, two or more of the abovementioned symptoms must be present for at least 1 month. However, signs of the disorder must be present for a minimum of 6 months. In combination with the presence of symptoms, significant functional decline in work, social relationships, or self-care must also be indicated. Literature on the etiology of schizophrenia points to both genetic and environmental contributions to the onset of illness. Later in the chapter, we discuss several potential environmental factors which may influence differential diagnostic patterns observed in the schizophrenia spectrum disorders. The World Health Organization (WHO), based on findings from multi-international sites, suggests that prevalence rates and manifestations of psychosis are similar worldwide (Jablensky et al., 1992; Kirkbride et al., 2012; Stilo & Murray, 2010). However, this finding has not been consistently supported. Rather, other studies suggest that worldwide, the prevalence of schizophrenia spectrum disorders may be higher in some racial/ethnic groups. This chapter reviews the literature on racial and ethnic diagnostic patterns with an attempt to identify factors that may account for this disparity. It is important to point out that the WHO multi-site studies (Jablensky et al., 1992; Sartorius et al., 1986) also indicated that patients from developing countries may have a more benign illness course, such that patients from developing countries tend to remit more quickly and require fewer hospitalizations than patients from developed countries. This topic, however, will not be addressed in the current paper as it has been tackled extensively elsewhere (e.g., Cohen, Patel, Thara, & Gureje, 2008; Haro et al., 2011; Hopper & Wanderling, 2000; Jablensky et al., 1992; Kulhara, Shah, & Grover, 2009; Weisman, 1997). This chapter will largely focus on the empirical evidence examining differential diagnostic patterns among Blacks and Whites with some attention to Hispanics/Latinos and Asians.

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As the literature is sparse regarding other racial/ethnic (e.g., Native Americans) and population subgroups (e.g., lesbian/gay/bisexual/transgender (LGBT)), findings related to these groups will not be discussed in this chapter.

This chapter will begin with a review of literature examining racial and ethnic diagnostic patterns in the United States (USA), other developed countries, and among immigrants to the USA. Literature regarding racial/ethnic differences in symptom severity and presentation will also be reviewed. We then examine potential factors, such as diagnostic decision-making, cultural mistrust, and the role of stress and environmental factors, which may contribute to the observed diagnostic discrepancies. Finally, we offer suggestions for improving diagnostic practices, such as utilization of the Cultural Formulation Interview, as well as recommendations for further research.

The terms race and ethnicity can be considered separately, with race referring to, "the category to which others assign individuals on the basis of physical characteristics, and the generalizations and stereotypes made as a result" (American Psychological Association, 2003), and ethnicity referring to a group of people that share a country of origin, language, religion, or cultural background (Rice & O'Donohue, 2002). For the purposes of this chapter, we refer to race/ethnicity broadly as these constructs are related and typically not distinguished from one another within the literature base. Relatedly, when discussing differences among racial/ethnic groups, we will generally utilize the broad terms White, Black, Hispanic/Latino, and Asian. However, when reporting results from previous studies, we will utilize the terminology designated by the authors, particularly if they are referring to a specific subset of a racial/ethnic group (e.g., Caribbean Blacks, Chinese Americans).

Diagnostic Patterns Among Racial/Ethnic Minorities in the USA

In the USA, the literature demonstrates that racial/ethnic minority patients are more likely to receive a schizophrenia spectrum disorder diagnosis when compared with their White counterparts. In this section, we review the empirical data examining this phenomenon in an attempt to identify potential mechanisms which may contribute to the observed racial/ethnic disparities. Three main hypotheses outlined in the literature include (1) the *clinician accuracy hypothesis*, in which different racial/ethnic groups exhibit varying levels of psychopathology which our current diagnostic procedures accurately capture, (2) the *clinician bias hypothesis*, in which all racial/ethnic groups have a similar symptom presentation but biases in diagnostic procedures yield false differences, and (3) the *cultural relativity hypothesis*, in which psychopathology manifests itself differently across racial/ethnic groups, and current diagnostic practices are not sensitive to detect these differences. The literature examining the evidence for and against the abovementioned hypotheses is reviewed below.

Utilizing data from the US Census and the Department of Mental Health (n = 18,533), Kposowa, Tsunokai, Butler, and Butler (2002) found that African-Americans, Asians, and Hispanics/Latinos were significantly more likely to be diagnosed with schizophrenia when compared to Whites. Similarly, a medical record review study of over 2,000 patients conducted by Choi et al. (2012) revealed that African-American and Hispanics/Latinos males were more commonly diagnosed with schizophrenia spectrum disorders when compared with Whites. A chart review study conducted by Delbello, Lopez-Larson, Soutullo, and Strakowski (2001) also observed that when compared with African-American women and White males and females, African-American males were diagnosed more frequently with schizophrenia spectrum disorders. A study conducted utilizing the National Psychosis Registry comprised of 134,523 veterans (Blow et al., 2004) found that African-Americans were more than four times as likely (4.05) and Hispanic/Latino patients were more than three times as likely (3.15) to be diagnosed with schizophrenia when compared with White patients.

While diagnostic disparities of schizophrenia spectrum disorders have been observed among

all racial/ethnic minority groups, this pattern appears most pronounced for Blacks. Reviewing data from Indiana state psychiatric hospitals over an 8-year period, Barnes (2004) found that African-Americans were four times as likely as their White counterparts to be diagnosed with schizophrenia. However, these results should be interpreted with caution, as this study did not control for potential covariates (e.g., age, gender, symptom severity, number of previous hospitalizations) that could have impacted findings. A longitudinal study (from 1981 to 1997), which followed individuals born to mothers in the USA who identified as either African-American or White, also confirms this pattern such that African-Americans were approximately three times as likely as Whites to be diagnosed with schizophrenia (Bresnahan et al., 2007). Eack and Newhill (2012) found comparable results in their sample in which African-Americans were more than three times as likely as Whites to be diagnosed with schizophrenia. A host of other studies also support this finding (e.g., Minsky, Vega, Mishkimen, Gara, & Escobar, 2003; Neighbors et al., 1999; Neighbors, Trierweiler, Ford, & Muroff, 2003; Strakowski et al., 1996; Strakowski, McElroy, Keck, & West, 1996).

While several studies demonstrate higher prevalence of schizophrenia spectrum disorders for Hispanics/Latinos as well (Blow et al., 2004; Choi et al., 2012; Kposowa et al., 2002), a handful of studies have demonstrated contradictory findings for this racial/ethnic group. For example, Minsky et al. (2003) found that both European-Americans and Hispanics/Latinos were less likely to be diagnosed with schizophrenia spectrum disorders than African-Americans. Results of this study demonstrated that Hispanic/Latino patients had diagnostic patterns more similar to Whites than to African-Americans. Thus, further research with Hispanic/Latino populations is warranted to clarify contradictory findings regarding the prevalence of schizophrenia spectrum disorders in this group. Similarly, research examining diagnostic patterns among Asians is sparse and additional research in this area is needed as well. Though further research using Hispanic/Latino and Asian populations is warranted, the bulk of the literature base, including several studies with large samples, suggests that Blacks are more likely to receive a schizophrenia spectrum diagnosis than are Whites. The evidence for other racial/ethnic groups appears inconclusive at this time.

Diagnostic Patterns Abroad and Among Immigrants to the USA

The studies reviewed above have all been conducted in the USA. Thus, a logical next question may be, does this diagnostic disparity exist in other countries? And, what about individuals who migrate to the USA? In other words, are the differential patterns due to diagnostic practices specific to the USA or are there more universal racial/ethnic differences in prevalence rates of schizophrenia spectrum disorders?

It appears that the differential diagnostic pattern is not observed solely in the USA. A study that examined medical records from psychiatric wards of general hospitals in Montreal, Canada, and Padua, Italy, showed similar results (Jarvis, Toniolo, Ryder, Sessa, & Cremonese, 2011). The authors found that Black patients at both sites were three to four times more likely to be diagnosed with a schizophrenia spectrum disorder when compared with patients from other racial/ethnic groups. Similarly, the literature demonstrates that African and Caribbean Blacks living in England are at increased risk for both schizophrenia and mania (Sharpley, Hutchinson, McKenzie, & Murray, 2001). Importantly, the authors noted that even when adhering to strict diagnostic criteria, the higher rates of psychotic disorders among Black patients remained. Consistent with these findings, in England, Coid et al. (2008) report a raised prevalence of psychotic disorders for Blacks and other racial/ethnic minorities when compared with White, British counterparts. It should be noted that the aforementioned studies have all been conducted in developed countries. Thus, it is possible that the developed nations share a common thread, which leads to the diagnostic pattern commonly observed. However, a clear underlying cause has yet to be identified.

Cantor-Graae and Selten (2005) conducted a meta-analysis which found that a personal or family history of migration is a risk factor for the development of schizophrenia. Bourque, van der Ven, and Malla (2011) also conducted a meta-analysis which similarly found an increased risk for development of schizophrenia spectrum disorders for first-generation immigrants and that this risk persists for second-generation immigrants as well. Veling's (2014) meta-analysis also found that immigrants (both first and second generation) were at a twofold increased risk for schizophrenia spectrum disorders. Interestingly, Weiser et al. (2008) note that immigrants that differ in culture and physical appearance may be at a higher risk for development of schizophrenia. Similarly, Berg et al. (2011) found that "visible minority status" was associated with increased and more severe symptomatology.

Results suggest that post-migration factors may play a role in the development of schizophrenia spectrum disorders. Contrary to these findings, however, Snowden, Hastings, and Alvidrez (2009) compared the likelihood of lifetime psychiatric hospitalization among foreign-born Caribbean Blacks, US-born Caribbean Blacks, US-born African-Americans, and non-Hispanic Whites. They found that overall, Black patients were more likely to be hospitalized than non-Hispanic Whites. When separated out by nativity, US-born Caribbean Blacks had the greatest odds of hospitalization, followed by African-Americans. However, the odds of hospitalization for foreign-born Caribbean Blacks were considerably lower and not significantly different from the non-Hispanic Whites.

Taken together, the empirical evidence seems to clearly demonstrate that Blacks in the USA are three to four times as likely to be diagnosed with a schizophrenia spectrum disorder when compared to their White counterparts. While a similar pattern for other racial/ethnic minorities including Asian and Hispanic/Latino patients has been observed (Blow et al., 2004; Choi et al., 2012; Kposowa et al., 2002), further research with these populations is required to clarify contradictory findings. Additionally, studies from other developed countries also suggest diagnostic disparities in racial/ethnic minority patients (Coid et al., 2008; Jarvis et al., 2011; Sharpley et al., 2001). Thus, this does not appear to be a pattern that is limited only to the USA.

Racial/Ethnic Differences in Symptomatology

When examining the literature on diagnostic disparities among racial/ethnic groups, an important question that emerges is whether differences in diagnosis are the result of racial/ethnic differences in the severity or presentation of symptoms. The WHO, among others, has suggested that there are no major racial/ethnic differences in symptom expression or in presentation of the core symptoms of schizophrenia (e.g., Hutchinson, Takei, Sham, Harvey, & Murray, 1999; Sartorius et al., 1986). However, other studies that have compared racial/ethnic groups both within countries as well as between countries, have found differing levels of symptom severity as well as different symptom expression profiles, depending on one's racial/ethnic background. For example, Chang, Newman, D'Antonio, McKelvey, and Serper (2011) found that when comparing symptom severity, Chinese Americans had the fewest symptoms and hospitalizations, whereas both African-Americans and Hispanic/Latino patients had the highest (Euro-American patient scores fell between Chinese-American and African-American and Hispanic/Latino scores). Furthermore, several studies have demonstrated that Black patients often present with greater symptom severity and are more likely than White patients to endorse experiencing Schneiderian first-rank symptoms, which include specific types of auditory hallucinations and delusions of control (e.g., Cheng & Goldstein, 2004; Ihara et al., 2009; Strakowski et al., 2003).

Strakowski and colleagues (1996) speculated that their observed differences in diagnostic patterns (African-American patients were significantly more likely than White patients to be diagnosed with schizophrenia) may have been due to African-American patients presenting with more severe first-rank symptoms. In a subsequent

study, Strakowski et al. (2003) attempted to replicate results previously found and test this hypothesis. Although first-rank symptoms were in fact more common in African-American men, Strakowski et al. (2003) report that this finding did not explain the differential diagnostic pattern. The authors speculated that differences may instead be attributed to clinician perceptions about the chronicity of psychotic symptoms, as African-Americans were perceived to be less likely to have periods of recovery. Relatedly, Arnold et al. (2004) attempted to determine whether African-Americans presented with more first-rank symptoms and whether this affected clinician diagnostic decisions. The authors were examining whether results supported the presence of "true" racial/ethnic group differences or clinician tendencies to more frequently assign first-rank symptoms to African-American patients. Results indicated that in both the race/ethnicity-blind consensus rating and unblinded structured interview conditions, African-American males had higher total psychotic scores as well as higher first-rank symptom scores when compared to Euro-American male counterparts (Arnold et al., 2004).

The literature on symptom presentation seems to suggest that different racial/ethnic groups (particularly Blacks) do in fact have differing symptom profiles. Strakowski and colleagues (1996) observed that African-American patients had symptom profiles in which they more frequently endorsed experiencing hallucinations whereas their White counterparts had increased persecutory delusions. Previous research has also demonstrated that White patients tend to express more negative symptoms and behavioral problems when compared with Black and Hispanic/Latino patients (Brekke & Barrio, 1997). Weisman et al. (2000) found differences in symptom expression in patients with schizophrenia based on race/ethnicity, such that Mexican-Americans presented with more somatic symptoms whereas their Anglo-American counterparts presented with more blunted affect and persecutory delusions. Interestingly, in a study that examined the expression of negative symptoms in Anglo-American and Mexican-American patients with schizophrenia, the authors did not find any significant differences in negative symptom profiles (Dassori et al., 1998). Weisman de Mamani and Caldas (2013) similarly found that when comparing African-American, Hispanic/Latino, and Anglo patients, no differences were observed in negative symptoms profiles. However, African-American patients were found to have greater positive symptom severity.

Contrary to the previously discussed studies, but in line with Sartorius et al. (1986), Barrio et al. (2003) did not find any overall differences in positive, negative, or general psychopathology scores when comparing African-American, Euro-American, and Hispanic/Latino patients. However, when examining individual items, the authors found that African-Americans had higher hallucination and suspiciousness scores when compared to Euro-American patients. The authors also found that Hispanics/Latinos scored higher on the somatic concern items when compared with both Euro-American and African-American patients.

Whaley and Hall (2008) conducted a content analysis of African-American delusions and hallucinations in an attempt to better understand diagnostic racial disparities. The authors found evidence for racial/ethnic themes (i.e., racism) present within African-American hallucinations and delusions. They also found that delusions were more commonly endorsed and also tended to have more cultural content, such as general racial/ethnicity issues (e.g., "White men can see me through the radio and TV") and racism (e.g., "White men are lying to keep me down"), than hallucinations (Whaley & Hall, 2008). Whaley and Hall (2009a) replicated and extended their findings in an unrelated sample of African-American patients and found that race/ethnicity-related and religious themes were present in their content analyses of African-American hallucinations and delusions. Results demonstrated that race/ethnicity-related themes were most prevalent in persecutory delusions and religious content was most prevalent in other types of delusions (Whaley & Hall, 2009a). As a way to expound upon their prior work, Whaley and Hall (2009b) designed a study to determine if the content of

African-American hallucinations and delusions impacted clinician diagnostic decisions. Results indicated that when comparing diagnoses from medical records, structured interviews, and cultural experts, the data did not demonstrate any significant differences. In fact, contrary to their hypothesis, the authors noted that the presence of race/ethnicity-related themes actually decreased the frequency of receiving a paranoid schizophrenia diagnosis (Whaley & Hall, 2009b). Consequently, while the content of delusions and hallucinations may differ based on one's race/ethnicity, content does not appear to be an explanation as to why clinicians make differential diagnoses based on race/ethnicity.

Bauer et al. (2011) examined different types of hallucinations in schizophrenia in order to determine if the prevalence of hallucinations varied and might be influenced by culture. Bauer et al. (2011) examined the 1-year prevalence of hallucinations in seven different countries: Austria, Poland, Lithuania, Georgia, Pakistan, Nigeria, and Ghana. The authors found higher rates of visual hallucinations in the developing cultures, with the highest rates in West Africa (Bauer et al., 2011). In line with prior research, auditory hallucinations were the most prevalent hallucination across sites. The highest rates of both auditory and visual hallucinations were found in West Africa (i.e., Nigeria and Ghana). The authors note that while age and duration of the illness may impact the prevalence and types of certain hallucinations, culture also appears to play a role in symptom expression.

Utilizing a unique sample of Pakistanis living in Britain, Pakistanis living in Pakistan, and British Whites living in Britain, Suhail and Cochrane (2002) examined the impact of culture on types of schizophrenia symptoms commonly expressed. Results demonstrated the greatest differences in delusions and hallucinations when comparing the British Pakistani and Pakistanis living in Pakistan groups. The two groups that were both living in Britain showed similar symptoms. Results seem to suggest a greater impact of the immediate environment as opposed to one's culture of origin on symptom expression (Suhail & Cochrane, 2002). The authors suggest that British Pakistanis living in Britain do not reflect a high degree of assimilation to Western culture and values. However, despite socio-religious and cultural differences, British Pakistanis actually demonstrate close proximity to Western beliefs and perceptions similar to those of British Whites. For example, both British Whites and British Pakistanis demonstrate similar beliefs regarding thought insertion via the television, radio, and other electronic devices (which are more common in developed Britain versus developing Pakistan). In summary, several studies suggest that one's culture of origin may influence rates and types of symptoms expressed. However, the results of Suhail and Cochrane's (2002) study suggest that one's current environment may be what is most influential in symptom expression.

Biases in Diagnostic Decision-Making?

Many have speculated that diagnostic disparities may be due to the overdiagnosis or misdiagnosis of schizophrenia spectrum disorders among racial/ethnic minorities. The empirical studies that have attempted to identify the factors that impact clinician diagnostic decisions are reviewed below. Previous research has demonstrated that in clinical practice, many clinicians fail to use semi-structured interviews, adhere to Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria, or ask about key symptoms when diagnosing (Garb, 2005). In fact, Miller, Dasher, Collins, Griffiths, & Brown (2001) found that even when using semi-structured interviews, the mental health professionals in their study only assessed 50% of the key criteria for a disorder. While this is an issue that needs to be further examined, a handful of studies have attempted to determine whether clinician biases or differential decision-making processes play a role in the diagnostic disparities observed. In a two-phase study design which varied patient race/ethnicity and diagnosis, Neighbors et al. (1999) utilized two diagnostic interview styles: clinician-structured (phase one) and semi-structured diagnostic instrument (phase two). In both

types of interview styles, Black patients were more likely to receive a diagnosis of schizophrenia, whereas White patients were more likely to be diagnosed with a mood disorder. Neighbors et al. (2003) found the same pattern using a semi-structured interview and DSM criteria. Schwartz and Feisthamel (2009) tested the hypothesis that mental health counselors make differential diagnoses based on a patient's race/ethnicity. Consistent with previous literature, the authors found that African-Americans were in fact diagnosed with psychotic disorders at a disproportionately high rate. While the authors believe the results suggest a "subconscious bias" toward diagnosing more severe disorders when assessing African-Americans, the authors note that treatment recommendations were more objective (Schwartz & Feisthamel, 2009).

Trierweiler, Muroff, Jackson, Neighbors, and Munday (2005) tested whether clinician race/ethnicity affected diagnostic decisions. In this study, African-American and non-African-American clinicians administered diagnostic interviews to adult inpatients at two urban Midwestern psychiatric hospitals. A total of 234 patients diagnosed with either schizophrenia or a mood disorder (bipolar, major depression) were included in the analyses. Upon completion of the diagnostic interview, all clinicians completed a questionnaire which assessed the most important factors influencing their diagnostic decision-making process (Trierweiler et al., 2005). The authors found that while African-American clinicians relied more heavily upon situational factors (e.g., stability/change in psychiatric condition, aggressive behavior, substance use) than non-African-American clinicians, this was not associated with diagnostic decision-making among this group. However, when non-African-American clinicians relied more heavily on situational factors during the diagnostic interview, the patient was more likely to be diagnosed with a mood disorder than with schizophrenia (Trierweiler et al., 2005). In a similar study, Trierweiler et al. (2006) found differential diagnostic decision-making processes depending on the race/ethnicity of the clinician. Specifically, they noted that African-American clinicians tended to pay more attention to positive symptoms, whereas non-African-American clinicians were more likely to associate negative symptoms with a schizophrenia diagnosis. However, in this study, clinician judgment patterns were not found to be affected by patient race/ethnicity.

Whaley (1997) attempted to determine whether the racial/ethnic differences seen in diagnostic patterns were due to either the *clinician bias hypothesis*, which states that Blacks and Whites have similar symptom presentation but clinicians judge them differently, or the *cultural relativity hypothesis*, which states that Blacks and Whites have culturally differing ways of expressing psychopathology, but clinicians are either unaware or not sensitive to these racial/ethnic differences. Results demonstrated racial/ethnic variations in paranoid symptom expression suggesting that Blacks and Whites have different ways of expressing psychopathology which therefore supported the *cultural relativity hypothesis*. Whaley (1997) further argued that these sociocultural differences in paranoid symptoms may, at times, contribute to the misdiagnosis of psychosis, as clinicians may misconstrue "normal" paranoid behavior as indicative of psychosis rather than as cultural differences in the expression of normal behavior (Whaley, 1997). To further clarify this differentiation, Whaley (1997) asserts that normative paranoia reflects mild and reality-based issues of trust, suspicion, and self-consciousness (e.g., concern that someone intends to take advantage of you), whereas pathological paranoia consists of fully formed delusions of persecution and grandiosity (e.g., concern that the CIA is following you and intends to do you harm).

However, when Sohler and Bromet (2003) compared research diagnoses with hospital diagnoses in a sample of patients with psychosis, the authors reported that they did not observe a racial/ethnicity bias in the assignment of diagnoses of either schizophrenia or mood disorders. They did note that hospital clinicians had a more difficult time diagnosing Black patients, as Blacks were more likely to be discharged without a definitive diagnosis or with a psychosis not otherwise specified (NOS) diagnosis (Sohler &

Bromet, 2003). However, since low agreement between hospital and research diagnoses was observed for both Black and White patients, the authors report that the issue of low agreement was not a problem unique to Black patients, and therefore, no evidence for racial/ethnicity bias in the diagnostic decision-making process was observed. Thus, study results seem to suggest that overt racial/ethnic bias is not playing a major role in diagnostic decision-making.

The majority of the literature has examined whether Black patients are more likely than White patients to be diagnosed with schizophrenia. However, a few studies indicate that other racial/ethnic minority groups, including Hispanics/Latinos, have also been found to have disproportionately higher rates of being diagnosed with schizophrenia spectrum disorders. Vega, Sribney, Miskimen, Escobar, and Aguilar-Gaxiola (2006) found that auditory hallucinations and delusions of persecution were fairly common among Mexican-American individuals. However, they caution that although the prevalence rates of psychotic disorders among Mexican-Americans are higher when compared to Mexican immigrants or Mexicans living in Mexico, clinicians must proceed with care to determine whether the presence of symptoms is related to psychosis or is merely a cultural expression of emotional distress (Vega et al., 2006). Similarly, consistent with prior research on African-Americans, Contreras et al. (2009) found that Hispanic/Latino patients were often diagnosed with schizophrenia, but when additional assessments, including family interviews and psychiatric records, were consulted, an affective disorder diagnosis was instead often applied. The authors note that the additional information helped clinicians to further pinpoint specific diagnoses and also provided them with etiological information that assisted in diagnostic decision-making (Contreras et al., 2009).

Some research suggests, however, that clinicians may be more accurate in diagnosing Hispanic/Latino patients than in diagnosing patients from other racial/ethnic groups. Anglin and Malaspina (2008) found the highest agreement between clinical and research diagnoses for Hispanics/Latinos, followed by White patients. Clinical and research diagnoses for African-American patients showed the lowest agreement. It is unclear as to why clinicians in this study were able to most reliably diagnose Hispanic/Latino patients, especially considering potential language and cultural differences. The authors speculate that the location of the inpatient unit in a predominantly Hispanic/Latino community may have sensitized clinicians to diagnostic issues in Hispanic/Latino populations, as they have increased exposure and opportunities to learn about specifics of this culture.

Cultural Mistrust, Paranoia

Some research has demonstrated that Black patients have higher levels of paranoia (e.g., Combs, Penn, & Fenigstein, 2002) as well as higher levels of schizotypy (Sharpley & Peters, 1999). However, it is unclear whether these higher levels reflect an increased risk for schizophrenia or are simply and accurately reflecting the social reality for these groups (Sharpley & Peters, 1999). The previously reviewed studies suggest that overt racial/ethnic bias is not likely to be playing a role in the differential diagnostic patterns observed but it is possible that clinicians may view factors such as historical mistrust, wariness of discrimination, or perceived racism as indicative of psychosis (Combs et al., 2002). Iacovino, Jackson, and Oltmanns (2014) conducted a study which suggests that racial/ethnic differences in paranoia may be partially explained by problems that are more commonly experienced by Black individuals (e.g., lower socioeconomic status (SES), childhood traumas) and the impact of these factors (e.g., unequal access to social and economic resources, perceived discrimination, etc.) on symptom expression. Due to the history of slavery and colonization in the USA and the Caribbean islands, being more wary of Whites, especially for older Black individuals who may have experienced overt racism and discrimination firsthand, may reflect an accurate and adaptive reaction. Research has also demonstrated that an oral tradition in which these types

of accounts are passed down from generation to generation are common in African-American culture (Ball, Lawson, & Alim, 2013). Further, racial discrimination is a dynamic process, such that its effects amass not only in individual lives but also across generations (Hammond, 2011). Past and present negative experiences with certain organizations (e.g., medical institutions, law enforcement) may perpetuate beliefs such as medical mistrust and distrust of the police (Ball et al., 2013; Brunson & Gau, 2015). In fact, evidence suggests that Black youths not only expect poorer treatment from certain groups (e.g., law enforcement) but actually receive poorer treatment when compared to other racial and ethnic groups (Hagan, Shedd, & Payne, 2005; Lee, Steinberg, & Piquero, 2010; Lee, Steinberg, Piquero, & Knight, 2011). Thus, it appears that these cultural beliefs remain relevant for both older Black individuals and today's Black youth. Accordingly, Whaley (1998) cautions that cultural mistrust should not automatically be interpreted as psychopathology. In further support of Whaley (1998), Combs et al. (2006) found that perceived racism by African-American patients predicted cultural mistrust and subclinical, but not clinical levels of paranoia in those patients.

Other studies suggest that high levels of cultural mistrust in African-Americans are associated with greater psychopathology. In fact, based on results from the Cultural Mistrust Inventory and content analyses, Bell and Tracey (2006) found that a curvilinear model best explained the relationship between cultural mistrust and psychological health with moderate levels of trust in Whites being associated with the greatest levels of psychological health in their sample of African-Americans (Bell & Tracey, 2006). Thus, these results suggest that both low and high levels of mistrust of Whites may not be psychologically healthy for African-Americans. Additionally, studies have shown that higher levels of cultural mistrust and perceived discrimination are associated with increased rates of psychosis (McKenzie, 2006), and a diagnosis of schizophrenia in African-Americans (Whaley, 2002). In fact, Whaley (2002) demonstrated that even among African-American cultural experts, paranoid schizophrenia was more frequently diagnosed in African-American patients who endorsed high levels of cultural mistrust. Thus, it seems that cultural mistrust may contribute to a schizophrenia spectrum diagnosis (McKenzie, 2006; Whaley, 2002). However, while cultural mistrust may be a factor that contributes to an increased rate of schizophrenia in Black populations, cultural mistrust has not been found to contribute to the diagnostic disparities that have also been observed, at times, in other racial/ethnic minority groups (e.g., Asians, Hispanics/Latinos). It is clear that additional research is needed to confirm the diagnostic patterns seen in other groups and identify underlying or contributing causes.

The Role of Stress and Environmental Factors in Diagnostic Disparities

The diathesis-stress model of schizophrenia asserts that environmental stressors interact with an underlying biological predisposition toward the development of schizophrenia to trigger and/or worsen psychiatric symptoms (Jones & Fernyhough, 2007; Walker, Mittal, & Tessner, 2008). Thus, examination of environmental stressors (e.g., SES, urban residence, discrimination) is warranted to determine whether the diagnostic disparities observed are the result of racial/ethnic group differences or whether these differences are a function of environmental stressors associated with racial/ethnic minority status. Several studies have identified environmental factors such as unemployment, parental separation, social isolation, discrimination, achievement-aspiration mismatch, and urban residence that are linked to the development of schizophrenia (Janssen et al., 2003; Kirkbride et al., 2006, 2012; Morgan et al., 2007, 2014; Reininghaus et al., 2008). While these studies overall found that the effects of these factors were similar across racial/ethnic groups, the authors also note a higher prevalence of these incidents among racial/ethnic minority, particularly Black, populations (Janssen et al., 2003; Kirkbride et al., 2006; 2012; Morgan et al., 2007, 2014; Reininghaus et al., 2008).

To examine this question further, several studies have examined the relationship between race/ethnicity and diagnosis of schizophrenia while controlling for relevant environmental factors. Blow et al. (2004) examined racial/ethnic differences in diagnostic patterns among war veterans with psychosis and found that Blacks and Hispanics/Latinos were more likely than Whites to receive a schizophrenia diagnosis over a bipolar diagnosis, when controlling for SES, urban residence, and substance use. Relatedly, Barrio et al. (2003) examined racial/ethnic group differences in symptom expression among White, Black, and Hispanic/Latino outpatients with schizophrenia. While controlling for education and income, the authors found racial/ethnic group differences in excitement (higher among Whites), somatic concern (higher among Hispanic/Latinos), as well as hallucinatory behavior and suspiciousness (higher among Blacks). Barnes (2008) examined admission diagnoses among Black and White patients at a psychiatric hospital in Indiana and found that, after controlling for demographic variables (e.g., education, income, prior hospital admission), race/ethnicity was the strongest predictor of an admission diagnosis of schizophrenia. Flaskerud and Hu (1992) also examined the relationship of racial/ethnic group identity to psychiatric diagnosis among 26,400 Black, White, Hispanic/Latino, and Asian patients who had received services at a county mental health center. The authors report that, even when controlling for SES and primary language, a larger number of schizophrenia diagnoses were found among Blacks and Asians when compared to Whites and Hispanics/Latinos (Flaskerud & Hu, 1992). Overall, the literature indicates that while the effects of environmental stressors are related to schizophrenia and are more common in racial/ethnic minority populations, these stressors are not likely to fully account for the diagnostic discrepancies observed among racial/ethnic groups.

Summary and Recommendations

This chapter summarized the literature on racial and ethnic disparities in diagnostic patterns, as well as factors that may underlie these disparities, including biases in diagnostic decision-making, cultural mistrust, as well as environmental factors that may exacerbate stress. Several key findings emerged. First, Black patients (in the USA as well as abroad) are three to four times as likely to receive a schizophrenia spectrum diagnosis. As this finding has been demonstrated in several studies with large sample sizes, it does not appear to be circumscribed to one area or country. While several studies also seem to point to diagnostic disparities for other racial/ethnic minority groups (e.g., Asians, Hispanics/Latinos), the literature is less clear on these findings. Therefore, additional research is needed before making any conclusions about these groups. Second, with regard to symptomatology, the literature seems to suggest that racial/ethnic differences do exist in symptom prevalence, severity, and expression. Specifically, it appears that Black patients often present with greater symptom severity and are more likely to endorse experiencing Schneiderian first-rank symptoms (e.g., specific types of auditory hallucinations and delusions of control). Additionally, some studies have found that Black patients tend to more frequently endorse experiencing hallucinations (Strakowski et al., 1996), whereas their White counterparts tend to report more persecutory delusions (Strakowski et al., 1996; Weisman, Rosales, Kymalainen, & Armesto, 2005). Previous research has also demonstrated that Hispanic/Latino patients tend to express more somatic symptoms. The literature seems to point to fewer differences in negative symptom profiles but instead, suggests racial/ethnic variations in positive profile symptoms. Third, the reviewed literature suggests that overt racial/ethnic bias is not likely playing a major role in diagnostic decision-making but that misconstruing cultural differences in the expression of normal behavior (e.g., nonclinical expressions of paranoia) may lead to diagnostic errors (Sohler & Bromet, 2003; Whaley, 1997). Finally, research suggests that higher levels of cultural mistrust and other environmental factors (e.g., urban residence, low SES) are associated with a greater likelihood of receiving a schizophrenia spectrum diagnosis (Janssen et al., 2003; Kirkbride et al., 2006, 2012; McKenzie, 2006; Morgan et al., 2007, 2014;

Reininghaus et al., 2008; Whaley, 2002). In sum, there is little evidence for racial/ethnic bias in diagnosis, but it appears that clinicians may, at times, diagnose schizophrenia without fully understanding the social milieu in which it occurs.

Clinical and Research Recommendations The literature reviewed in this chapter suggests that racial and ethnic differences in symptom expression and presentation, clinician decision-making factors, cultural mistrust, and other environmental factors may play a role in diagnostic practices in schizophrenia spectrum disorders. While clinicians are generally advised to consider racial and ethnic variations in symptom presentation in their assessment and treatment of an individual, it is not always clear how one goes about doing this (Whaley, 2001). The Cultural Formulation Interview (CFI) in DSM-5 has now developed into a semi-structured interview with explicit questions, explanations, and instructions that may provide more direction for clinicians regarding how to account for racial/ethnic group variations in symptom expression (Aggarwal, 2013). Through a person-centered approach, the CFI works to elicit information about a patient's views of his or her symptomatology (e.g., "How would *you* describe your problem?") and to encourage the clinician to better understand the patient's problem within his or her own words and understanding (APA, 2013, pg. 752). The CFI also emphasizes to the clinician the importance of considering cultural and societal norms when attempting to better understand a patient's experience by including questions such as, "What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?" (APA, 2013, pg. 752). Finally, the CFI takes into consideration the likelihood that a clinician and patient may enter therapy with their own personal biases, backgrounds, or expectations by asking, "Have you been concerned about this and is there anything that we can do to provide you with the care you need?" (APA, 2013, pg. 754). These questions provide a clear framework for clinicians to consider their own potential biases, as well as to reflect on the patient's cultural understanding of his or her symptoms. While research is limited on the CFI, some initial studies suggest that use of tools such as the CFI could help to improve diagnostic accuracy (e.g., Adeponle, Thombs, Groleau, Jarvis, & Kirmayer, 2012).

The use of analog studies may be one way to further evaluate whether the racial/ethnic disparities observed in schizophrenia spectrum disorders are a function of assessor bias. Analog approaches use vignettes or trained actors to display schizophrenia symptoms while varying only the race or ethnicity of the hypothetical patient. Although previous studies (e.g., Weisman & López, 1996, 1997) have used analog approaches to study schizophrenia, no research to our knowledge has varied solely the race/ethnicity of the hypothetical patient to examine the impact that this has on diagnoses, while holding all other variables constant (something that is nearly impossible to do with actual clinical samples). Observing diagnostic differences with this approach would suggest that the differences reflect assessor bias over actual racial/ethnic differences in the prevalence or presentation of schizophrenia spectrum disorders. The simplicity and low cost of analog designs, in addition to the fact that they offer complete experimental control over symptom presentation, makes them ideal for follow up cross-cultural research on this topic.

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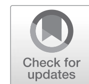
Part V

Issues and Implications for Instruction and Training



25 Intercultural Competence: Teaching It Is Worthwhile

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Globalization is bringing together people from different cultural and social backgrounds. Whereas this has increased the creativity and productivity of many societies (e.g., Simonton, 1999), it has also highlighted the need for people from different backgrounds to relate to one other. Clinicians, marketers, educators, physicians, and jurists, to name only a few professions, face new challenges as they meet clients, students, and consumers with sometimes different experiences and cultural expectations (cf. Morris, Savani, & Roberts, 2014). Along with these encounters has been the observation that some people seem to be "better" at interacting with those who are culturally different from themselves. Some business professionals are more successful working overseas, some clinicians are more successful in having their diverse clientele comply with therapeutic instructions, and some teachers are better able at instructing a diverse group of students. The new reality of diversity has produced efforts to match the cultural backgrounds of clients and professionals, to select those individuals for a task who already have experience in cross-cultural interactions, or to choose employees based on personality traits that render them likely to do well in intercultural situations (e.g., Leung, Ang, & Tan, 2014). However, there has long been a realization on the part of scholars and practitioners alike that the ability to negotiate cultural differences can be conceived of as a competence – which can be learned and trained.

In this chapter, after providing an overview of the concept of "culture" and its complications, we examine the concept of intercultural competence and its demonstrated outcomes.[1] We then attend to how intercultural competence is acquired and what training can and cannot accomplish. This is followed by a review of tools and techniques that have been used to teach intercultural competence, and we comment on their merits. We then discuss the challenge to intercultural competence training, such that it might increase, rather than decrease, cultural divides and that it induces a false sense of competence. We conclude that intercultural competence training works, at least in principle; yet, open questions remain concerning what kinds of methods are most beneficial for whom and under what circumstances.

[1] We choose the term intercultural competence instead of cultural competence or multicultural competence. Whereas the "inter" seems to refer to an international context, it highlights that this competence is aimed at facilitating interaction between members of different cultural groups, regardless of whether these involve individuals from different countries, or members of different cultural groups within the same country.

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The Question Before the Question About Intercultural Competence: What Is Culture?

The definition of intercultural competence hinges on a definition of culture (see Spencer-Oatey and Žegarac in Chap. 10 and Scupin in Chap. 11, this text). Whereas the concept has been invoked in many different ways, for present purposes we focus on a few characteristics. Culture refers to a range of learned behaviors, including attitudes and values, perceptions and expectations, associations and sense of self, as well as behavioral practices, regardless of whether people engage in them consciously or unconsciously. Whereas these cultural elements are frequently mentioned in the literature on intercultural competence (e.g., Bennett, 2014; Chao, Okazaki, & Hong, 2011; Egan & Bendick, 2008; Johnson, Lenartowicz, & Apud, 2006), providing an exhaustive catalog of all possible elements of culture is not critical; indeed, any learned aspects of behavior can be considered "cultural" because of the other characteristics reviewed below.

All Culture Is Shared Culture is a distributed set of practices, values, and beliefs, which is acquired through direct or indirect interaction with other members of a collective (e.g., Sperber, 1996). This acquisition may occur through interpersonal interaction, by speaking the same language, by accessing the same cultural products (including media), or by engaging in the same cultural practices. As such, culture defines a collective, in which individuals participate. It is often assumed that cultural groups are commensurate with national borders or national origins (e.g., "German culture vs. Japanese culture"), ethnic-racial groups ("Latino culture vs. Anglo culture"), and social class ("working-class culture vs. middle-class culture"), to name only a few examples. Often, these categorizations are reasonable first guesses as to the kind of shared cultural beliefs, values, and practices in which individuals might be participating. However, even when such group memberships characterize some commonalities and have important implications for individuals' lives, culture is primarily defined by how people do things together (Becker, 1982). As such, it also includes less prominent examples such as gun culture (Marino, Wolsko, Keys, & Pennavaria, 2016), honor culture (Nisbett & Cohen, 1996), deaf culture (Padden & Humphries, 2009), or cultures that emerge as a function of certain professions (e.g., Crank, 2014), academic disciplines (Reich & Reich, 2006), or organizations (Schein, 1990).

Culture Is Dynamic When the distribution of beliefs, values, and practices changes, so does the culture (Sperber, 1990). New ideas, new products, new policies, and new technologies have a profound impact on how people do things with and alongside each other (Kemmelmeier & Kühnen, 2012). For instance, the advent of the internet and especially social media like Facebook® and Twitter® has had a dramatic influence on how people relate to one another (e.g., Antoci, Sabatini, & Sodini, 2012; Turkle, 2012). It has allowed networks to be formed primarily based on political ideology and enabled them to access sources that are most likely to deliver news that are consistent with their existing dispositions (Bakshy, Messing, & Adamic, 2015; Barberá, Jost, Nagler, Tucker, & Bonneau, 2015). On the other hand, social networks have contributed to cultural changes in that they have allowed individuals to cross existing group boundaries (based on race, ethnicity, nationality, social class, etc.) and connect with those with whom they may not have had any interaction otherwise (e.g., Barberá, 2014).

Because through interaction people become more similar to one another (e.g., Wittenbaum & Stasser, 1998), this may have contributed to a reduction of cultural differences. For instance, relying on data from the 1970s, 1980s, and 1990s, Coon and Kemmelmeier (2001) and Oyserman, Coon, and Kemmelmeier (2002) documented substantive differences in the cultural values endorsed by undergraduate students of four different US racial-ethnic groups. Yet, subsequent analyses focusing on data from the late 1990s to the teens of the twenty-first century found some of these differences to be declining (Vargas &

Kemmelmeier, 2013); others seem to have disappeared altogether, at least among college students (Kaplan & Kemmelmeier, 2017).

Culture Is a Toolkit of Consensually Validated Ways of Understanding the World and Behaving in It Individuals have a repertoire of behaviors that are recognizable by members of the same cultural collective (DiMaggio, 1997; Swidler, 1986, 2001), and which can be deployed to engage in any social activity ranging from making friends, to succeeding at one's job. For instance, there is a range of culturally acceptable strategies in how to conduct a conversation, how to demand or how to show respect, or how to make oneself understood by referring to a base of knowledge that is shared between oneself and one's counterpart. The consequence is that individuals might travel between different corners of their cultural collective; yet, they "fit in" and know how things work without ever having met other members of this collective. Becker (1982) illustrates this with the examples of Jazz culture (cf. Ake, 2002): Musicians may travel between bands, cities, and communities of musicians, but they will encounter a shared set of tunes and a shared set of practices relating to improvisation, even when each solo may be different from any other (e.g., Becker, 1982).

Cultures May Impose Latent Cultural Demands Cultures are often characterized by general expectations of certain groups or inhabitants of certain roles. For instance, there are often cultural ideas about what constitutes acceptable behavior for men and women (e.g., Guimond, 2008; House, Hanges, Javidan, Dorfman, & Gupta, 2004; Kashima et al., 1995). For instance, honor cultures often imply that men continuously prove their masculinity and are ready to defend their reputation aggressively, if needed (IJzerman & Cohen, 2011; Nisbett & Cohen, 1996; Vandello & Bosson, 2013). In individualistic societies, individuals are expected to be unique and different, whereas in collectivist societies, the latent imperative might be that individuals accept their social obligations toward others (Janoff-Bulman & Leggatt, 2002). However, cultural demands can often be satisfied in a number of different ways: there may be a range of different ways in which to be an "honorable man": Depending on context, resource, and opportunity, a man who has become the target of an insult might either physically attack, sue the other party, or engage in any other form of retaliation (cf. Cross, Uskul, Gerçek-Swing, Alözkan, & Ataca, 2013). For instance, the expectation of filial piety, an important element of many Chinese cultures, may be satisfied by children having their parents move in with them or, depending on the circumstances, by paying for their care (e.g., Lan, 2002). At the same time, cultures differ in the extent to which there is a consensus on what type of behavior is expected. There are often modal responses to recurring situations; yet, cultures differ in their latitude of acceptable responses; some cultures are more likely to tolerate deviations from the norm than others (Gelfand et al., 2011; Uz, 2016). Indeed, the kinds of situations for which there exist widely shared norms and expectations may differ between cultures.

Cultures Are Never Homogeneous Regardless of which cultural group one wishes to examine, some of the distributed elements of culture enumerated above (e.g., beliefs, values, and practices) are not likely to be acquired by all individuals in the same way, nor will the same elements always coincide. Members of a culture who practice the same greeting rituals and who view themselves as independent agents in an individualistic society may differ in the basis of their moral or political values (e.g., Haidt & Graham, 2007). And even though their way of negotiating a business deal may make them recognizable to a member of the same corporate culture, their "nonverbal dialects" (e.g., Marsh, Elfenbein, & Ambady, 2003) may define them as a member of different national cultures. Indeed, it is often a matter of context or convention as to whether a particular deviation from the norm is merely evidence of the heterogeneity of a larger collective or whether it identifies a person as a member of an entirely different collective. How such boundaries are drawn may in itself be evidence of a cultural practice and membership in a

particular cultural community. For instance, there is a (sub)cultural group in the USA who view this country as a "Christian nation" and who view Muslim citizens of the USA as not "real Americans" (e.g., Haddad & Smith, 2014; Hing, 2001), whereas for others Muslims are merely a subculture within the larger panoply of the American religious landscape (see for similar debates surround the "English Only" movement in the USA, e.g., Wiley & Lukes, 1996).

Each Person Is a Member of Multiple Cultures How cultural elements (beliefs, practices, rituals, etc.) are distributed is contingent on with whom or with what individuals interact. Therefore, each person is typically a member of more than one cultural collective at the same time – each with its distinct shared practices, even when some of these practices overlap (Chen, Benet-Martínez, & Bond, 2008; Hermans & Kempen, 1998; Morris, Chiu, & Liu, 2015). Consider these brief descriptions: *Person A* was born and grew up in Oregon as the daughter of immigrants from Peru. After her father (himself of Japanese ancestry) left the family, her mother married a European American man who moved the family to Texas. In Oregon, she attended a predominantly white suburban school; her new school is majority Latino and located in the inner city. Her mother speaks Spanish to her, which she understands, but refuses to speak. *Person B* moved to Detroit from Iraq when he was 10; the Armenian family emigrated because as Christians they no longer felt safe. He struggled to learn English and was exposed to poor schools, but with the help of his family and his Armenian community, eventually he was able to attend a selective public university to pursue an engineering degree. Because of financial trouble, he was unable to finish his degree. After struggling for a few years, and very much to the chagrin to his family, he recently converted to Islam. *Person C* is an African-American gay man, son of a successful Chicago couple; he earned a doctorate in history and landed a tenure-track position at a small, but highly selective, private college in the upper Midwest, where he, after promotion and several years of service, recently accepted the position of dean. He is active for the ACLU and in his local gay community. Likely because of his dark skin complexion and dreadlocks, he gets stopped by police on his drive home at least once a year.

These brief biographies (though limited to cases within the USA) illustrate some of the complexities of culture. The cultural background and experiences of each of these individuals are multifaceted and include intersections of nationality, race/ethnicity, religion, sexuality, and regional cultures. Which aspects of one's cultural background and experience might be most relevant for one's actions or experience is driven by one's situation and context (Hong, Morris, Chiu, & Benet-Martinez, 2000; Oyserman & Lee, 2007). For *Person A*, being a Latina may not be a particularly salient identity at her majority-Latino school, whereas it was likely more prominent at her majority-White school (cf. McGuire, McGuire, Child, & Fujioka, 1978). *Person C* will be reminded of his membership in a racial group in a "driving while Black" incident, whereas interactions with his colleagues will make salient his status as a leader within the academic culture of his college. Often, institutions within the same society define distinct cultural realms with their distinct opportunities and affordances. An immigrant student may be competitive and independent at school but be expected selfless and communal in the context of his or her family, church, or neighborhood.[2]

Cultures Are Inherently Tied into the Structure of Social Environments Certain situations often enforce certain types of mindsets, values, and practices (e.g., Kitayama, Park, Sevincer, Karasawa, & Üskül, 2009; Markus & Kitayama, 2010). In turn, certain mindsets, values, or practices give rise to certain situations. For instance,

[2]Other aspects of multiple membership in cultural groups are beyond the scope of this chapter, such as questions of choice or how individuals position themselves relative to what others may perceive to be their cultural groups. For instance, *Person A*, though of Peruvian parentage, rejects Spanish as her language, whereas *Person B* voluntarily converts to Islam.

individualistic cultural contexts often require people to make personal choices (e.g., selecting ingredients of a Subway® sandwich). In a society in which one's personal identity and uniqueness are values, this is consistent with the cultural belief that one's individuality is expressed through personal preferences (Kim & Markus, 1999; Kim & Sherman, 2007). This, in turn, may foster an inclination for people to seek out objects and contexts, in which there is choice and preferences can be expressed (e.g., Snibbe & Markus, 2005). However, not all situations give rise to cultural responding in that members of different cultures will behave differently. Most cultures seem to have overlapping expectations as to how one is to behave as a passenger on a subway ride, whereas other situations are much more likely to call for culture-specific responding. A joint visit to a restaurant by two people from different cultures is much more likely to reveal their distinct cultural backgrounds and provide an opportunity for misunderstanding and disharmony, for instance, in how the restaurant bill is to be settled.

Implications for Culture Competence Training (ICT) From this brief characterization of culture, a number of implications for any type of ICT emerge. First, because all culture is learned, a priori the prospects of individuals being able to learn about different cultures are very good. Cultural learning is chiefly constrained by one's learning opportunities intersecting with type of learning processes required, one's motivation to learn, the extent to which new material jibes or interferes with what was learned before, as well as, occasionally, biological constraints, such as sensitive periods for language learning (e.g., Pinker, 1994).

Second, all learning about another culture is likely to remain incomplete as elements of culture are distributed unevenly among a collective. Indeed, someone who wishes to learn (or who wishes to teach others about) a different culture may begin by focusing on the types of situation for which a broad consensus exists in terms of behavioral expectations.

Third, the extent to which any knowledge about a cultural group applies to any particular person of that group will vary. Important reasons for this are multiple, overlapping group memberships and the highly contextual nature of cultural influence on behavior. Indeed, any knowledge of cultural differences may mainly "serve as latent conceptual anchors" that help observers understand the forces that guide individuals' cultural responses to events (Brannen & Salk, 2000, p. 451). Indeed, to understand the experience and behavior of someone who is a member of another culture, it is critical to consider that the other's behaviors are being shaped by a multitude of direct and indirect factors, of which membership in the cultural group may be only one factor. In this sense, knowledge about culture and cultural groups opens up new possibilities for understanding but never offers any "how to" manual where "one size fits all."

Fourth, encounters between people from different cultural groups do not necessarily reveal an insurmountable cultural divide. Two individuals may have at least some elements of culture in common – unless one is a New Yorker who has never left the city and the other someone from deep within New Guinean jungle who has never had contact with the outside world (both mythical creatures in the twenty-first century). In many instances, there will be shared cultural participation in spite of cultural differences, such that two individuals might vary in terms of their ethnicity background and upbringing, yet they are part of the same subculture of a sexual minority (Lukes & Land, 1990) or the same occupational or corporate cultures (e.g., Hall, Hockey, & Robinson, 2007; Schein, 1990). Ideally, ICT will equip individuals not only with the capacity to appreciate and bridge cultural differences but also recognize commonality.

No matter what cultural commonalities there exist between two interactants, during the process of interaction, cultural elements that contribute to a successful interaction are likely to recede into the background. Discrepancies in expectations and behavior will likely draw more attention (e.g., Wyer, Swan, & Gruenfeld, 1995),

especially when they cause friction and misunderstanding. For example, in an interaction between a gay African-American police officer and a straight African-American computer scientist may reveal that, depending on context and subject of conversation, cultural differences associated with sexuality or differences in professional culture emerge as more prominent. Being able to overcome these problems of interaction is the domain of intercultural competence – which, in essence, is a domain of applied problem-solving (Tan & Chua, 2003).

What Is Intercultural Competence?

Many different academic and applied fields have concerned themselves with the issue of intercultural competence. There is some variation in outlook and definition, depending on the purpose for which the field envisions that intercultural competence is required, be that to send business executives abroad (Johnson et al., 2006), to provide health services to a diversity community (Huey, Tilley, Jones, & Smith, 2014), or for war fighting (e.g., Rasmussen & Sieck, 2012). However, many approaches embrace the elements outlined in the tripartite model by Sue, Arredondo, and McDavis (1992), first articulated in the clinical literature, according to which intercultural competence includes (a) awareness of one's own cultural assumptions, values, beliefs, and biases, (b) understanding of the worldview and expectations of culturally different interaction partners, and (c) developing and deploying appropriate strategies to relate to an interaction partner in a successful manner (see also Sue, Ivey, & Pedersen, 1996). Chao et al. (2011) summarized these as cultural awareness, knowledge, and skills.

In management and organizational studies, the theory of cultural intelligence (Ang et al., 2007; Ang, van Dyne, & Rockstuhl, 2015; Earley & Ang, 2003) has been at the center of a vibrant literature devoted to understanding the multidimensional nature of competence for working successfully in culturally diverse settings. According to Earley and Ang (2003), cultural intelligence (CQ) consists of four components: metacognitive, cognitive, behavioral, and motivational intelligence. Within this framework, metacognitive CQ describes the process through which individuals become aware of and acquire an understanding of cultures. Cognitive CQ refers to individuals' knowledge about a specific culture, as well as knowledge about cultural differences; behavioral CQ refers to the ability to behave flexibly in, and adapt to, intercultural situations. Lastly, motivational CQ refers to one's capability to direct energy toward entering and thriving in cross-cultural situations. Metacognitive, cognitive, and behavioral CQ easily map onto Sue et al.'s (1992) awareness, knowledge, and skills (see Leung et al., 2014 for a review of other models in the organizational literature).

As Chao et al. (2011) point out, Sue et al.'s (1992) tripartite model does not explicitly mention any motivational component, presumably because in clinical settings it is assumed that providers want to serve a diverse population. Yet, as Hook, Davis, Owen, Worthington, and Utsey (2013) illustrate, focusing exclusively on competence has presented its own problems, whether it is disagreement about what should count as intercultural competence or the measurement of intercultural competence in clinical settings (see Worthington, Soth-McNett, & Moreno, 2007). Instead, the authors highlight the importance of a "multicultural orientation," a mindset which exceeds the strictly cognitive focus of the competence concept. Hook et al. (2013) argue that training ought to help clinicians "to overcome the natural tendency to view one's own beliefs, values and worldview as superior, and instead be open to the beliefs, values and worldview of the diverse client" (p. 354) (see also Dean, 2001; Tervalon & Murray-Garcia, 1998). Fostering openness to others' perspectives, arguably a motivation to approach rather than retreat from novelty, has been a central goal of many approaches aimed at enhancing intercultural competence in clinical and nonclinical settings (e.g., Rasmussen & Sieck, 2012; Sue, 1998). Intercultural competence is impossible to divorce from wanting to become more self-aware, being

willing to learn more and being ready to expend the effort in acquiring new skills. Even before the arrival of the CQ framework, theorists (e.g., Black & Mendenhall, 1990) who have relied on Bandura's (1986) social learning theory as an organizing framework have long understood that motivational aspects of learning, for example, how self-efficacious a person feels, are critical not only in the acquisition but also in how readily individuals will use what have they have learned in training.

Arguably, the very conception of culture makes the inclusion of a motivational component or mindset imperative. As discussed earlier, cultures are themselves dynamic, characterized by heterogeneity, and they are themselves subject to constant change (e.g., Hermans & Kempen, 1998; Matsumoto, Kudoh, & Takeuchi, 1996). There is no natural end point to cultural learning, neither for an established member of a cultural collective nor for an outsider who only interacts with members of a culture from time to time. Moreover, because of the variation that exists within (what an outsider might believe to be) a coherent cultural group, there must be a readiness to adjust one's behavior and one's beliefs. Hence, the development of intercultural competence is best understood as "an ongoing process that requires continuous learning" (Johnson et al., 2006; see also Tan & Chua, 2003). As Earley and Ang (2003) submit, CQ is not about having a stock of knowledge or behavioral repertoire; rather, it is about acquiring and applying general principles in how to pay attention to and learn about one's own and others' culturally shaped behavior (see also Ang et al., 2007).

Does Intercultural Competence Make a Difference?

In the organizational literature, numerous authors have linked intercultural competence to favorable objective and subjective outcomes. For instance, intercultural competence has been found to predict better task performance (e.g., Duff, Tahbaz, & Chan, 2012), greater job success above cognitive ability (Ang et al., 2007), better leader performance in culturally diverse teams (Groves & Feyerherm, 2011), more successful intercultural cooperation (Chua, Morris, & Mor, 2012; Mor, Morris, & Joh, 2013), as well as more successful psychological adjustment and well-being in light of changing cultural environments (Ang et al., 2007; Lin, Chen, & Song, 2012; see Ang et al., 2015, and Leung et al., 2014, for reviews).

Claims as to whether intercultural competence makes a difference hinge on the ability to measure this construct.[3] To the extent that measurement focuses on knowledge of a specific culture or cultural group, researchers do face the challenge to define what is part of a group's culture and what is not. Given the distributed and dynamic nature and inherent heterogeneity of any culture, such a definition is daunting and impractical. Often, there are variations between subcultures, and specific cultural behaviors are highly context-dependent and difficult to assess in a questionnaire format. Furthermore, as discussed above, cultural experiences occur in the intersection of multiple group memberships, which makes it difficult to discern which aspects in the experience and behavior of individuals are unique to what culture. For instance, even some authors who use the term "African-American culture" (Telfair, Nash, & Fisher, 1996) immediately acknowledge that the singular is indefensible and that there are many African-American cultures (e.g., Alim et al., 2008).[4] Very general or abstract characterizations are often not satisfying in that very different cultures give rise to very similar descriptions, even when the actual

[3] Here we limit ourselves to individual-level assessments of intercultural competence. For an example of organization-level measurement of cross-cultural competence and its correlates, see van Driel and Gabrenya (2013).

[4] Many authors acknowledge the inherent heterogeneity of cultures. For instance, in a large-scale, comprehensive ethnographic research project focusing on a preschool in China, Japan, and the USA, Tobin, Wu, and Davidson (1991) acknowledge that they are not showing *the* American/Chinese/Japanese approach to preschool but *an* American/*a* Chinese/*a* Japanese approach to preschool (see also Tobin, Hsueh, & Karasawa, 2009).

lived experience is highly distinct.[5] And whereas researchers have occasionally attempted to measure aspects of knowledge of some cultural groups (see Rutland & Kemmelmeier, 2017), to our knowledge there are no validated measures of cultural knowledge of specific cultural groups to date. Moreover, cultural-general or theory-driven methods of assessment and training have yielded results that are equivalent, if not superior, to any culture-specific alternatives (e.g., Bhawuk, 1998).

In the organizational literature, there are a number of proposals, though the cultural intelligence (CQ) framework offers currently one of the most successful empirical paradigms (Matsumoto & Hwang, 2013).[6] The four components of CQ are assessed using a 20-item self-report measure (e.g., Ang et al., 2007). Questions asked respondents to describe themselves with regard to their metacognitive CQ (e.g., "I am conscious of the cultural knowledge I use when interacting with people with different cultural backgrounds"), their cognitive CQ (e.g., "I know the cultural values and religious beliefs of other cultures"), their motivational CQ (e.g., "I know the cultural values and religious beliefs of other cultures"), and their behavioral CQ (e.g., "I change my verbal behavior (e.g., accent, tone) when a cross-cultural interaction requires it"). All questions refer to self-assessments without focusing on any specific cultural group.

Because of the seeming lack of specificity of the items, it may seem remarkable that responses on this CQ measures predict outcomes of consequence (e.g., Ang et al., 2015; see brief review above). Moreover, a range of personal experiences related to intercultural contact are reflected on the measures. For instance, bicultural individuals tend to score higher in CQ (Thomas, Brannen, & Garcia, 2010) as do students with international experience, even when this difference seems to disappear once students have taken part in a training (Eisenberg et al., 2013). However, the measure is consistent with the conception of CQ being a cultural-general capability and readiness to pay attention to and learn about one's own and others' culture (see also Brislin & Cushner, 1996; cf. Rasmussen & Sieck, 2015).

Notably, Ward, Fischer, Zaid Lam, and Hall (2009) have argued that CQ does not have any incremental validity compared to other established constructs, such as emotional intelligence, the ability to perceive and understand one's own and other's emotions (EI; Mayer & Salovey, 1997). Without a doubt, there is overlap in the concepts between CQ and EI, e.g., in the extent to which both highlight mindful self-awareness. Yet, intercultural competence cannot be reduced to a focus on emotion; CQ is much more specific to intercultural encounters. Focusing on relationship development between partners of different or similar cultural backgrounds, CQ has been shown to predict greater relationship quality in culturally diverse dyads, but not in culturally homogeneous dyads (Rockstuhl & Ng, 2008; see also Rockstuhl, Seiler, Ang, Van Dyne, & Annen, 2011).

In other areas of the behavioral and social sciences, evidence of the beneficial consequences of intercultural competence has been harder to come by. This may seem peculiar in light of the fact that educational institutions have long placed a great emphasis on cultural sensitivity or diversity training (including diversity requirements as part of various courses of study, including the training of applied psychologists). This occurred often without robust empirical evidence to demonstrate their beneficial consequences on objective outcomes (e.g., Herzog, 2010). Demonstrations of greater therapeutic success with culturally tailored therapy regimes (e.g., Huey et al., 2014) do not necessarily speak to the importance of therapists' intercultural competence. And whereas authors argued in favor of developing therapists'

[5]For instance, focus on the descriptions of national cultures, Hofstede, Hofstede, and Minkov (2010) describe both South Korea and El Salvador as highly collectivistic (p. 97); yet, this similarity is highly abstract and does not imply that a person knowledge about one culture would be able to succeed in the other.

[6]Matsumoto and Hwang's (2013) review identified the Multicultural Personality Inventory (Van Der Zee & Van Oudenhoven, 2000), the Intercultural Adjustment Potential Scale (Matsumoto et al., 2001), and the Cultural Intelligence Scale (Ang et al., 2007) as the most promising measures of intercultural competence. Leung et al. (2014) reached essentially the same conclusion.

intercultural competence, evidence was frequently limited to clinical observation and case studies (e.g., Chen, Kakkad, & Balzano, 2008). Other studies disproportionately relied on self-reports, rather than objective outcome assessments, with there being inconsistencies among therapist-reported, client-reported, and observer-reported intercultural competence (Cartwright, Daniels, & Zhang, 2008; Worthington et al., 2007).

Yet, recent investigations have produced evidence supporting objective benefits of intercultural competence in the practice of counseling and clinical psychology. Hook et al. (2013) documented that therapist-client relationships in which the therapist is higher in "cultural humility" (Tervalon & Murray-Garcia, 1998) tend to be characterized by a stronger therapeutic alliance, a critical variable for psychotherapy success (e.g., Martin, Garske, & Davis, 2000). Similarly, clients who rate their therapist high in cultural humility reported better psychotherapy outcomes (Owen et al., 2016). A recent meta-analysis documented for the first time that higher client perceptions of their therapist's intercultural competence predicted better therapy process and outcome (Tao, Owen, Pace, & Imel, 2015). Thus, in spite of debates concerning definition, measurement, and the criteria for effectiveness, intercultural competence seems worth developing.

The Process of Acquiring Intercultural Competence

The typical way through which competence in a culture is acquired is through full immersion, namely, when a person is born into a community or society and grows up in it. Starting with the earliest mother-child interactions (e.g., Miller, Wiley, Fung, & Liang, 1997; Phillips & Shonkoff, 2000), whether through direct experience, observation, imitation, explicit cultural instruction by trusted sources, or active reflection and inference-making, people become versed in the ways of their own cultural groups. Much of the acquisition of culture occurs alongside language acquisition and is embedded in a rich context with its own cultural requirements and affordances (e.g., Markus & Kitayama, 2010). In short, socialization makes members of a cultural group into intuitive experts, who become a repository of cultural knowledge and skills. This repertoire facilitates interaction with members of one's own culture, who can take the knowledge and skills in each other for granted. Indeed, cultural knowledge can operate outside of conscious awareness (e.g., Bargh & Williams, 2006) and may become "embodied" (Voestermans & Verheggen, 2013). This process, for instance, is illustrated by body movements that are practiced as part of cultural rituals. When people engage in the same body movements outside of the ritual context, this triggers thoughts and feelings which were previously acquired as part of the ritual (e.g., Kemmelmeier & Rennung, 2017; Ransom & Alicke, 2013).

Competence in the ways of one's own cultural groups turns to incompetence in an intercultural interaction between two individuals with non-overlapping intercultural competences. To the extent that previously tacit expectations do not hold, the result is disruption and misunderstanding. Being aware of their inability to continue, interaction partners often engage in efforts of correction. Such efforts may be doomed, unless they can learn what works in the interaction and adjust their behavior accordingly. Only when a mutually intelligible mode of interaction is found can the interaction continue without the mechanics of the interaction drawing attention.

This sequence is reminiscent of Howell's (1982) four-level model of competence acquisition, which assumes a succession of unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence. In our example, *unconscious incompetence* describes the reliance on tacit knowledge and practices, of which interactants initially do not realize that it is not shared by their partner. Failure of one's own knowledge and practices requires that the interacting individuals pay attention and identify the source of the problem. If one's ability is to be developed, it is critical that individuals attribute the lack of success in their interaction not to malevolence, incompetence, or some idiosyncratic characteristics of their

interaction partner. Rather, it is important that they become aware that it is their own lack of cultural knowledge and practices, at least as applied to the interaction, that does not yield success. This can be described as *conscious incompetence*, which is likely to spark efforts at correcting that which went wrong.[7]

The experience of incompetence is a powerful motivator to consult other sources, such as trusted experts (ideally knowledgeable in one's own and the other culture), literature, media, trainings, or any other type of relevant instruction. The prime way of acquiring knowledge of another culture is direct experience – as is the case for the acquisition of the cultures in which each person is born into or enters at an early age. This includes mainly interacting with those of a different cultural background. Spending time in different cultural environment, be that a foreign country, friends in an immigrant neighborhood, or a family of a different ethnicity, social class, or religion may offer the best chance for an immersive experience, with opportunities for observation, participation, asking questions, and practicing a different language (if applicable).

To the extent that individuals learn about how and why members of other cultures differ in terms of cultural knowledge and practices, they can become aware of what is needed to continue the interaction. Actively engaging in the acquisition of cultural knowledge and skills, which can be brought to bear during an intercultural interaction, characterizes *conscious competence*. At this point, experimentation in the application of newly learned cultural knowledge and skills is critical. Even interaction partners who have expanded their knowledge about their partner's culture may not yet be fully aware which skill or strategy might be best deployed under what circumstances. Sue (1998) recommends to rely on a hypothesis testing approach, where interactants try out behavioral strategies but repeat or adjust their behavior in similar situations based on the responses that they elicit.

When behavioral strategies with changing interaction partner from another culture routinely allow for coherent interaction, conscious attention is no longer required. Interactants can operate relying on their *unconscious competence* – as they tend to do within the culture of their group into which they were first socialized.

What Intercultural Competence Training Might Accomplish

Howell's (1982) model outlines an idealized path of skill acquisition, but it highlights how intercultural competence training (ICT) may be able to intervene. In the simplest case, intercultural competence training can alert students to the fact that, in intercultural encounters, their everyday expectations and practices, rooted in their own cultural context, may no longer be sufficient. In other words, ICT may allow students to skip the stage of unconscious incompetence but induce an awareness of at least the possibility of their own intercultural incompetence.

Chiefly, ICT can help with turning conscious incompetence into conscious competence. ICT can provide students with knowledge and skills concerning interactions with members of a specific culture. Culture-specific competence is often trained in organizations that send sojourners for a certain time abroad, as occurs in international corporations or in the diplomatic service. In the international context, such training approximates what might be accomplished with an "area studies" approach in that students learn about various aspects of the country, its people, and acquire a basic understanding of cultural behaviors that might differ from their own (e.g., Ito & Triandis, 1989; Watzlawick, 1978). Similar trainings are sometimes provided to case workers, officers, or health-care providers who are expected to interact with specific populations. However, as discussed above, such general

[7]This experience is rarely one-sided: all participants may seek to correct and remedy what went wrong in order to be able to continue the interaction. However, one party may be more motivated to adjust their own behavior when the relationships are asymmetrical. For instance, a teacher, therapist, and salesperson might feel that is their responsibility to improve their own communication relative to the students, client, or customer or because their own professional success depends on being able to do so.

knowledge about another culture is inherently overgeneral and will lack in specificity. No matter what a student may have been told, not all Latinos will practice *familismo* (Steidel & Contreras, 2003), nor will all European American and Protestant men be task- rather than relationship-oriented (Sanchez-Burks, 2004). Rather, such knowledge about other groups provides individuals with hypotheses as to what they might expect. Yet, even when these hypotheses provide an advantage in many intercultural interactions, they will not always be borne out. When there are intersecting group memberships or situational constraints, behavioral expectations with regard to a specific membership may not be helpful. Likewise, hypotheses concerning the behavior of members of particular group may underestimate the natural variation that occurs within that group, even when one's expectations are generally accurate (cf. Wolsko, Park, Judd, & Wittenbrink, 2000). Lastly, though one's interaction partners may be from another culture, it might them who are interculturally competent enough to adapt to one's own cultural behavior.

More generally, ICT can help increase an individual's capacity to deal with intercultural situations in general. Arguably, increasing the cultural-general intercultural competence is the typical goal of many educational institutions and intercultural competence trainings, regardless of whether they are geared toward a multicultural population at home or cultural diversity abroad (e.g., Eisenberg et al., 2013; Erez et al., 2013). The goal is to sensitize individuals to the cultural dimensions of their own and other's behavior, which includes building awareness of one's own (possible) incompetence. But more importantly, it seeks to focus attention on the fact that individuals rely on their own cultural knowledge and provide them with a repertoire of behaviors to increase attention to others. For instance, some ICTs seek to increase other-orientation through specific cues to engage in perspective taking, which has been demonstrated to increase intercultural cooperation (Mor et al., 2013). In an ideal scenario, ICT allows people to disconfirm their preconceptions about those they perceive as culturally different from them. Rosenblatt, Worthley, and MacNab (2013) demonstrated that CQ increased to the extent that students in a CQ training program realized that their experiences interaction with cultural others did not confirm their expectations.

To illustrate, in group discussions and in schools in Western cultures, it is often expected that those who have an opinion on the matter at hand express it – even if their contribution challenges the apparent views of others. The extent to which individuals volunteer to speak up is taken as evidence of interest in the discussion or understanding of the subject under discussion (e.g., Jenkins, 2000; Liu & Littlewood, 1997). Yet, in many cultures it is considered rude to challenge the views of another, especially when the other person is older or status-higher than oneself; rather, silence in the presence of a higher-status person is an expression of respect (Jones, 1999). Hence, failure to participate in the discussion cannot necessarily be taken as lack of engagement or even lack of competence. Indeed, to encourage conversation it often requires empathic understanding of the interpersonal concerns, and active encouragement or skillful moderation, e.g., on the part of a teacher, to signal that personal views can be expressed in a risk-free manner. Thus, a lack of intercultural empathy may have left Westerners' stereotypes of Chinese as passive intact; yet, the practice of perspective taking would have allowed stereotype-disconfirmation information to emerge.

Lastly, ICT can support intercultural competence by building self-efficacy. Self-efficacy is the belief that one possesses the necessary skill and resources to deal with a difficult situation successfully (Bandura, 1986). Self-efficacy beliefs tend to be domain-specific and may be focused on the intercultural domain (Jeffreys & Dogan, 2012; Johnson et al., 2006; Rasmussen & Sieck, 2015; Rehg, Gundlach, & Grigorian, 2012). Specifically, personal experience with culturally difficult situations, the experience of understanding and bridging intercultural differences during training, as well as learning from observation or instructions can all foster a sense of self-efficacy. To the extent that individuals experience themselves as efficacious, they are

more likely experience a potentially difficult situation as a challenge rather than a threat (Jerusalem & Schwarzer, 1992); they are less likely to give up, and they ultimately are more likely to enjoy the intercultural encounter.

In terms of Howell's (1982) model, ICT may be able to advance students from unconscious incompetence to conscious incompetence and on to a kind of conscious competence that offers them a chance at understanding the cultural influences shaping another's behavior. However, it is beyond the scope of ICT to achieve a level of unconscious competence, nor may it even be desirable. If the purpose of ICT is to prepare sojourners for a stay in a specific foreign country, achieving unconscious competence is unrealistic; trainings are time-limited and cannot provide the same immersive, potentially lifelong learning experience that any native has experienced. But with much of ICT being aimed at building a culture-general intercultural competence, reaching Howell's unconscious competence itself may not even be desirable. After all, a critical aspect of intercultural competence is to be aware of one's own cultural responses – in order to be able to control or withhold them and select a response that will further individual goals or advance the interaction. If the purpose for ICT is to facilitate interacting in a multicultural society, the types of cultural issues and types of clients with whom a physician, therapist, nurse, teacher, or lawyer will interact are highly variable, nor can one ever be sure that one's interaction partner will neatly fit in any established cultural category.

For instance, a mental health-care professional may meet a gay Chinese engineering student who presents with insomnia and symptoms of depression. He resents engineering but welcomed the opportunity to escape his parents' attention by studying in the USA, which allowed him to avoid telling his parents about his sexuality. As the only child, his parents want him to have a career in the USA and a traditional family and eventually will have him take care of them in their old age. His performance as an engineering student has recently suffered, but he is reluctant to confide in his friends, a group of fellow engineering students from China, for fear of burdening them with his pain and being ostracized for his sexuality. Whereas this client brings up a number of cultural issues, the ones associated with the clinician's next client might be starkly different, even if he presents with a similar set of symptoms. She may see a middle-aged Sikh man, a naturalized US citizen, who as a young man distanced himself from his religion by cutting his hair and shaving his beard – which resulted in his Indian family disowning him. He recently grew his hair again, began wearing the traditional head dress, and now regularly attends the temple in his town, which offered him the spiritual and cultural connection he craved, and led to a reconciliation with his elderly parents. Yet, the consequence is strife with his wife and children, who reject the traditional ways. He says he is being undermined at work in his position as an executive at a food processing company. After wearing the traditional turban on Sikh holidays, he became (ironically) the target of anti-Muslim hostility, had his vehicle vandalized and has received death threats. Without a doubt, the clinician will be able to get to know each of these men, but as an African-American woman, her increased understanding of their cultural backgrounds may not support her understanding of the Chicana woman who visits her office next. Rather, she will likely need to practice intercultural competence by being aware of the cultural issues this client may present, be aware of her own responses to them, and, based on her clinical skill and experience, select a suitable strategy forward.

Intercultural Competence in Practice

Even if one accepts that intercultural competence is beneficial, the present discussion of the concept has been somewhat abstract. Below we discuss four thumbnail scenarios that serve to illustrate how and why intercultural competence may render interactions more successful. Whereas the scenarios are not nearly as complex as many real-life situations, they aim to illustrate different kinds of cultural knowledge.

Scenario 1 In the context of a professional psychology conference held in the USA, one of the authors once attended a dinner at a restaurant along with an American, a Dutch, and a group of three Spaniards, all of whom were newly acquainted. We enjoyed each other's company; there was wine, good food, and friendly conversation. When the bill came, the US residents took the lead in explaining to the four Europeans, all of whom had little experience traveling to the USA, how the tip was calculated and which sum was de facto owed. Whereas this cultural piece of knowledge was easily negotiated, what followed was not. The Spaniards proceeded to put each a sixth of the money in the middle of the table. The Dutch, after reviewing the bill, declared that he was not going to pay more than what he had consumed – an amount (including tip) that was below one sixth of the overall sum. The American man, addressing the Spanish women, burst out: "But you only had a salad!" – incredulous that she was willing to pay more than what she owed by his calculation. When she answered that this was fine, he mentioned that she did not need to pay for his dinner. This situation was eventually resolved (the author, himself a long-term transplant to the USA from Germany, took on the role of cashier and was able to resolve the situation). Yet, it revealed clear differences in cultural expectations concerning how to define a relationship and what implications flowed from it. The American and Dutch operated on the basis of an equity standard, based on which individuals' input into a joint endeavor (here: dinner) are equivalent to their output. However, the Spaniards operated on the basis of an equality standard, such that each person's input constituted an equal share of the overall benefit, regardless of their output (Morris & Leung, 2000). More broadly, the various parties applied different relational models (Fiske, 1992). The Spaniards applied a *communal sharing* model, according to which a lovely evening with new friends would have been undermined by haggling over money; indeed, making individual demands would have challenged the newly formed friendships. The American and the Dutch did not feel the new relationships to be incompatible with a *market pricing* model, in which each person is responsible for their own consumption, and individual choice and personal responsibility maintained by each person choose what they want to spend.

There is little doubt that each person, regardless of cultural background, has at some point engaged in *communal sharing* relationships: parents care for small children without expecting them pay rent, members of a romantic couple take care of each other when one of them is sick, and soldiers fight for people whom they have never met. On the other hand, each single person has experience with *market pricing* relationships: any job in which one's pay is based on one's performance or hour worked, any trip to the market where the product received is commensurate to its cost, or any other situation in which "you get what you paid for." Oftentimes, cultural differences, such as the one described in the dinner story, do not exist because one type of relationship exists in one culture that does not exist in another. Rather, cultural knowledge comprises knowing what kind of relationships there typically exists between what kinds of actors and when the rules governing a relationship might change. Presumably, the Spaniards would have followed the same market pricing principles ("you get what you pay for") had they been asked to contribute to paying a bill shared with people whom they had never met. Yet, the experience of a communal dinner changed this; yet, for the American and the Dutch, it did not. In sum, acquiring intercultural competence requires individuals to understand that others might have different expectations concerning a relationship, that they might be familiar with the general "rules" of a relationship, but that these rules may apply different to different agents. Specifically, intercultural competence in the above situation would have implied (a) being able to anticipate that there might be different cultural expectations that would have likely become evident when paying the bill, (b) being aware that oneself has culturally grounded expectations as to how these situations are typically resolved, and (c) coming up with a strategy of how to defuse the situation that did not make the Dutch feel that they overpaid

and the Spaniards feel that the American and the Dutch wished to undo the warm glow of the evening.

Scenario 2 This scenario gains currency from the fact that the majority of suicides involve the use of a firearm (CDC, 2015; Wintemute, 2015), with the presence of a firearm in the home increasing the risk of suicide (Kellermann et al., 1992). With older White men being the group most likely to own a firearm (e.g., Morin, 2014), it may not be surprising that this group's suicide rate is among the highest of any demographic in the USA, when residing in rural areas of states with an honor culture (e.g., Conwell et al., 2002; Crowder & Kemmelmeier, 2014, 2017) or very conservative states (Kposowa, 2013).

M.T. was a retired police officer in a rural South Carolina town who visited his primary care physician for his annual checkup. Being in his late 70s, M.T.'s wife recently died. The relationship with his adult daughter, which used to be smoothed over by his wife, had become strained, though she lived in the same town. The relationship with his son was better, but the son lived in Illinois, and M.T. was not as much part of the son's family as he wished to be. His eyesight was failing, and he was concerned that he would lose his driver's license. With his mobility already limited by arthritis, he already felt like a burden and dreaded the idea of having to rely even more on his daughter than he already had to. During his checkup with a young physician, who recently took over after his doctor of many years retired, M.T. reluctantly confessed to having thoughts of suicide. The physician proceeded to tell M.T. to get rid of his handgun as he is a danger to himself. He told M.T. that he does not need a gun because crime was down, and it probably would not help much anyways given his eyesight. M.T. got a sense that the physician was a liberal who questioned his Second Amendment rights and did not return to this office. Four months later he ended his life using one of his handguns. In this scenario, the physician may have felt affirmed in his original recommendation; yet, his attempt clearly backfired. Though likely unintentionally, he positioned himself opposite M.T. across a cultural divide. He was not sensitive to M.T.'s perspective on the interaction: rather than respecting M.T.'s pride in being able to defend himself – a central characteristic of masculinity in honor cultures – the physician offered advice that essentially questioned M.T.'s assumptions. In this scenario, intercultural competence on the part of the physician would have implied that (a) he would be attentive to his own assumptions about handguns, (b) he understands what handgun and gun ownership signify in terms of the local culture, and (c) he is able to devise a strategy that limits access to the firearms yet without entering any culture wars (e.g., Betz & Wintemute, 2015; Marino et al., 2016; Wintemute, Betz, & Ranney, 2016).

Scenario 3 A middle-school student from a Mexican immigrant family was being referred to a clinical psychologist for evaluation. Her grades were poor; she had been acting out, received detention for fighting, and faced suspension. When the student and her mother visited the clinician, both were standoffish, though the daughter seemed to be on her best behavior in the presence of her mother. The mother elaborated that she did not want her daughter to get involved with boys at this early age and needed the school to protect her innocence. The conversation also revealed that home life is sometimes unpredictable because of the mother's recurring headaches and *nervios* ("nerves"), which require the daughter to take care of her two younger brothers. The daughter said that, since the nerve attacks began, the mother did not work anymore but that she has to watch her siblings much more than before because the mother cannot come out of her room. The clinician said that he will be seeing the daughter for a number of sessions. However, the daughter's situation in school did not improve. This intervention did not change the family's situation, and the family dynamic that may have sustained the daughter's behavior was not affected. Though success would not have been guaranteed, the clinician made no attempt to connect the mother with relevant resources to address what might be a mood or anxiety disorder

(e.g., De Snyder, de Jesus Diaz-Perez, & Ojeda, 2000; Weller, Baer, de Alba Garcia, & Rocha, 2008). The situation also would have been complicated by the cultural stigma against mental disorder (e.g., Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007), which might have deterred the mother from seeking help and might have complicated the mother-daughter relationship. In this scenario, intercultural competence would have implied (a) being attentive to the family dynamic, (b) understanding that *nervios* refers to an indigenous mental health syndrome that is indicative of pathology, and (c) devising a strategy for intervention which respects cultural concerns concerning mental disorder and family but which also takes advantage of the respect that an authority person, such as clinical psychologist, may enjoy.

Intercultural competence allows participants to understand a dimension of the interaction that would have been otherwise obscure. It allows one to anticipate and mitigate conflict (Scenario 1); recognize that there may be a cultural divide, in light of which one's own message might be interpreted (Scenario 2); or understand what references to an indigenous concept may mean (Scenario 3).

Yet, cultural awareness, understanding, skill, and motivation do not guarantee improved interactions. In the dinner scenario (Scenario 1), any anticipation of cultural differences in paying the dinner bill would have been inconsequential if the American and Dutch participants in the dinner simply had enjoyed the interaction much less and thus refused any manner than each person paying for their own consumption. In the suicide scenario (Scenario 2), the protagonist may have refused to hand over his firearms to others on a temporary basis, least of all to his daughter, as this would have reinforced his sense that he is becoming a "lesser man" in his old age. Finally, in the *nervios* scenario (Scenario 3), the mother might have rejected the idea of entering treatment for fear that her community or her husband would consider her *loca* ("crazy"); the daughter might have still become involved in fights.

Here we suggest that, to the extent that intercultural competence relies on accurate knowledge, actors may a greater understanding and appreciation of the possible responses of their interaction partners, and they may broaden the repertoire of their own responses. To put it in terms of Howell's stage of conscious competence, cultural knowledge offers the opportunity to generate additional hypotheses concerning an interaction partner's experience and behavior that may not have been possible otherwise.

Teaching Intercultural Competence

There is agreement in the literature that direct experience is the primary source of cultural learning. A widely used framework for ICT is Kolb's (1984) experiential learning theory, which argues that cultural learning requires generally four steps. First, individuals engage in experiences with their social environment. Second, they reflect on these experiences, often aided by a critical exchange with others. Third, they draw abstract conclusions and generalizations about their own and others behavior, which can serve as guiding theories for future behavior. Lastly, they engage in new experiences, which serve as testing grounds or "experiments" to assess the viability or effectiveness of new behaviors (see also situated learning theory; Lave & Wenger, 1991). Notably, this approach nicely fits with Sue et al.'s (1992) emphasis on self-awareness, seeking to understanding the perspective of one's interaction partners and devising means to overcome any apparent differences in approach and perspective. Moreover, encouraging learners to draw inferences from their concrete experience and test them through new experiences may foster what Sue (1998) referred to as "scientific mindedness." Rather than drawing firm conclusions, learners are encouraged to come up with hypotheses, which can then be tested (see also Howell's 1982 concept of conscious consciousness).

Traditional Teaching Methods If experience is the main driver of intercultural competence, it is clear that the impact of traditional methods of classroom teaching is limited (see Fowler & Blohm, 2004). Lectures allow instructors to

provide information about a specific culture or cultural context, which can be communicated in a condensed format. Especially as a first step in any training to enhance intercultural competence, lectures can be beneficial, as learning characteristic of one's own or other cultures is an important component of intercultural competence (e.g., cognitive CQ; Earley & Ang, 2003).[8] Similarly, lecture-based training is certainly preferable to no training at all (e.g., Bird, Heinbuch, Dunbar, & McNulty, 1993; Rehg et al., 2012). However, lectures seem best suited to provide an overview of the nature of cultural divides, even ones within students' own environment (e.g., Stephens, Fryberg, Markus, Johnson, & Covarrubias, 2012). Lectures' ability to convey experiences is often limited to "war stories" which provide examples of the kinds of experiences students might face in actual intercultural encounters, without providing the experience of such encounters. However, at least as part of international management program, Earley (1987) documented that a lecture-based training provided additive benefit above and beyond experiential training (simulations and role-playing exercises).

In university settings, ICT typically includes readings that illustrate important aspects of culture. Readings play an especially important role in graduate education, where students are expected to acquire and digest potentially complex information in text format. Readings offer the advantage that they can be selected with different educational goals in mind. Texts can provide access to experiential dimension. Whether fiction or nonfiction, cultural readings can be successful in conveying diversity of cultural experience, and they can serve an excellent starting point for a discussion. Yet, as most readings in university settings, student engagement is likely to be variable with other demands and interests getting in the way of a "deep reading" of a homework assignment.

[8]Learning characteristics of one's own culture primarily occurs in light of learning about or experience with another culture.

Many instructors aiming to increasing the intercultural competence of their students rely on movies, both feature films and documentaries. When done well, movies can provide evocative and memorable experiences especially where effective storytelling is involved. However, these experiences have typically been designed by a director with a particular purpose in mind. At their best, they provide a surrogate; they cannot replace personal experience, whose implications for one's life are more immediate, and which do not allow individuals to distance themselves as easily from the thoughts and feelings they experienced at the time.

Lectures, readings, and video are well suited to convey information, and foster awareness of the nature and types of cultural differences, and encourage reflection. Yet, experiential learning, these approaches fall short in that they do not necessarily entail that students develop and practice new behavioral strategies themselves.

Vignettes and Scenarios A common approach, especially in organizational settings, for enhancing intercultural competence is the use of written scenarios, which lend themselves for evaluation, feedback, and discussion. They form the centerpiece of the "cultural assimilator," a cross-cultural training program that is frequently used in business organizations in order to prepare sojourners for their stay abroad (Fiedler, Mitchell, & Triandis, 1971). Though there are different varieties of the cultural assimilator, the approach has been empirically validated, and it is effective in increasing sojourners' adjustment, well-being, and work performance in a host culture (Bhawuk & Brislin, 2000). Some view this type of program as the standard against which to compare other approach aimed at preparing sojourners (e.g., Sanchez-Burks, Lee, Nisbett, & Ybarra, 2007).

The cultural assimilator approach focuses on so-called critical incidents as they might occur between two members of different cultures. Students are provided with a written scenario and are asked to interpret the behavior described and make choices from a list of multiple attributions

and possible behavior (e.g., Brislin & Cushner, 1996). Critical incidents include different levels of difficulty, reflecting the extent to which previous research has established that students may be able to provide the answer deemed correct based on the commonly expected response in the host culture. When students provide a correct response, they are able to move on to the next critical incident. If the response deviates from the expected one, students are provided with an explanation as to the cultural issues in question and asked to choose another response.

To illustrate the technique, we summarize a vignette provided by Cushner and Brislin (1986) aimed at teacher training: Californian elementary school teacher Marie who lands a position in Honolulu, HI. In her third-grade classroom, she emphasizes an individualized learning approach and motivates her students by highlighting the trajectory of individual student improvement. At the end of her first grading period, it is noticed that students of Japanese and European ancestry receive higher grades and more individual awards than Hawaiian children, which earns her a reproach from the principal who feels that she does not treat all students equally. Teacher trainees are being asked whether Marie should deal with this problem (1) by intensifying her individualized instruction and ensure that it reaches every Hawaiian American child; (2) by understanding that Hawaiian children are socialized to work for group, not individual rewards; (3) by realizing that Hawaiian children are used to Japanese teachers, rather than Caucasian ones; or (4) by considering that Hawaiian children face the typical cultural deprivation that is typical for many minority groups around the world. The second response is presented at the best, though each response option is presented with a paragraph that does discuss its merits or fallacy. This Marie scenario forms 1 of 100 critical incidents that is part of a culture-general assimilator, a set of scenarios not exclusively focus on a specific culture, but instead themes of cultural differences, such as hierarchy, values, role of group vs. individual, belonging, etc. (Brislin, Cushner, Cherrie, & Yong, 1986). Experimental studies documented that working through these scenarios significantly predicted sojourners' adjustment to their host cultures and a greater ability to anticipate and explain cultural misunderstandings (e.g., Bhawuk & Brislin, 2000).

The "critical incidents" lend themselves to self-study but can also be used in the context of an interactive discussion. The materials may reveal students' own culturally rooted expectations and interpretations and highlight important dimensions of difference between cultures. Though they do not provide any direct experiences, the "cultural assimilator" approach encourages critical reflection, especially when the first response turns out to be incorrect, and the student receives feedback. Especially in association with readings, lecture, or other forms of instruction, the learner is encouraged to draw abstract conclusions, which then can be tested on the next critical incident scenario. Overall, research confirmed that this approach allows students to gain an understanding of different concerns in the interactions between members of different societies (e.g., Bhawuk & Brislin, 2000).

The goal of the "cultural assimilator" is to render the behavior of a newcomer to a culture similar to that of natives of this culture. The fact that it has been shown to accomplish this goal to some degree is its greatest strength but also its greatest weakness. It assumes that there is considerable uniformity in the expectations of members of the host culture, which is not always realistic. Moreover, it presumes little experience on the part of the student as well as their other-culture counterparts. In the international context, because of the presence of US media and cultural products around the world, many Americans traveling abroad encounter people who do not necessarily to expect Americans to assimilate or even speak their language. Sometimes, members of foreign society might wish to practice their own English on the American visitor and test out their own knowledge of American culture.

Still, the "critical incidents" approach itself has a number of advantages. It is very adaptable, in the sense that suitable incidents might be constructed for a specific purpose (see Albert, 1983

for instructions of how to construe a critical incident). Likewise, it can be easily integrated with other approaches, such as lecture and experiential methods.

Simulations There are a number of exercises available that seek to promote intercultural competence by simulating aspects of cross-cultural encounters. They provide individuals with the experience of incompetence and force them to reflect on their own and others' behavior and generate abstract conclusions and hypotheses, which can be tested immediately in the ongoing situation. To illustrate, we briefly describe the "anthropology exercise."[9]

In this exercise, a group of participants is divided into "anthropologists" and "the tribe," with the latter outnumbering the former at least three to one. Those assigned to the role of anthropologists are separated from the tribe and instructed that their task would be to find out about tribal life by posing a series of questions that the members of the tribe would be able to answer with a "Yes" or a "No." Conversely, when the anthropologists are out of the room, the members of tribe are told that the anthropologists would soon try to study tribal life by posing a series of Yes-No questions. However, rather than paying attention to the content of the question, tribal members are instructed to respond with a Yes if the anthropologist smiled when posing the question and No if he or she did not smile. The anthropologists are then invited back into the room to learn about the tribe. No matter what line of inquiry the anthropologists pursue, they quickly discover that the response they receive appear to be inconsistent and logically contradictory. It produces conscious incompetence, to use Howell's (1982) term, and inspires critical reflection. The key to understanding the "weird" behavior of the tribe is typically the various anthropologists observing each other (often aided by discussion), which allows them to generate a testable hypothesis concerning the contingency between facial expression and the answer. Whether the anthropologists make the correct discovery or not, all group members then discuss their observations and experiences, with the facilitator encouraging students to draw conclusions.

Whereas this simulation is rather simple, others are more involved. The well-known is BaFá BaFá simulations by Shirts (1995) requiring a couple of hours and commercially available materials, though its effectiveness has been empirically documented (Bruschke, Gartner, & Seiter, 1993). In this simulation game, participants become part of one of two "tribes" with distinct cultural characteristics, which participants subsequently experience when interacting with members of the other tribe (for implementation and variants, see Swift & Denton, 2003). There exist a range of related experiential simulations, exercises, and role-plays (Tan & Chua, 2003; see Fowler & Blohm, 2004 for an overview), some with proven track records (e.g., Bücker & Korzilius, 2015).

Cultural exercises and simulations lend themselves to be used in classroom settings, even when many of them require organizational effort. A drawback is that sometimes commercially available materials are required, but the main constraint is time, as many simulations do not fit easily into the rigid university schedule.

Immersion and Practical Experiences Rather than simulations, many training programs include actual intercultural encounters, typically with people from different cultural communities within the same society (e.g., Canfield, Low, & Hovestadt, 2009; MacNab, 2012). Such communities might include members of different racial, ethnic, national, or religious groups, which individuals visit, and where individuals' (typically self-chosen) tasks include extensive one-on-one interactions. These experiences are integrated into a class, in which students are also exposed to more traditional instructional methods. For instance, Harmon-Vukić and Schanz (2012) structured a course around a visit to an Indian

[9]One of the authors (MK) was exposed to this exercise as part of a training by Patricia Gurin at the University of Michigan during the 1990s and has used it on occasion, yet without being able to locate any literature on it.

reservation, with prior readings aimed at providing students with context and using post-visit assignments for students to process their experiences. Likewise, MacNab (2012), and subsequent studies relying on the same method (e.g., Rosenblatt et al., 2013), required students to go into to the community to get to know a culturally different group, with this experiential part of the course being embedded in a larger process of preparation and postexperience assignments, feedback, and group discussion. MacNab documented meaningful increases in metacognitive, motivational, and behavioral CQ as a function of the experience.

Unless the class itself involves travel to another country (e.g., Eisenberg et al., 2013), an alternative approach is to have individuals participate in online projects, in which they collaborate with members of different cultures. Erez et al. (2013) assigned MBA students to virtual teams, each of which was composed of students from all over the world. Over a period of 4 weeks, collaboration and cultural sharing increased team members' CQ, which persisted until half a year later.

Student responses to experiential learning elements of a course are generally very positive, but they require much planning on the part of the instructor. Nevertheless, in line with the literature on ICT, concrete engagement with members of other groups of all the available methods, immersion, and practical experiential exercises have the potential of increasing students' intercultural competence the most.

Virtual Reality Advances in technology offer novel possibilities that are as of yet not explored for ICT. Though not reviewed here, role-playing exercises have long been used in ICT. Virtual reality now allows individuals experience themselves and the (virtual) world from a different vantage point – with measurable consequences. Maister, Slater, Sanchez-Vives, and Tsakiris (2015) demonstrated a reduction in implicit racial biases when Whites virtually inhabited an African-American avatar (see also Farmer, Maister, & Tsakiris, 2013). Where prejudice or intergroup anxiety (Stephan, 2014) constitute obstacles to harmonious interactions by members of different cultural groups, immersive virtual reality may offer a powerful tool, even when important aspects of this method are not yet understood (Maister et al., 2015).

Intercultural Competence Training, Stereotyping, and Essentialism

In spite of some demonstrated successes of ICT, various authors have express concern that ICT might produce unhelpful distortions (e.g., Brown, 2009; Chao et al., 2011; Egan & Bendick, 2008). To the extent that an ICT focuses primarily on cultural differences, it might end up "exotifying" other cultures (Bennett, 2014). Moreover, ICT might encourage students to essentialize cultural differences. Both might increase stereotyping and foster cultural divisions.

The evidence concerning increases in stereotyping is somewhat counterintuitive in light of the widespread assumptions that stereotyping is inherently bad. Yet, social psychologists have long conceived of stereotypes as a type of knowledge about a social category and its members (Macrae, Stangor, & Hewstone, 1996). This knowledge might not only be negative ("Germans follow rules blindly") or positive ("Canadians are polite"), but stereotypes might also be demonstrably accurate ("Men are taller than women") or inaccurate ("Arabs are terrorists"). In the context of attempts to improve interethnic relations in the USA, Wolsko et al. (2000) contrasted the consequences of messages advocating color blindness and messages advocating multiculturalism (i.e., celebrating cultural differences). The authors found that a focus on meaningful cultural differences did indeed increase Whites' perceptions of stereotypical differences between Blacks and Whites. Yet, Whites saw stereotypical differences regardless of whether they favored Blacks or Whites, and they stereotyped their own group as much they stereotyped the other. Importantly, when multiculturalism was emphasized, Whites'

views of African-Americans were more accurate based on objective criteria.[10] Moreover, viewing the group in stereotypic ways was related to the expression of more favorable intergroup attitudes. Even though White participants saw Blacks as more alike than was objectively warranted (a common outgroup homogeneity effect; Judd & Park, 1988), their study revealed that drawing attention to group differences may not inherently have detrimental consequences. The results by Wolsko et al. (2000) are consistent with subsequent research by Richeson and Nussbaum (2004) who found colorblind vs. multicultural messages to *increase* explicit and implicit racial biases (see also Bonilla-Silva, 2017).

Consistent with critics' suspicions, Fischer (2011) documented that a comprehensive ICT delivered as part of an organizational behavior class increased students' belief in the essence of cultural groups. Essentialism refers to the belief that social categories are defined by unobservable qualities ("essences") which are inherent to the members of a particular social category. Medin and Ortony (1989) argued that essentialist beliefs facilitate the categorization of social and natural objects and thus, from early childhood on, help individuals make sense of and navigate the social world (see also Keil, 1989). Belief in an unalterable essence is facilitated by socially constructed narratives. For instance, Heine, Dar-Nimrod, Cheung, and Proulx (2017) demonstrated that the availability of genetic explanations often leads non-expert members of the public to believe that their genetic heritage ("their essence") determines life outcomes, even when this is not supported by evidence. Likewise, socialization history may equally serve as the basis of essentializing members of a category, such as when people grew up in a particular cultural context (Rangel & Keller, 2011). This social essentialism may give rise to ideas such as "You can take the girl out of the country, but can't take the country out of the girl" (e.g., Mieder, 1992).

Even though essentialism is often viewed as inherently negative, students arriving at the assumption of a cultural essence, at least for a time, may be an immediate effect of ICT, even when its authors did not intend for this to occur. First, the goal of much intercultural competence training is to sensitize students to the fact that each of us is shaped by his or her cultural background and upbringing. This message alone often encourages the assumption that each person carries within them the traces of their cultural autobiography, which end up influencing expectations, experience, and behavior. This is not the only message that ICT may seek to convey; yet, it is an important one.

Second, essentialist beliefs serve as explanatory devices (e.g., Yzerbyt, Rocher, & Schadron, 1997), which facilitate learning about cultural differences. Assuming an essence allows behavior to be seen as the results of a cultural disposition. This facilitates generalization because all members of the same cultural group are assumed to possess the same disposition (Chao et al., 2011). To the extent that small empirical covariations are observed, they are more easily generalized to essentialized groups than nonessentialized groups (e.g., Prentice & Miller, 2007). In other words, learners understand more easily in what ways members of another group might differ from members of their own groups.

Belief in an essence may increase the danger that another culture is perceived as more homogeneous and monolithic than is really warranted. Moreover, essentialist beliefs have been linked to stereotyping and prejudice (Bastian & Haslam, 2006; Jayaratne et al., 2006; Williams & Eberhardt, 2008). Yet, essentialist beliefs are not identical with prejudice. In some instances, essentialist beliefs are only weakly or not at all related to prejudice (e.g., Haslam, Rothschild, & Ernst, 2002), or greater endorsement of essentialist beliefs is related to more favorable views of group members (e.g., Haslam & Levy, 2006). As demonstrated by Mahalingam (2007) and Morton and Postmes (2009), essentialist beliefs can serve to

[10]Based cultural stereotypes, the authors asked White participants to predict the average SAT/ACT scores of Blacks and Whites (related to the negative stereotype that Blacks are less competent), and they asked about church attendance (related to the positive stereotype that Blacks are more religious than Whites). The accuracy of responses was evaluated based on national data (see Wolsko et al., 2000, Appendix B).

increase the cohesion of an oppressed group and energize its pursuit of social change. Thus, there is no inherent link between essentialist beliefs and prejudice or stereotyping (see also Chao & Kung, 2015). From this perspective, Fischer's (2011) observation that cultural essentialism increased following a ICT of several weeks cannot serve as evidence of its inherent dark side.

Instead, it may be more helpful to assume that essentialist beliefs emerge as part of learning about other cultural groups – and one's own. They allow students to identify coherent patterns in the behavior of members of other groups; they are also being sensitized to patterns in behavior and experience that they share as members of their own cultural group. This, however, has the potential to inspire awareness and critical reflection of how oneself is a product and "carrier" of one's cultural heritage – an awareness that all theorists deem to be a critical component of intercultural competence (e.g., Earley & Ang, 2003; Sue et al., 1992; Sue, 1998).

Moreover, the discovery that other cultures are at least in certain aspects different from one's own can be understood as evidence of a conscious incompetence – an awareness of difference that is not yet accompanied by students being able to bridge this difference. Indeed, Fischer (2011) observed that, by the end of the training, students' cognitive and metacognitive CQ had decreased, consistent with the idea that "students realized[d] their limits in terms of intercultural competence." As Ang et al. (2015) highlighted, Fischer's ICT may have presented cultural differences as daunting, but not provided sufficient opportunity to engage in the four-step of experiential learning, in which participants also have the opportunity to engage with those who are culturally different and try out different ways of relating to them.

At the same time, there is no doubt that cultural trainings *can* reinforce stereotyping (e.g., Buchtel, 2014). When ICT targets cultural differences within one's own society (e.g., those marked by racial or ethnic differences), students might become defensive, especially when a discussion of specific cultural groups casts some as the proverbial "good guys" and "bad guys." This type of discussion evokes a sense of threat and can prompt students to take sides. Such divisions can only be overcome by highlighting that, in spite of the reality of cultural differences, many similarities exist (Bennett, 2014). Moreover, it may be important to highlight the variability that exists within each group, including the fact no one is only a member of a single cultural category. Again, as part of ICT, concrete experiences with members of a culturally different group often disconfirm stereotypic expectations (Rosenblatt et al., 2013; Wolsko, Park, Judd, & Bachelor, 2003). More generally, it appears that experiential methods, whether in the within-classroom simulation or interactions with members of different cultural groups outside of the classroom, are less prone to such challenges.

ICT and False Competence

Another challenge to the effectiveness of ICT comes from students feeling a false sense of competence (Brown, 2009; Chao et al., 2011). Having gone through a training, individuals might feel that they know everything they need to know. Especially in the clinical sciences, there is good evidence that self-assessments of intercultural competence may not coincide with more objective assessments (e.g., Cartwright et al., 2008). Even when ICT trainings try to harness as sense of self-efficacy with regard to intercultural interactions, any tendency to apply "knowledge without critical self-awareness" (Chao et al., 2011) can be seen as contradicting the goal of an ICT, at least those focused on intercultural competence within a multicultural context. Virtually all approaches to the topic of intercultural competence highlight the importance of practicing an awareness of one's own culturally rooted assumptions, expectations, and preference and question them. In this sense, any training toward intercultural competence must always be aimed at cultivating a sense of cultural humility – even when previous authors have tended to distinguish these concepts (Hook et al., 2013; Tervalon & Murray-Garcia, 1998).

Conclusion

Only a few years ago, Mendenhall et al. (2004) described the success record of ICT as "mixed." Surely, the benefits of intercultural competence training have been at times exaggerated, strong claims have been advanced without much robust evidence, and sometimes authors have even argued that the effect of intercultural competence cannot be documented with established research methodology (e.g., Sue, 2003). Yet, at the present time, there exist persuasive demonstrations that intercultural competence has objectively positive implications (e.g., Leung et al., 2014; Owen et al., 2016). Especially the organizational literature has demonstrated that it can be trained effectively using experiential methods (e.g., Eisenberg et al., 2013; Erez et al., 2013; MacNab, 2012; Rosenblatt et al., 2013). This does not imply, of course, that all approaches will always work, nor does it mean that any unintended negative effects will entirely disappear. Rather, the question to ask might be: Given that acquiring and practicing intercultural competences are important, which training is most beneficial for whom under what circumstances?

Answers to this question are few and far between. For instance, in the case of predeparture trainings aimed at preparing managers for overseas assignments, the literature has documented some abject failures (e.g., Puck, Kittler, & Wright, 2008). It appears that even well-intended trainings might not yield benefits when they do not have the buy-in from participants, or if participants are not entirely clear what support they will require – if any. Consistent with the idea that most cultural learning is experiential and occurs on the job, international corporations, such as McDonalds®, have shifted from predeparture classes to post-arrival support, when expats have a clearer sense of their own training needs (Morris et al., 2014). In other words, the classical model based on which training is supposed to occur *prior* to students encountering the reality for which they are being trained for may not necessarily be appropriate when it comes to the acquisition of intercultural competence.

Likewise, one wonders whether Owen et al.'s (2016) critical finding – a link between a client's perceptions of her therapist's cultural humility and psychotherapy outcome – is really driven by ICT (see also Tao et al., 2015). Contemporary psychotherapy training involves therapists being self-aware and paying close attention to their client's issues. However, much of these skills will be practiced and applied regardless of whether the client is a member of a different cultural group or not. This does not deny that the training should attend to matters of culture and diversity; yet, one wonders whether separate educational requirements, such as diversity classes, are most productive and will translate into a perception of cultural competence on the part of the client. This does not call into question the need for clinicians to become interculturally competent. Rather, the question that is unanswered to date is whether the type of ICT that many applied clinical psychologists are receiving translates into an objective benefit, and if not therapists in training are learning more from direct interaction with a culturally diverse clientele.

Research has also demonstrated that students who score higher on trait open-mindedness (e.g., Fischer, 2011) or who seem more engaged in the class (e.g., Buchtel, 2014) exhibit more favorable training results. With the existing research being primarily based on volunteers (often students who deliberately chose a cross-cultural management or cultural psychology course), results might have been positively biased. Training might even backfire when students are not engaged (Buchtel, 2014) or when they experience the training as an attempt to be reformed against their will (e.g., Whitehead & Wittig, 2004). If one accepts that there is a societal need for intercultural competence (e.g., Morris et al., 2014), and if one even assumes that students disinterested in culture are least likely to have it, the most formidable challenge will be to "motivate the unmotivated" (cf. Hidi & Harackiewicz, 2000). From this perspective, enhancing motivational aspects of intercultural competence might be critical if the goal is to increase intercultural competence across many strata of society.

At the present time, we suspect that experiential approaches, such as the one proposed by MacNab (2012), are most likely to engage these students. Interacting with those who are culturally different has the potential to produce surprises, and trigger situational interest, where there may have been little intrinsic interest before. Yet, there is a clear need for more research to put these ideas to an empirical test.

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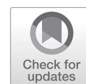

26 Cultural Competence: A Form of Stereotype Rationality

Sean T. Stevens, Lee Jussim, Lillian A. Stevens, and Stephanie M. Anglin

As societies become more diverse, interactions among people from varied backgrounds will likely benefit from increased cultural competence so that individuals can more readily understand, empathize, and communicate with one another. Although there are many definitions of cultural competence (e.g., Campinha-Becote, 2002; Cross, Bazron, Dennis, & Isaacs, 1989; Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000), most emphasize the need to understand one's own culture, an awareness of cultural differences, and an understanding that there is also likely a wide variation among individuals within a given culture. Although research on cultural competence initially emerged from concerns over the inadequacy of healthcare and education services available for ethnic minority groups (Cross et al., 1989; Delpit, 2006; Schim & Miller, 1999; Sue, 1998), as globalization progresses and as any population becomes more racially, ethnically, and culturally diverse, skill at understanding and navigating such differences becomes increasingly more important.

Terms like "skill" or "competence" are synonymous with being good or successful at something. Thus, cultural competence involves some sorts of skill(s). In this chapter, we argue that one central component of such competence is accuracy. Understanding diverse cultures implies *accurately* understanding those cultures. Cultural competence, in this view, requires that anyone whose work puts them into sustained contact with individuals who are different from themselves, hold beliefs about people from different racial, ethnic, and/or cultural groups that are generally true. Furthermore, *deploying* those understandings in a competent manner also requires another set of understandings: that cultural generalizations do not uniformly apply to all members of any ethnic or cultural group, that individual differences are usually vast, and that, therefore, one cannot mindlessly assume all individuals perfectly fit even an accurate understanding of their cultural background.

Cultural competence, therefore, requires *accuracy* in perceiving cultural groups and their individual members. To us, this is tantamount to a call to increase (1) stereotype accuracy and (2) sensitivity to individual differences.

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These two issues have a long history of scientific research behind them in social psychology. Quite a lot is now known about the (in)accuracy of stereotypes and also about the interplay of stereotypes and sensitivity to individual differences. This chapter takes the perspective that a high level of cultural competence implicitly includes stereotype rationality. That is, cultural competence requires reasonable and rational use of stereotypes when individuating information is absent, scarce, or irrelevant (see, e.g., Fox, 1992) *and* the use of and reliance on relevant individuating information when it is available.

However, it is also clear that the very idea that stereotypes may be accurate and function approximately rationally is anathema to many social scientists (for reviews, see Jussim, 2012; Jussim, Crawford, & Rubinstein, 2015a). Therefore, before connecting stereotype rationality to cultural competence, this chapter first briefly reviews some of the moral and scholarly obstacles that have led social and applied psychologists to resist accepting their own data on stereotype accuracy.

Stereotype (In?)Accuracy

Everyone "knows" that stereotypes are inaccurate, so aren't we barking up the wrong tree by even attempting to link stereotype accuracy to cultural competence? If stereotype accuracy is an oxymoron, an empty set because stereotypes are "inaccurate," won't any attempt to link stereotype accuracy to cultural competence be doomed to failure from the start? To address these questions, we first briefly review some of the reasons stereotypes have such bad reputations. Before proceeding, however, we clarify what we mean by stereotype accuracy and how we define stereotypes.

We contend that only descriptive or predictive beliefs about a group can be assessed for their accuracy. The accuracy of a belief such as "rich people vote for Republicans" can be evaluated; the accuracy of "I don't like people who vote for Republicans" however cannot be evaluated in the same way, even if it is psychologically important. Additionally, one cannot evaluate the accuracy of a stereotype when it resembles a prescriptive belief such as "men should not wear dresses." This is because prescriptive beliefs represent notions or opinions about how things should be and thus cannot be evaluated for their accuracy.

Thus, we define stereotypes as *beliefs about the attributes of social groups*. This definition identifies stereotypes as one kind of generalization, that is, subject to exceptions as no generalization will ever be 100% accurate. Jussim (2012) previously suggested that accuracy can be assessed in two different ways – discrepancies from perfection and correspondence with reality. Accurate discrepancies from perfection can be either bull's eyes, or judgments within 10% of perfection, and near misses, judgments between 10% and 20% of perfection. A high degree of accurate correspondence of a stereotype with reality is indicated by a correlation of 0.40 or higher, a value double the typical effect size obtained in most social psychological studies (see Richard, Bond, & Stokes-Zoota, 2003) and one that corresponds to being right about 70% of the time (see Rosenthal, 1991). A moderate degree of correspondence is indicated by a correlation between 0.30 and 0.40, meaning the judgment is accurate about two-thirds of the time (Rosenthal, 1991).

Furthermore, we contend that stereotypes may or may not:

1. Be accurate and rational
2. Be widely shared
3. Be consciously applied
4. Be rigid and resistant to change
5. Exaggerate real group differences
6. Lead people to assume group differences are essential or biological
7. Cause or reflect prejudice and discrimination
8. Cause biases in person perception and result in self-fulfilling prophecies
9. Play a major role in some social problems

This definition allows for a stereotype to be accurate or inaccurate and thus turns the issue of accuracy into an empirical question.

Are Stereotypes Inherently Bad?

In contrast to the definition offered above (for similar definitions, see Ashmore & Del Boca, 1981; Judd & Park, 1993; Ryan, 2002), much of the research on stereotypes has approached them like a social disease. Chen and Bargh (1997) concluded that "research has shown many ways in which stereotypes, *like a dangerous virus*, can survive and perpetuate themselves despite attempts to eradicate them" (p. 557, emphasis added). Stereotypes are routinely defined or characterized as inaccurate or as exaggerations with only a tiny "kernel of truth" (Allport, 1954/1979; see recent reviews by Jussim, 2015a; Jussim et al., 2016). Stereotypes are often associated with prejudice and discrimination, and considered either sources of social inequality and oppression, or tools to justify and rationalize such social ills (e.g., Fiske, 1998; Jost & Banaji, 1994; Plous, 2003; Stangor, 1995). Consequently, many articles contend that stereotypes must be overcome, prevented, or stopped (e.g., Devine, 1989; Fiske & Neuberg, 1990). Worse still, both high- and low-prejudice individuals are equally knowledgeable of cultural stereotypes, which are often activated automatically, in ways that are outside of awareness (Devine, 1989). In other words, if allowed free reign, stereotypes cause a wide range of evils, distortions, and social problems.

For all these reasons, social psychologists have understandably approached stereotypes as a kind of social toxin. Perhaps equally understandable, but scientifically untenable, is the corresponding belief that because stereotypes contribute to these many malignant outcomes, they must also be – in the main – inaccurate. The tacit equation is, if stereotypes are associated with social wrongs, they must be factually wrong. However, the accuracy of stereotypes is an empirical question, not an ideological one. And for those of us who care deeply about stereotypes, prejudice, and social harmony, getting to the truth of these collective cognitions should guide inquiry about them.

The Black Hole at the Bottom of Most Declarations that Stereotypes Are Inaccurate

The claim that stereotypes are inaccurate has become so widely accepted within the social sciences that it is often made without reference or citation to any relevant empirical findings. Even when citations are provided, they usually refer to a paper that declares stereotypes inaccurate itself without providing any empirical evidence supporting the claim. This has occurred even though, in science, the convention is to support empirical claims with evidence.

For example:

> Journalist and political commentator Walter Lippmann, who coined the term (of stereotypes), made a distinction between the world "out there" and the stereotype – the little pictures in our heads that help us interpret the world we see. To stereotype is to allow those pictures to dominate our thinking, leading us to assign identical characteristics to any person in a group, regardless of the actual variation among members of that group. (Aronson, 2008, p. 309)

This implies that people assign *identical* characteristics to *any* person who is a member of a group and that any individual perceiver may assign such characteristics to an individual. This is an extreme claim, and Aronson (2008) does not provide any citations to support such a claim. Simply put, in almost 100 years of empirical research on stereotypes and person perception, there is not a single study or shred of evidence that there is even one person who believes all members of a group have identical characteristics:

> The term stereotype refers to those interpersonal beliefs and expectancies that are both widely shared and generally invalid. (Ashmore & Del Boca, 1981) (Miller & Turnbull, 1986, p. 233)

Miller and Turnbull (1986) provide a citation, to Ashmore and Del Boca (1981). However, Ashmore and Del Boca (1981) did not review previous definitions of stereotypes, nor did they provide empirical evidence about stereotype accuracy. Ashmore and Del Boca's (1981) conclusion was concerned

with the idea that stereotypes were best characterized as "beliefs about the personal attributes of a social group (p. 21)."

Finally, even the American Psychological Association (APA, 1991) has been pulled into this black hole. They declare that:

> Stereotypes 'are not necessarily any more or less inaccurate, biased, or logically faulty than are any other kinds of generalizations, Taylor, *supra* note 11, at 84, and they need not inevitably lead to discriminatory conduct. (p. 1064)

They then declare the following:

> The problem is that stereotypes about groups of people are often *overgeneralizations and are either inaccurate or do not apply to the individual group member in question*. (Sex Bias in Work Settings, *supra* note 11, at 271 (emphasis in original) (p. 1064)

When a person, persons, or an organization evaluates the rationale for first declaring stereotypes to be not necessarily inaccurate and then immediately follows that declaration with a claim that stereotypes are either inaccurate or inapplicable is beyond the scope of this chapter. The APA, however, does include a reference to an article by Heilman (1983), which does declare stereotypes to be inaccurate, and also reviews evidence of bias and discrimination. But, it neither provides nor reviews empirical evidence of stereotype accuracy (for more examples see Jussim, 2012).

Thus, like most other declarations of stereotype inaccuracy, these examples end in a black hole (for numerous examples of this point, see Jussim, 2012; Jussim, Crawford, Stevens, & Anglin, 2015b; Jussim et al., 2016). This state of affairs runs counter to one of the most widely accepted conventions in science – that one's claims about the state of the world should be driven by data and supported by empirical evidence. More important than "convention violation," however, is that this state of affairs means that the abundant *declarations* that stereotypes are inaccurate are itself based, not on flawed science but on *no science at all*. Before showing that such evidence does not exist, however, we first address logical problems inherent to defining stereotypes as inaccurate.

The Illogic of Defining Stereotypes as Inaccurate Given the frequency with which stereotypes are assumed to be bad and inaccurate, both in the popular culture and the social scientific literature, the first order of business is to define "stereotype." What do researchers mean when they define stereotypes as inaccurate or declare them to be inaccurate? The accuracy issue becomes "settled" if stereotypes are defined as inaccurate. In this section, we explain why a more agnostic approach is needed.

First, let's take definitions. Researchers have a great deal of leeway with respect to how they define their constructs. However, once they do so, they are then required to accept the implications of their own definitions.

As noted above, only descriptive statements can be accurate or inaccurate. "Rich people vote for Republicans" can be evaluated for accuracy; the accuracy of liking or disliking Republicans cannot (just as the accuracy of liking/disliking bananas cannot). Stereotypes as prescriptive beliefs, too, cannot be evaluated for their accuracy. Accuracy is irrelevant to notions such as "men should not wear dresses." Therefore, if one defines stereotypes as "inaccurate," one cannot logically include anything *other* than descriptive or predictive statements (and beliefs about such statements) as "stereotypes."

Any labeling of stereotypes as inaccurate (which is included in definitions of stereotypes) must therefore refer to descriptive or predictive beliefs. What, then, are the implications of labeling such stereotypes as inaccurate? That depends on exactly what this definition means. It might be that "all beliefs about all groups are stereotypes, and all are inaccurate." This definition requires concluding that it is inaccurate to believe two groups differ and inaccurate to believe they do not differ. This is logically impossible, so this meaning of "stereotypes are inaccurate" can be dismissed out of hand. All beliefs about all groups cannot possibly be inaccurate.

Alternatively, it might mean, "Not all beliefs about groups are inaccurate, but stereotypes are the subset of beliefs about groups that are inaccurate." According to this variation, beliefs that

are accurate are *not* stereotypes; only inaccurate beliefs about groups are stereotypes. This, however, also needs to be dismissed, unless one is willing instead to dismiss the vast body of research on stereotypes. That is because we are aware of no research – not a single study – that has been framed as follows:

> *Is THIS SPECIFIC belief about THIS SPECIFIC group a stereotype? We are going to figure out whether THIS SPECIFIC belief about THIS SPECIFIC group is a stereotype by assessing whether that belief is inaccurate. If THIS SPECIFIC belief is inaccurate, we will conclude that it is a stereotype. If THIS SPECIFIC belief accurately described THIS SPECIFIC group, we will conclude that it is not a stereotype.*

Absent an a priori demonstration that a belief about a group is inaccurate, the researcher cannot know that a stereotype is under study. No research framed as studying inaccurate stereotypes includes such an a priori demonstration. If one does not know that one is even examining a stereotype, the results, no matter what they are, cannot be known to reveal anything about a stereotype. Thus, anyone subscribing to such a definition cannot also review any empirical studies that constitute research on "stereotypes" because no such research can be known to exist, if one accepts this definition.

Thus, given our definition of stereotypes (see above), we therefore conclude that: (1) Defining stereotypes as inaccurate is logically incoherent because such a definition implies that all beliefs about groups are inaccurate. Thus, believing that two groups differ is inaccurate, while believing that two groups do not differ is also inaccurate. (2) If we accept that stereotypes are not simply beliefs about groups, and instead are the subset of beliefs about groups that are inaccurate, then one is required to demonstrate that a specific belief about a group is inaccurate before it can be declared a stereotype. Thus, declaring stereotypes to be empirically inaccurate is unjustified whenever scholars do so without reference to actual empirical studies demonstrating inaccuracy (which is almost all of the time, see above). These problems are readily solved by *not* defining stereotypes as inaccurate, and our preferred definition (see above), first proposed by Ashmore and Del Boca (1981), neither presumes nor precludes (in)accuracy.

Obstacles to Acknowledging That Stereotypes Are Not Inherently Inaccurate There may be many reasons for the persistence of stereotype inaccuracy claims (see Jussim, 2012). One strong contender is the motivation to combat social problems such as prejudice and inequality. Pervasive claims of pervasive stereotype inaccuracy appear to primarily stem from concerns about rationalizing prejudice and inequality (e.g., Fiske, 1998; Jost & Banaji, 1994; Stangor, 1995). Emphasizing the inaccuracy of stereotypes removes any "blame" from the target group and instead identifies the perceiver who employs stereotypes in social perception as an intentional or unintentional villain. Acknowledging the potential for stereotype accuracy risks being seen as "blaming the victim" – which is a bad thing to do because it means we have callously joined the oppressors and perpetrators of injustice.

Of Mice and Stereotypes When mice are used as research subjects, a set of rules and regulations requires scientists to treat them as morally and humanely as possible. For instance, mice need to be kept in clean cages and fed on a regular schedule, unless of course one is studying the effects of hunger. Although, with good reason, mice can be sacrificed for scientific purposes, they cannot be sacrificed gratuitously. Yet, under different circumstances, the same rights would not be granted to the same mouse (Herzog, 1988). If a researcher employs snakes as a research subject, rules and regulations would require they be treated as morally and humanely as possible. They would require clean cages and feeding schedules. Snakes prey on and eat mice. Thus, in this scenario the mouse is food and has no rights as a research subject. What does this tangent have to do with stereotypes and cultural competence? In both cases when one changes the context, the moral interpretation changes.

Taking group differences seriously is often viewed as morally offensive, if we are discussing stereotypes. But taking those same group differences may be viewed as justified and even beneficial in other contexts. For example, cultural psychology contains a plethora of findings documenting differences between groups and culture. East Asians are more "collectivist" than "individualistic" Western Europeans and Americans (Markus & Kitayama, 1991) and also think in fundamentally different ways than Westerners (Norenzayan & Nisbett, 2000). Sociologists discuss differences between cultures of honor, dignity, and victimhood (Campbell & Manning, 2014). Demographic statistics such as life expectancy, birth rates, and fertility rates are often cited in discussions of health policy (Murray & Lopez, 2006), and there is widespread support for promoting knowledge about groups across many professional settings (Cross et al., 1989; Delpit, 2006; Schim & Miller, 1999; Sue, 1998).

In a similar vein, social and personality psychologists rely on "known-groups" validity (Cook & Campbell, 1979) when validating a new questionnaire. For instance, religious leaders (e.g., priests, rabbis, imams) should score higher on measures of religiosity than atheists or agnostics; and Whites should show more prejudice toward Blacks on all sorts of measures than African-Americans. Validity – one of the core, essential ingredients of psychological research – takes for granted that groups differ in many ways and uses that knowledge in the service of advancing science.

Thus, context influences whether it is socially acceptable to take group differences seriously. When one is discussing stereotypes, prejudice, and oppression, it is often unacceptable to discuss the accurate perception of group differences, particularly demographic group differences. Examples of this include Google engineer James Damore, who was fired for a memo he wrote and shared internally that discussed the possibility of biological influences on gender differences in preferences and abilities, and Larry Summers who resigned as the President of Harvard after controversy erupted because he suggested the greater male variability hypothesis (see Halpern et al., 2007; Hyde & Mertz, 2009) may explain the lower percentage of women (compared to men) in STEM fields (for a more in-depth discussion of Damore's memo and the greater male variability hypothesis, see Stevens & Haidt, 2017a, 2017b). Yet, in other contexts, e.g., when one is validating a measure using known-groups validity or when one is trying to advance cultural understandings, taking group differences seriously is not merely acceptable, it is encouraged.

Conceptual Overlap Between Cultural Competence and Stereotype Accuracy

Cultural Competence

Cultural Competence can be viewed as an ability to understand cultural diversity and to demonstrate an awareness and sensitivity to difference (Schim & Miller, 1999). In other words, *culturally competent* individuals possess an accurate awareness of their own culture and accurate knowledge about the different cultural groups with whom they work. This allows them to productively apply specific techniques and strategies when interacting with people from different cultural backgrounds (Sue, 1998).

Research on cultural competence stemmed, in part, from concerns within the healthcare industry about cultural and linguistic mismatches between practitioners and patients (e.g., Comas-Diaz & Griffith, 1988; Jenkins, 1985; LeVine & Padilla, 1980; Trimble & LaFromboise, 1985). Some scholars suggest that these mismatches can negatively impact the validity of assessment and impede the development of a rapport between the practitioner and patient (Sue, 1998). Ethnic matching between practitioner and patient/clients has often led to better treatment and outcomes for a wide variety of groups in a wide variety of contexts (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995; Yeh, Takeuchi, & Sue, 1994). Similar concerns about cultural mismatching are also prevalent in teacher-student interactions in education (Delpit, 2006; Erickson, 1975; Sue et al., 1991; Takeuchi et al., 1995; Yeh et al., 1994).

Stereotype Accuracy

Accuracy is quantitative and probabilistic, not absolute. It refers to correspondence between belief and criteria (Funder, 1987, 1995; Jussim, 1991, 2005, 2012). As such, accuracy questions are fundamentally about how close the content of people's beliefs are to a criterion or set of criteria, *not* the processes of social perception. Thus, declaring a stereotype to be moderately, or even highly, accurate does not preclude the possibility that it also contains errors and biases that distort the process of person perception.

A culturally competent individual is an accurate social perceiver. This individual possesses knowledge about *other* cultures and how these *different* cultural backgrounds can produce *differences* in behavior. Thus, calls for increased cultural competence represent calls for more *accuracy* in the perception of *real group differences*. Therefore, a culturally competent individual is one who possesses valid knowledge about cultural group differences, but who also makes use individuating information (relevant information unique to each individual) when it is available.

A review of the empirical evidence suggests that considerable cultural knowledge is relatively common. Many studies have assessed the accuracy of the racial and ethnic stereotypes held by student and nonstudent samples (see Jussim, et al., 2015a, for a review). Although none have found people are perfectly accurate, most find moderate-to-high levels of accuracy (Ashton & Esses, 1999; Kaplowitz, Fisher, & Broman, 2003; McCauley & Stitt, 1978; Ryan, 1996). When inaccurate, research often finds that people underestimate (Kaplowitz et al., 2003; McCauley & Stitt, 1978; Wolsko, Park, Judd, & Wittenbrink, 2000) rather than exaggerate real differences. Similar patterns have been found for many other stereotypes, such as gender stereotypes (Briton & Hall, 1995; Cejka & Eagly, 1999; Diekman, Eagly, & Kulesa, 2002; McCauley & Thangavelu, 1991; McCauley, Thangavelu, & Rozin, 1988; Swim, 1994), and stereotypes of college majors, occupations, sororities, and jazz vs. modern dancers (Cejka & Eagly, 1999; Clabaugh & Morling, 2004; Judd, Ryan, & Park, 1991).

These studies typically employ a methodological approach where subjects are asked to assess a group or a variety of groups on some criterion or criteria. These assessments are then compared against data on the group or groups measured (for a review of this methodology, see Jussim, 2012). For instance, Ashton and Esses (1999) assessed the accuracy of beliefs about differences in academic achievement in Canada among nine different ethnic groups in Toronto. Subjects were asked to estimate high school grades for members of each group, using the grading scale used throughout Canadian high schools. Judgments were compared against the average grades published by the Toronto Board of Education. Subjects indicated near bull's eye level accuracy for almost all of the nine ethnic groups.

Political stereotypes, however, appear to represent an exception to this pattern of underestimating real differences between groups. Such stereotypes tend to accurately identify differences between rival political groups on policy positions (Chambers, Baron, & Inman, 2006; Chambers & Melnyk, 2006) and moral values (Graham, Nosek, & Haidt, 2012). However, political stereotypes often *exaggerated* these group differences (Chambers et al., 2006; Chambers & Melnyk, 2006; Graham et al., 2012; see also Crawford, Modri, & Motyl, 2013; Dawes, Singer, & Lemons, 1972; Judd & Park, 1993; Keltner & Robinson, 1996; Robinson, Keltner, Ward, & Ross, 1995). The exaggeration of political group differences appears to be particularly pronounced among activists who strongly identify with their political groups and those whose own views are more extreme (e.g., Chambers et al., 2006; Chambers & Melnyk, 2006; Westfall, Van Boven, Chambers, & Judd 2015). For instance, Chambers and Melnyk (2006) reported that pro-choice activists, who identified women's reproductive rights as a core value issue, exaggerated the difference between their positions on women's reproductive rights and those of pro-life activists. Likewise, pro-life activists, who identified the value of human life as a core value issue, exaggerated the difference between their positions and the positions of pro-choice activists. The extent of exaggeration was

strongest among those individuals who most strongly identified with a political group (see also Chambers et al., 2006).

These political findings could be relevant to cultural competence. When individuals believe that their groups are in political conflict with another ethnic, cultural, or national group, their stereotypes may tend to exaggerate real differences. Although such a pattern is plausible, no empirical research has directly tested this question. However, we speculate that political conflict may undermine the accuracy of stereotypes held by individuals whose cultural groups are in conflict and hinder the development of cultural competencies.

Cultural Competence as Stereotype Rationality

Cultural competence quickly becomes important when interacting with individuals from different backgrounds, as do doctors with patients, employers with employees, and teachers with students. In professional fields where calls for increases in cultural competence have occurred, such as education and healthcare, the rejection of a one-size-fits-all approach in favor of individualized approaches that account for *real differences* between groups and individuals results in greater success on a variety of outcomes (Ammar & Spada, 2006; Bruce, Sims, Miller, Elliott, & Ladipo, 2007; Rogers & Soyka, 2004; Todtling & Trippl, 2005). Teachers may leverage their knowledge of students' zones of proximal development (Vygotsky, 1978) to deliver more nuanced specific instruction based on their understanding of the learners' needs. Likewise, healthcare research has encouraged the investigation of group-specific processes related to different demographic categories such as race and gender to understand the etiology of illness and to make better treatment recommendations (Bruce et al., 2007).

In this section, therefore, we consider the evidence that bears on how and when people apply their knowledge about groups to their judgments of individuals. Do people judge others primarily on the basis of stereotypes or are they sensitive to individual differences?

The Rational Application of Stereotypes

The rational application of stereotypes involves using them cautiously in most cases and jettisoning one's reliance on them when relevant individuating information becomes available (see Jussim, 2012). That stereotypes associated with race/ethnicity and gender often correctly approximate group differences *and* underestimate them suggests that even when employing stereotypes, people often do so cautiously. They do not typically leap to extreme judgments about groups. The cautious and judicious application of cultural stereotypes sounds a lot like cultural competence. It combines the *accurate* recognition of group differences with a sensitivity to the high degree of variability in individuals' abilities, characteristics, and personalities. These points raise an empirical question: How well do people correspond to this ideal?

A common claim is that stereotypes lead people to "ignore individual differences" (see Jussim et al., 2015a, b for a review). If this were true, it would certainly constitute evidence of unjustified stereotyping. Does the evidence indicate people ignore individual differences?

Some evidence has often been misinterpreted as indicating that it does. Across a wide range of stereotypes, in the absence of individuating information, or in the presence of ambiguous individuating information, stereotypes do influence people's judgments of individuals. Such effects are indeed evidence of bias. Under conditions without individuating information or with ambiguous individuating information, people judge individual men to be more assertive than individual women, students from lower social class backgrounds to have lower academic achievement than those from more privileged backgrounds, and Democratic politicians to be more liberal than Republican politicians

(e.g., Crawford, Jussim, Madon, Cain, & Stevens, 2011; Darley & Gross, 1983; Locksley, Borgida, Brekke, & Hepburn, 1980).

Such findings, though revealing bias in person perception, are not evidence of people "ignoring individual differences." If studies present no individual differences, then there are no individual differences to be ignored. Even if studies hold individual differences constant in order to experimentally examine effects of stereotypes, they cannot assess whether people ignore or rely on those differences. Experiments cannot test the effects of factors that are held constant; they can only test the effects of manipulated variables (i.e., variables that actually vary).

Overall, therefore, research that examines the role of stereotypes in person perception without individuating information or with ambiguous individuating information held constant often finds evidence of bias in person perception. Nonetheless, this is reasonably rational and constitutes people doing as well as they can under uncertainty. Stereotypes, like other categories, are often relied upon when there is little or no other useful information. Just as it is reasonable to predict that any particular daily high temperature is lower in Anchorage than in Akron if one has no direct daily temperature information, it is similarly reasonable to predict that a person from Mississippi is more religious than one from Massachusetts if one has no direct information about either's religiosity.

To test whether people ignore individual differences, experimental research must actually manipulate those differences. Nonexperimental research, too, can examine this question by, e.g., assessing the relationship of individual differences in the real world (which almost always are highly variable) to person-perception judgments. What, then, has been found by research that has actually been capable of testing whether stereotypes lead people to ignore individual differences? It has found they do not ignore individual differences. When individuating information is available, people rely on it so heavily that it is one of the largest effects in all of social psychology (Jussim et al., 2015b; Kunda & Thagard, 1996). People perceive assertive targets as more assertive than passive targets, regardless of whether those targets are male or female, and they perceive students with histories of high grades and standardized test scores as performing at higher levels and having higher ability than those with histories of low grades and standardized test scores, regardless of those students' race/ethnicity, gender, or social class (see Jussim, 2012, for a review). Furthermore, when individuating information is clear, relevant, and available, most studies find that people's reliance on stereotypes is small to nonexistent both in the laboratory and real world contexts such as classrooms (Jussim, 2012; Jussim et al., 2009; Kunda & Thagard, 1996).

So, rather than stereotypes leading people to ignore individual differences, the empirical pattern is almost completely opposite. *Clear, relevant individual differences lead people to (mostly) ignore their stereotypes.* The evidence from the stereotype and person-perception literature strongly suggests that people often function in a manner that is approximately rational and which approaches recommendations for cultural competence (understanding differences between groups, while being sensitive to individual differences). They generally use whatever information is most available and useful to them when making a prediction or judgment about another person's behavior. If a stereotype is available and useful, they will usually use it; if individuating information is available and useful, they will use it.

It is reasonable and rational to use stereotypes under many circumstances. In the absence of individuating information, when such individuating information is perceived as irrelevant, and when it is scarce (see Fox, 1992), people have little else to go on besides the stereotype. The rationale for believing doing so is unjustified derives primarily from the false presumption that stereotypes are inaccurate. But once one accepts that many stereotypes are reasonably accurate, relying on them in the absence of useful individuating information is manifestly rational.

Limitations

Of course, there are also many limitations to the perspective presented here. We have focused quite narrowly on striking similarities between cultural competence and stereotype accuracy. However, there are also striking differences too. Cultural competence can be viewed as a subset of stereotype accuracy because stereotypes can be about any type of group. With respect to the range of skills included, however, stereotype accuracy is also a subset of cultural competence, because competence includes a wide variety of interpersonal skills, not just accuracy.

Furthermore, our perspective has not addressed prejudice or discrimination. One can perceive a group accurately and still despise them and discriminate against them. The extensive evidence we have reviewed on stereotype accuracy and rationality does not preclude the possibility of prejudicial attitudes or and discriminative actions. It would be a major mistake to interpret this chapter as arguing that discrimination is a thing of the past and that oppression and inequality do not exist or are trivial. This chapter has not addressed those issues. To the extent that encouraging cultural competence has the goal of reducing prejudice in applied psychologists, this chapter has been largely irrelevant. Given that people generally are more attracted to those who are similar to them (Byrne, 1961), it is even possible that high stereotype accuracy in perceptions of group differences would increase prejudice. Overall, however, the evidence is that stereotypes and prejudice are only weakly related (Park & Judd, 2005).

In addition, this chapter has reviewed the evidence that, for most of the stereotypes examined, the people studied have generally been fairly accurate. However, disproportionately, those people have been college students (although a substantial minority of studies have also examined nonstudent samples) in North America. It is possible that relatively educated samples are disproportionately likely to be informed about group differences. Given a wide range of differences between Western samples and other people (Henrich, Heine, & Norenzayan, 2010), perhaps less educated and less western samples hold less accurate stereotypes.

Last, although accuracy has been assessed among a wide variety of stereotypes, there are many that have not been studied. It is possible that many unstudied stereotypes are far less accurate than the ones reviewed here. If so, people's overall levels of cultural competence may not be quite as strong as our review of stereotype accuracy seems to suggest. However, at least when conflict and prejudice do not interfere, the evidence reviewed here strongly suggests that, even when initially ignorant about a specific group, overcoming that ignorance may not be particularly difficult. People seem to be fairly well-attuned to learning about group differences.

Implications for Applications

Our perspective suggests that cultural competence interventions are likely to be effective if several conditions are met. First, prejudice and conflict levels between those undergoing training and those they are being trained about should be low. Second, the training should not unintentionally increase prejudice or conflict – which it can easily do if it frames the need for such training in an accusatory manner, implying that those being trained suffer some sort of deficiency and/or are somehow responsible for others' disadvantages (e.g., Moss-Racusin et al., 2014). Third, such training should emphasize that it is reasonable for thoughtful people to be informed about real group differences. At the same time, however, such programs should also emphasize the importance of *not* assuming all or most members of some group share any particular cultural attribute, and encourage a sensitivity to individual differences, not just group differences.

Conclusions

Social and applied psychologists cannot continue to have it both ways. They cannot deny group differences exist when studying stereotypes in order to maintain that stereotypes are inaccurate, but

then embrace the existence of group differences when discussing the need to promote cultural competence or related goals, such as multiculturalism or diversity. It seems odd to, on one hand, encourage people to develop cultural competencies and then, on the other, condemn them for holding supposedly inaccurate stereotypes. This sort of mixed message risks discouraging people from actually developing cultural competencies, if they fear accusations of racism or bigotry because they believe groups may differ. The "stereotypes are inaccurate" message also risks erroneously communicating to earnest people that "differences should not be taken seriously, we are really all the same" (see also, Pinker, 2002). It risks blinding people to real and important differences between groups that might sometimes be very important to understand (e.g., when they are a doctor or teacher).

Group differences are real, many, and varied (Henrich et al., 2010; Jussim, 2012; Stevens & Haidt, 2017a, 2017b). Culturally competent people strive to recognize them and apply their knowledge of them rationally, gently, and flexibly in interpersonal interactions. The accurate identification and documentation of group differences could improve cross-cultural interactions in healthcare, education, and business. Whether we refer to this process as the application of accurate stereotypes or cultural competence, we are encouraging the same end result. People are better at social perception than the social sciences have often suggested. People are, of course, not perfect. However, research to date shows that they often make good use of the typically limited information available to them. Programs to enhance cultural competence could harness this skill by providing people with more substantive information about particular groups while emphasizing the value of sensitivity to individual differences.

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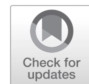

27 Cultural Competence Training in the Context of Civil Liberties, Academic Freedom, and Reverse Prejudice: At Least Do No Harm

William O'Donohue

"Beware that, when fighting monsters, you yourself do not become a monster… for when you gaze long into the abyss. The abyss gazes also into you."

—Friedrich Nietzsche

"It is a fair summary of constitutional history that the landmarks of our liberties have often been forged in cases involving not very nice people."

—Supreme Court Justice Felix Frankfurter

The rationale for cultural sensitivity (CS) training can involve the usual reasons for education regarding any domain, i.e., a presumed lack of knowledge or a presumed lack of key skills thought necessary in order to competently function in some context. Of course, this rationale also brings forth basic questions regarding important specifics concerning this educational aspiration: what exactly are the set of learning outcomes? What exactly is this body of knowledge and skills to be learned? Indeed, a more radical question is: does such knowledge/skills actually exist (e.g., does the field really have the requisite understanding of the Hispanic-American culture or cultures or how to successfully train therapists in relevant culturally sensitive behavior)? Have well-designed studies shown that such knowledge or skills are actually causally related to the desired improved functioning in these professional contexts? How can one effectively teach/transmit such knowledge, and are there student variables that interact with such learning?

Many of these questions previously have been raised by others about cultural sensitivity training (e.g., Benuto & O'Donohue, 2015; Frisby, 2013; O'Donohue & Benuto, 2010) and therefore will not be the focus of this chapter. Instead, this chapter will explore a relatively novel set of questions: does cultural sensitivity impinge on important constitutionally protected civil liberties such as freedom of religion and freedom of speech? The question of the relationship between cultural sensitivity and constitutionally protected individual rights has been insufficiently examined. The constitution does not protect hate speech—but it is an interesting fact that it does protect "insensitive" speech—partly because the judgment of what constitutes insensitive speech or conduct might be relative to political/value positions—e.g., proabortion speech may cause negative reactions/claims of insensitivity to individuals with one set of moral/political beliefs—and antiabortion speech might cause negative psychological states/concerns about insensitivity in individuals with the opposite set of beliefs and values. And these political/value issues can impact professional services—gender,

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abortion, sexuality, religion, morality, poverty, and race relations—many of the hot button political/value issues of the day can be issues that arise in professional services. Clients can be impacted by these; researchers can frame theories and experiments that are related to these; instructors can teach content relevant to these; policy-makers are concerned about these; and prevention scientists are concerned with these.

In addition, but possibly somewhat less concerning, this chapter also examines the question of whether cultural sensitivity training may impinge on academic freedom. Does the cultural sensitivity movement produce a chilling effect on scholarship? Or does it directly or indirectly restrict free scholarly inquiry by the real or threatened sanctions such as being investigated, adjudicated, and possible dismissal that can be associated with claims that insensitive behavior has occurred?

Another important set of relatively novel questions involves what might be called "reverse prejudice." Can cultural sensitivity training, somewhat paradoxically, be, at times, itself based on prejudice by possibly tolerating or transmitting certain "favored" prejudices—i.e., false, insensitive, and stereotypical assertions about majority groups? Are groups like the religious, males, whites, and heterosexuals being characterized accurately, or are problematic generalizations being claimed about them, and therefore are they being treated fairly in cultural competence training? If such reverse prejudice is occurring, is this harmful, or hypocritical, or counterproductive to the ideals of the movement? And if this is the case, what can be done to correct this?

In addition, it is important to note that one aspect of the complexity of negative generalizations regarding the majority is that individuals who have majority status on one dimension (e.g., males) sometimes can have minority status on another dimension (e.g., African-Americans)—a type of what has become known as "intersectionality," but a majority/minority intersectionality that has received little attention. For example, do possibly prejudicial utterances about males by certain radical feminists (e.g., "All males are rapists"; see, e.g., MacKinnon, 1987, although similar concerns can also be raised by the construct of "male rape culture") pertain to these minority males also, or are all such comments somehow restricted to only for what might be called "majority intersectionality"—white, heterosexual males? Are such pejorative allegations deemed unproblematic when applied to majority group members but only seen as problematic when applied to males who are also minority group members? Or are these prejudicial statements, when fairly and objectively viewed, even more problematic because these feed into and reinforce certain pernicious stereotypes such as black males being "oversexed" and preying on white women? Are these also pernicious because this movement then is not associated with a thoroughgoing commitment to reduce all prejudice and discrimination but devolves into a movement where certain favored prejudices are overlooked and in which a partisan identity politics occurs—in which each group advocates for its own interests? Has this asymmetry been properly recognized in extant cultural sensitivity training? If this is not the case, what can be done in a better, more consistent, and more thoroughgoing approach to cultural sensitivity training that remediates these problems with reverse prejudice?

Cultural Sensitivity Training and Constitutionally Protected Civil Liberties

It is interesting to reflect that in a fundamental way cultural sensitivity is directly related to civil liberties: at its core it attempts to ensure that discriminated individuals who often have some sort of minority status can enjoy the same rights and opportunities as majority group members. This is clearly a laudable goal. It also is a goal that certainly ought to have differential priorities as some groups have experienced, and continue to experience, more prejudice and discrimination than others. For example, the Irish in America were subject to significant discrimination in the

1900s but little if any in the twenty-first century. It also ought to take a psychological approach to these problems: what conditions result in what effects and how can negative effects be avoided and positive effects be promoted?

In the United States, a series of federal laws have been enacted to define protected classes. Currently, the following demographic characteristics are "protected" by federal law:

- Race—Civil Rights Act of 1964
- Color—Civil Rights Act of 1964
- Religion—Civil Rights Act of 1964
- National origin—Civil Rights Act of 1964
- Age (40 and over)—Age Discrimination in Employment Act of 1967
- Sex—Equal Pay Act of 1963 and Civil Rights Act of 1964
  - The Equal Employment Opportunity Commission interprets "sex" to include discrimination based on sexual orientation and gender identity. [1]
- Pregnancy—Pregnancy Discrimination Act
- Citizenship—Immigration Reform and Control Act
- Familial status—Civil Rights Act of 1968 Title VIII: Housing cannot discriminate for having children, with an exception for senior housing
- Disability status—Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990
- Veteran status—Vietnam Era Veterans' Readjustment Assistance Act of 1974 and Uniformed Services Employment and Reemployment Rights Act
- Genetic information—Genetic Information Nondiscrimination Act

One of the reasons these federal laws were enacted is that the groups targeted in these laws experienced prejudice and discrimination in a myriad of ways, including ways that affected their health and affected ways that healthcare was administered (or not administered) to them by the extant healthcare system. Thus, these groups prima facie ought to be of some concern to cultural competence training. However, it is important to note that cultural competence training has a standard set of priorities regarding cultural groupings that does not perfectly align with this list of federally protected groups. Some of these legally protected classes are usually ignored or given short shrift in conventional cultural sensitivity training (e.g., the groupings of religion, age, pregnancy, family status, and veteran status). Interestingly, has been no explicit argument for the scope and priorities of cultural groups dealt with in standard cultural sensitivity training. Some groupings that have been ignored are surprising, as these groups historically have had significant impact with the delivery of behavioral health services (e.g., veterans and in general the military). As another example anti-Semitism was one of the largest problems in the twentieth century and still remains a significant problem, and yet cultural considerations related to Judaism are also typically ignored in conventional cultural competence training.

Why is this the case? One hypothesis is that the scope and priorities of cultural competence training is more influenced by the political ideologies most associated with proponents of the cultural sensitivity movement. For example, most mental health professionals are liberals (Redding, 2015), and these liberals have their own priorities and these are simply more concerned with GLBTQ issues than veteran issues, for example. Second, the lack of perfect alignment between protected classes and cultures targeted in standard cultural sensitivity training might also be due to the political advocacy skills of certain groups (certain groups are more activist and perhaps better at advocating for their interests than others). What needs to be accomplished is the intellectual work of determining the scope and priorities of groups in the cultural competence movement. However, the point now is that currently these might have more to do with politics (and as such values and ethics—see O'Donohue, Chap. 5, this volume) than with science or the pragmatics of healthcare delivery.

There also are often other difficult intellectual problems in understanding these overarching goals, as the interests of various individuals and

groups can conflict especially in a diverse society. It is not at all clear that cultural sensitivity training has properly recognized and attempted to resolve these conflicts or to adopt the meta-view that reasonable people may disagree.

The Constitution and the Bill of Rights afford important protections and liberties to all American citizens. For example, the First Amendment to the Constitution states:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

Generally, cultural sensitivity has not appropriately emphasized religion as a possible cultural grouping; although it is a federally protected category, it is a constitutionally protected freedom, and individuals can experience discrimination on the basis of their religion. Adherents of the cultural sensitivity movement have provided no rationale for its emphasis on ethnicity or sexual orientation and its de-emphasis on religious status—particularly because it is also clear that here too is an important intersectionality—in that there are many religious individuals in some key minority groups that have been typically the focus of standard cultural sensitivity training. For example, compared with other racial and ethnic groups, African-Americans are among the most likely to report a formal religious affiliation, with fully 87% of African-Americans describing themselves as belonging to one religious group or another, according to the US Religious Landscape Survey, conducted in 2007 by the Pew Research Center's Forum on Religion & Public Life. Latinos also reported affiliating with a religion at a similarly high rate of 85%; among the public overall, 83% are affiliated with a religion.

In addition, there has been little emphasis on understanding the mores and relevance of these religious beliefs on healthcare utilization in cultural competence training. There certainly is a mixed literature on the role of religion in mental health—some favorable studies of pastoral counseling (see, e.g., Worthington, Kurusu, McCollough, & Sandage, 1996)—and yet claims of the pernicious effects of religion (e.g., the construct of "religiosity" on mental health, e.g., Ellis, 1988). Specifically, there has been very little attention in mainstream cultural sensitivity training given to groups such as Mormons, very little attention to Catholics and very little attention to Jews and very little attention on fundamentalist Protestants, even though these groups would appear to both define communities and perhaps even cultures (given ill-defined this term has been, see Chap. 1 in this volume) and even though these individuals have been and continue to, experience prejudice and discrimination. The concern is that many mental health professionals may hold secular biases and may even themselves be hostile and prejudiced against the religious (see Cummings, O'Donohue, & Cummings, 2009). The view is often along the lines that "smart" individuals would be oriented toward science and it is only the intellectually inferior or poorly educated who will remain religious (see, e.g., Houts, 2009, as a usual corrective). Again, the concern is both that extant cultural sensitivity is not thoroughgoing in its attempt to identify and root out prejudice—but rather it accepting of the prejudices of secular individuals—and thus overlooks some of the key prejudices that may exist in its trainees. The second concern is that in behaving consistent with these prejudices, the cultural sensitivity movement may deprive individuals of their constitutionally protected rights to practice their religion.

Some of these issues are complex and again require serious intellectual work in the cultural competence movement that to date has simply not been done. Specifically, how ought the complex issues of abortion and homosexuality to be dealt with in a culturally sensitivity training with religious Catholic Hispanic-Americans? Are the views of the Catholic Church misogynistic and homophobic? Is it deemed to be culturally incompetent to either support antiabortion views or to be proabortion? Many African-Americans are Protestants, particularly Baptists and African Methodist Episcopalian, yet again, this religious dimension is ignored in most cultural sensitivity training regarding the culture

of African-Americans. These religions have moral positions on a number of political and value issues. It would be most ironic if in the cultural sensitivity movement, minority individuals are still seen as these mental health professionals want to see them as opposed to how they actually are—a problematic situation in any "sensitivity" training, to say the least. This religious dimension of these cultures may be ignored also because many of these religions have teachings that run afoul of the leftist political bias of most psychologists.

In fact, it is misleading to simply say that current cultural sensitivity gives short shrift to the religious dimensions of the cultures it examines: cultural sensitivity training can include messages that are outright hostile to the religious—proclaiming those who are practicing their religious beliefs as so "insensitive" or "incompetent" that they simply cannot be allowed to practice their profession. Claims of cultural insensitivity have been used to expel religious individuals from training programs in behavioral health (e.g., Cummings and O'Donohue, Chap. 7, this volume). For example, two graduate students in clinical programs in Missouri State University were expelled from these because in practicing their religious beliefs they could not condone homosexual behavior and wanted to (reasonably given these beliefs) refer gay clients to other therapists who had pro-gay values. Why wasn't this simply seen as "diversity" on the part of the religious with a corresponding need to respect such diverse values? Or more basically, a situation in which students were behaving according to their constitutionally protected right to practice their religion? In both lawsuits that emanated from this, the university eventually paid a financial settlement to the expelled students although they were not readmitted to their training programs. Cultural sensitivity movement has not done the tough intellectual and legal work to understand how its agenda can be harmonized with constitutional protections associated with the freedom to practice religion.

Another problem is how standard cultural sensitivity training interacts with free speech rights. Certainly there also are well-known restrictions on free speech. Generally, defamation or false statements, child pornography, obscenity, damaging the national security interests, hate speech, and fighting words are seen as exemptions to freedom of speech. However, it is important that none of these exceptions to the right of free speech would generally cover the kinds of speech proscribed by cultural sensitivity training. Thus, it is important to note that many of the statements thought to be culturally insensitive may in fact be constitutionally protected free speech. One has to remember that speech that is incorrect, or poorly reasoned, or even offensive to another is still protected under the constitution. Put plainly: one has the constitutional right to say insensitive things and believe insensitive beliefs. Of course, part of the complexity of this is that what is judged as "insensitive" is a complex matter and may vary along a number of variables.

Health professionals as part of their expert status also must exercise restrictions on their free speech, for example, a physician must not state medical information, that is, false, e.g., "Don't use antibiotics for your strep throat as these are ineffective." Similar restrictions on speech would apply to educational and behavioral health professionals. However, again, there is generally wide latitude given to behavioral health professionals in this domain often due to the fuzzy and complex task of interpreting bodies of research—as such behavioral health professionals are often free to recommend a wide variety of therapies for a particular problem, many of these would not be evidence based or have any other properties that would be deemed advantageous by many, such as "best practices." And science simply cannot decide value questions, and many of the positions proscribed in cultural sensitivity training are precisely these value questions. One has to be mindful of what kinds of statements are being proscribed in cultural sensitivity training and the justification for these prohibitions in the light of constitutionally protected free speech. Again, there is intellectual work that has not been accomplished by this movement.

Of most concern is the possibility that the speech being proscribed is political speech, that

is, generally at odds with the political ideology of the liberal left. If this is the case, then standard cultural sensitivity training becomes little more than coercive political indoctrination. Redding (2015) has written how the field of contemporary psychology does not have political diversity, and this lack of political diversity might produce a corresponding lack of intellectual diversity. Over 90% of psychologists self-identify with liberal political positions and vote Democratic. There has been a disturbing tendency associated with the cultural sensitivity movement to infringe upon political free speech—partly because this training construes controversial political issues as having only one acceptable "sensitive" position—the position of the political Left. In this training, voicing support for abortion is seen as sensitive to women's rights, but voicing opposition to abortion is seen as illicit and insensitive; being against gay marriage is seen as homophobic and needing remediation, while being for marriage equality is seen as sensitive. Supporting the slogan "All lives matter" is seen as racist as opposed to a preference for the slogan "Black lives matter." Of course, each of these judgments align along a political dimension—the first position is the position of the political left; the second proscribed position is generally associated with the political right. Has science and conceptual argument established these value positions as unequivocally true that they ought to be prescribed as the only legitimate, "sensitive" option—especially when many minority members themselves, perhaps due to their religious beliefs might hold the opposite position? How can cultural sensitivity embrace both political diversity and a respect for the religious dimensions of some of its favored cultural groupings to really respect not become political indoctrination?

In recent years this political problem has perhaps become more acute on college campuses, but there is little evidence that the cultural sensitivity movement has attempted to respond to these egregious situations in a way that one might expect if they were truly committed to respect, diversity, and sensitivity. Conservative speakers are not invited to speak on campuses, or disinvited due to the protests of others, or interfered with so they cannot speak, or even assaulted and threatened with harm if they do come to campus. Sometimes the attempts to justify these prohibitions are made on grounds that the remarks were "insensitive" or made the hearer feel "uncomfortable" or were "triggers", or were racist or homophobic, or even caused traumatization (see Cummings and O'Donohue, Chap. 7, this volume). These are the kind of reactions that cultural sensitivity training often attempts to target. Again, more intellectual work needs to be done with regard to what speech can be legitimately proscribed in cultural sensitivity training versus what is an illegitimate infringement on constitutionally protected free speech rights and the extent to which a political ideology is being inculcated in such trainings.

To a lesser extent, there has been also been some restrictions on the freedom of assembly on college campuses. Some of the rationale for this has been that organizations like fraternities and other social clubs are associated with values that ought to be condemned—the allegations can range from being misogynist to being racist to promoting sexual assault. For example, the following is draft language at Harvard:

> Harvard students may neither join nor participate in final clubs, fraternities or sororities, or other similar private, exclusionary social organizations that are exclusively or predominantly made up of Harvard students, whether they have any local or national affiliation, during their time in the college. The college will take disciplinary action against students who are found to be participating in such organizations. Violations will be adjudicated by the administrative board.

The North-American Interfraternity Conference also issued a statement in response to this: "Freedom of association and speech are paramount for the intellectual and spiritual growth of students. We urge Harvard to focus on creating a culture of health and safety on campus that also respects students' rights."

Notable also is the response of Harvard psychologist Steven Pinker. He states "This is a terrible

recommendation, which is at odds with the ideals of a university.

1. A university is an institution with circumscribed responsibilities which engages in a contract with its students. Its main responsibility is to provide them with an education. It is not an arbiter over their lives, 24/7. What they do on their own time is none of the university's business.
2. One of the essential values in higher education is that people can differ in their values, and that these differences can be constructively discussed. Harvard has a right to value mixed-sex venues everywhere, all the time, with no exceptions. If some of its students find value in private, single-sex associations, some of the time, a university is free to argue against, discourage, or even ridicule those choices. But it is not a part of the mandate of a university to impose these values on its students over their objections.
3. Universities ought to be places where issues are analyzed, distinctions are made, evidence is evaluated, and policies crafted to attain clearly stated goals. This recommendation is a sledgehammer which doesn't distinguish between single-sex and other private clubs. It doesn't target illegal or objectionable behavior such as drunkenness or public disturbances. Nor by any stretch of the imagination could it be seen as an effective, rationally justified, evidence-based policy tailored to reduce sexual assault.
4. This illiberal policy can only contribute to the impression in the country at large that elite universities are not dispassionate forums for clarifying values, analyzing problems, and proposing evidence-based solutions, but are institutions determined to impose their ideology and values on a diverse population by brute force."

Again, the cultural sensitivity movement needs to be concerned about whether their attempt to "do good" is properly respectful of constitutionally protected rights or whether it devolves into coercive, authoritarian attacks on these rights.

Academic Freedom and Cultural Sensitivity Training

Academic freedom is the value that freedom of inquiry by faculty members is essential to fulfilling the mission of the university including the principle that scholars should have freedom to teach or communicate ideas or information (including those that why may be inconvenient or problematic to internal or external political groups or authorities) without being targeted for reprisals, repression, job loss, or imprisonment. The basic idea is that the search for truth is best conducted with the seeker is not afraid of repercussions for their scholarly conclusions or for their critiques of orthodoxy or other favored views.

The history of academic freedom is interesting. Historically for many centuries, the concern was that certain institutions most associated with the political right were the threats to academic freedom: the churches and the police in particular. However, more recently there appears to have been an important shift: at most universities professors have little concern about these institutions threatening their academic freedom. Most university researchers and professors have nothing to fear from the police or the church. Rather, now the threats to academic freedom come from the political Left—for example, that the teachings of the professor or the academic interests will be seen as "insensitive" or racist or homophobic and as such the professor will experience serious reprisals.

For example, recently at the University of Kansas a controversy surrounding Professor Quenette's comments arose on November 12, 2015, during a graduate seminar discussion about race. The previous day, Kansas University held a forum on racial and cultural issues in response to student protests over racial issues at the University of Missouri. According to *an open letter* written by some of Quenette's students, during a part of the discussion focusing on how the graduate students can bring up these issues with their

students, Quenette said, "As a white woman I just never have seen racism…It's not like I see "Nigger" spray painted on walls…." Later, when the topic shifted to minority student retention rates in higher education, Quenette responded to one student who argued that the lower retention rate of black students stems from racism and poor institutional support by saying, "Those students are not leaving school because they are physically threatened everyday but because of academic performance." Following this class, eight graduate students, some of whom were not even in the class, filed complaints against Quenette. In their open letter, the students called on the university to terminate Quenette, arguing that her comments were "unacceptably offensive" and violated *KU's Racial and Ethnic Harassment Policy*, among other university policies. The students also refused to continue attending her class.

Quenette was placed on paid leave, pending the outcome of an investigation. In *a letter* sent to KU Chancellor Bernadette Gray-Little last month, FIRE explained that Quenette's comments were germane to the class discussion, were not targeted at any group or individual, and were protected under the First Amendment. Late Friday, the university announced that Quenette did not violate university policy and may return to teaching. One must remember the issue is not whether one thinks Quenette was right—or her comments well-formed and justified—the question is whether she has a right to voice these—or no right and even the necessity to be fired because of these. Academic freedom would suggest that she had the right to voice these views—and others had the right to criticize these views.

Two other interesting cases (among many) are what happened to both Dr. Kenneth Zucker and Michael Bailey, two prominent sex researchers. Both cases are interesting as these individuals would both see themselves, with good reason, to be relatively liberal politically—however apparently not sufficiently so for some. Professor Zucker was recently fired from the Center for Addiction and Mental Health at the University of Toronto because his views on gender identity and its clinical treatment were viewed as problematic by certain transgendered activists. Dr. Zucker, a clinical psychologists, argued that some children suffering from gender identity problems should receive therapy that aimed at having their behavior to become more consistent with their anatomical sex. Zucker had published data and had clinical experience that this approach with some frequency successfully resolved the gender identity issues. Certain transgendered activists thought that this approach to be an unethical and insensitive position—essentially a form of "reparative therapy" and successfully advocated for him to be fired. His treatment approach came under scrutiny in March 2015 when *Cheri DiNovo, MPP*, who is a Canadian politician tabled a *private member's bill* that banned all conversion therapies for gender identity. Zucker's academic freedom was not honored, and because his views were not consistent with the views of certain transgendered activists, he was fired.

J. Michael Bailey also a clinical psychologist and professor of psychology at Northwestern University was also targeted by transgendered activists partly because he published a book *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* (Bailey, 2003), and in it he endorsed a theory called autogynephilia. Basically the idea is that some men who self-identify as transgendered are aroused erotically by the thought of being a woman. That is, that for some this is an erotic interest not an identity problem. This is viewed as a problematic position by some transgendered activists because they believe that it can undermine public support as if this is an erotic interest rather than a biological gender mismatch the belief is that the public will be less supportive. James, a transgender advocate, attacked Bailey by constructing a website with pictures of Bailey's children taken from his public website beside sexually explicit captions. Numerous claims were made against Bailey that prompted a university investigation in which he was eventually cleared. Alice Dreger (2015)—who herself resigned from Northwestern due to her claims of censorship—wrote an extended and illustrative treatment of Bailey in her

book *Galileo's Middle Finger*, a book that is highly recommended. In her conclusion, Dreger states of the activists who attacked Bailey's work:

> Forms of scholarship that deny evidence, that deny truth, that deny the importance of facts, even when performed in the name of good, are dangerous, not only to science and to ethics but to democracy.

Finally, it might be useful to consider the recent policy on "trigger warnings" of the American Association of University Professors (2014). Trigger warnings are a construct of relatively recent origins that suggest that students ought to be at least warned if course content might cause or trigger any negative emotions—as such it is thought to be sensitive behavior especially as minorities due to past discrimination and ill treatment might have from more triggers. However, this document will be quoted extensively as it so aptly deals with the issues of academic freedom and concerns of "sensitivity":

> A current threat to academic freedom in the classroom comes from a demand that teachers provide warnings in advance if assigned material contains anything that might trigger difficult emotional responses for students. This follows from earlier calls not to offend students' sensibilities by introducing material that challenges their values and beliefs. The specific call for "trigger warnings" began in the blogosphere as a caution about graphic descriptions of rape on feminist sites and has now migrated to university campuses in the form of requirements or proposals that students be alerted to all manner of topics that some believe may deeply offend and even set off a post-traumatic stress disorder (PTSD) response in some individuals. Oberlin College's original policy (since tabled to allow for further debate in the face of faculty opposition) is an example of the range of possible trigger topics: "racism, classism, sexism, heterosexism, cissexism, ableism, and other issues of privilege and oppression." It went on to say that a novel like Chinua Achebe's *Things Fall Apart* might "trigger readers who have experienced racism, colonialism, religious persecution, violence, suicide and more." It further cautioned faculty to "[r]emove triggering material when it does not contribute directly to the course learning goals." As one report noted, at Wellesley College, students objected to "a sculpture of a man in his underwear because it might be a source of 'triggering thoughts regarding sexual assault.' While the [students'] petition acknowledged that the sculpture might not disturb everyone on campus, it insisted that we share a "responsibility to pay attention to and attempt to answer the needs of all of our community members." Even after the artist explained that the figure was supposed to be sleepwalking, students continued to insist it be moved indoors."*
>
> The presumption that students need to be protected rather than challenged in a classroom is at once infantilizing and anti-intellectual. It makes comfort a higher priority than intellectual engagement and—as the Oberlin list demonstrates—it singles out politically controversial topics like sex, race, class, capitalism, and colonialism for attention. Indeed, if such topics are associated with triggers, correctly or not, they are likely to be marginalized if not avoided altogether by faculty who fear complaints for offending or discomforting some of their students. Although all faculty are affected by potential charges of this kind, nontenured and contingent faculty are particularly at risk. In this way the demand for trigger warnings creates a repressive, "chilly climate" for critical thinking in the classroom.
>
> Our concern extends to academic libraries, the repositories of content spanning all cultures and types of expression. We think the statement of the American Library Association regarding "labeling and rating systems" applies to trigger warnings. "Prejudicial labels are designed to restrict access, based on a value judgment that the content, language, or theme of the material, or the background or views of the creator(s) of the material, render it inappropriate or offensive for all or certain groups of users….When labeling is an attempt to prejudice attitudes, it is a censor's tool."
>
> Institutional requirements or even suggestions that faculty use trigger warnings interfere with faculty academic freedom in the choice of course materials and teaching methods. Faculty might feel pressured into notifying students about course content for fear that some students might find it disturbing. Of course there may be instances in which a teacher judges it necessary to alert students to potentially difficult material and that is his or her right. Administrative requirements are different from individual faculty decisions. Administration regulation constitutes interference with academic freedom; faculty judgment is a legitimate exercise of autonomy.
>
> There are reasons, however, for concern that even voluntary use of trigger warnings included on syllabi may be counterproductive to the educational experience. Such trigger warnings conflate exceptional individual experience of trauma with the anticipation of trauma for an entire group and assume that individuals will respond negatively to certain content. A trigger warning might lead a student to simply not read an assignment, or it might

elicit a response from students they otherwise would not have had, focusing them on one aspect of a text and thus precluding other reactions. If, for example, *The House of Mirth* or *Anna Karenina* carried a warning about suicide, students might overlook the other questions about wealth, love, deception, and existential anxiety that are what those books are actually about. Trigger warnings thus run the risk of reducing complex literary, historical, sociological, and political insights to a few negative characterizations. By calling attention to certain content in a given work, trigger warnings also signal an expected response to the content (e.g., dismay, distress, disapproval) and eliminate the element of surprise and spontaneity that can enrich the reading experience and provide critical insight.

Some discomfort is inevitable in classrooms if the goal is to expose students to new ideas, have them question beliefs they have taken for granted, grapple with ethical problems they have never considered, and, more generally, expand their horizons so as to become informed and responsible democratic citizens. Trigger warnings suggest that classrooms should offer protection and comfort rather than an intellectually challenging education. They reduce students to vulnerable victims rather than full participants in the intellectual process of education. The effect is to stifle thought on the part of both teachers and students who fear to raise questions that might make others "uncomfortable."

The classroom is not the appropriate venue to treat PTSD, which is a medical condition that requires serious medical treatment. Trigger warnings are an inadequate and diversionary response. Medical research suggests that triggers for individuals can be unpredictable, dependent on networks of association. So color, taste, smell, and sound may lead to flashbacks and panic attacks as often as the mention of actual forms of violence such as rape and war. The range of any student's sensitivity is thus impossible to anticipate. But if trigger warnings are required or expected, anything in a classroom that elicits a traumatic response could potentially expose teachers to all manner of discipline and punishment.

Instead of putting the onus for avoiding such responses on the teacher, cases of serious trauma should be referred to student health services. Faculty should, of course, be sensitive that such reactions may occur in their classrooms, but they should not be held responsible for them. Instead, as with other disabilities, a student diagnosed with PTSD should, in advance, agree on a plan for treatment with the relevant health advisors who, in some cases, may want to alert teachers to the presence of a trauma victim in their classroom. The Americans with Disabilities Act contains recommendations for reasonable accommodation to be made on an individual basis. This should be done without affecting other students' exposure to material that has educational value.

It is probably not coincidental that the call for trigger warnings comes at a time of increased attention to campus violence, especially to sexual assault that is often associated with the widespread abuse of alcohol. Trigger warnings are a way of displacing the problem, however, locating its solution in the classroom rather than in administrative attention to social behaviors that permit sexual violence to take place. Trigger warnings will not solve this problem, but only misdirect attention from it and, in the process, threaten the academic freedom of teachers and students whose classrooms should be open to difficult discussions, whatever form they take.

This document presents a nuanced analysis to a complex matter, and as such it ought to influence thinking about the relationship between cultural sensitivity training and academic freedom. All too often in cultural competence, training someone's "discomfort" is considered sufficient to condemn the utterance or behavior without considerations of issues relating to academic freedom, freedom of religion, and freedom of speech.

Cultural Sensitivity Training and Reverse Prejudice

In some sense a fundamental question is: in cultural sensitivity training, are its claims and concepts to be treated symmetrically or asymmetrically? For example, although it is clear that one of the most important rationales for CS training is that the majority group is ignorant of the culture(s) of various minority groups, can the reverse also be true—i.e., that a minority members can also be ignorant of key information relevant to the culture(s) of the majority group and thus might need training and skills related to this (majority) culture, and possibly even training in combating stereotypes, simplistic thinking, and even prejudice regarding certain majority members?

Another rationale often given for the necessity of CS training is that the majority group member can engage in a variety of problematic behaviors,

e.g., make insensitive or even prejudicial statements, or more recently, concerns regarding the majority member engaging in various microaggressions or even have and abuse institutional power—but, again, are these set of concerns also symmetric, can the reverse be true? Can a minority member also make insensitive or prejudicial statements toward the majority group or a majority group member that ought to be a target of any thoroughgoing sensitivity training? Can a minority group member engage in macroaggressions toward the majority group? Even somewhat paradoxically can the minority member have a kind of institutional power that can be used is such as way in which majority group members are treated unfairly? Of course, this gives rise to another question: is such asymmetrical behavior, if found to occur, in some way lessened or make irrelevant because the concern in asymmetric prejudice against minorities is the only legitimate concern due its more pernicious effects?

Perhaps this asymmetric treatment of prejudice might be one of the reasons that there has been so little progress in the cultural sensitivity movement (see other chapters this volume): the asymmetric ways in which the CS movement treats humans cause a certain type of distancing due to what is seen as a lack of authentic, thoroughgoing commitment to appreciating diversity, to promoting tolerance, to creating a thoroughgoing antipathy to prejudice and discrimination. Instead of seeing these thoroughgoing commitments to these alleged values at its core, the cultural sensitivity movement can contain and promote reverse prejudice, restrict civil liberties and constitutionally protected freedoms, and promote a whole host of other assorted judgments such as capitalism is seen as bad (even though it is the mechanism that has lifted more from poverty).

At the outset let us stipulate a few important points so these do not interfere with, or distract from, the central arguments of the remainder of this chapter:

1. Prejudice and discrimination in the United States and elsewhere have existed historically and exist today, and these are overwhelming directed at and experienced by members of minority groups. Historical events such as slavery, Jim Crow, the mistreatment of Indigenous peoples, the Holocaust, the disenfranchisement of women, the internment of the Japanese, and so on can have long-lasting and significant impact on the psychological health and functioning of these individuals, even when those historical events did not occur in their lifetimes. For example, the Holocaust although ending in the mid-1940s can have significant psychological effects on Jewish youth born in the twenty-first century. Slavery and Jim Crow laws can have effects on African-Americans born generations after these events have ended and so on.
2. These problems can be institutionalized—these can permeate important societal institutions such as the justice system, the economic system, the educational system, and even the health system in subtle and not so subtle ways.
3. This prejudice and discrimination directed at minority groups is morally wrong, harmful in many practical ways, and ought to be a priority for remediation.
4. If the same level of prejudice and discrimination is directed at a minority individual and a member of the majority group, ceteris paribus, the member of the minority group would in all likelihood suffer more harm. For example, if a minority member and a member of the majority each have prejudicial attitudes toward the other "all whites are bad" vs. "all blacks are bad" that this is not morally equivalent, the attitude of the majority empowered class is more pernicious because of the advantageous position that the person and group has enjoyed and continues to enjoy. In short, prejudice and discrimination directed at a minority member is more harmful than prejudice directed at a majority group member. However, saying one is more harmful does not in any way obviate or justify the lesser harm.
5. These problems are of professional concern in the healthcare and educational professions as these can affect education, health, and healthcare delivery in important ways. Specifically, for example, these can affect the therapist-

client relationship in a myriad of ways: (1) these can create psychological problems for discriminated minorities that may cause them to present for treatment; (2) prejudice and discrimination can create barriers to entry for help for these problems or other problems; (3) prejudice and discrimination of a therapist can cause the therapist to behave improperly and non-therapeutically with the minority client; (4) assessments and therapies can be developed which are based on assumptions that do not apply or do not apply as well to minority group members; and (5) these problems can create workforce shortages in that minority members are underrepresented in the healthcare workforce which in turn can present barriers and problems for minority members.

However, as deeply troubling and concerning as the above considerations are, these do *not* entail the following:

1. The above does not entail that individuals who share demographic characteristics with historical groups that did harm bear current guilt for these historical acts and can be confronted with this guilt. For example, a 20-year-old German in 2017 bears no guilt for the Holocaust as he or she had no role in the historical events known as the Holocaust.
2. The above does not also entail that at majority group members who are "privileged" by current prejudice or racism can be maligned and prosecuted on the basis of their demographics. Part of the reason for this is that majority categories are not uniform in their association with privilege—e.g., some whites are very poor—and a hallmark of prejudicial attitude is to see something uniform when it is not.
3. This does not also entail that the problem of prejudice is only found simply in the majority-minority relationship but it also can be found in the minority-minority relationship. For example, in the 1992 Los Angeles riots that was violence and rioting as well as problematic statements made between African-Americans and Korean-Americans. This too shows the necessity of identifying and treating prejudicial statements emerging from minority members about other minority members. Another example is found in the recent law suits from Asian-American groups claiming that race-based college admissions are unfair and prejudicial toward them—their claim is essentially that other minority groups are privileged over them.
4. This also does not entail that it is impossible to exaggerate the current harm done to particular minority members. Rather, careful and just weighing of evidence is not needed to understand if any insensitivity, racism, or discrimination has occurred in any individual case and the amount of harm experienced. Due process is important and ought to be implemented. Due process is needed to adjudicate these claims because there ought to be a presumption of innocence, a reasonable burden of proof that needs to be met—a claim by a minority individual due to their minority status is insufficient to establish the truth of the entire allegation. The infamous Duke Lacrosse case (see Taylor & Johnson, 2010) is a prime example of a situation in which majority demographics of alleged perpetrators of rape (white, male, heterosexual) of a minority member (African-American, poor, female) functioned as a rationale to obviate due process and careful weighing of the evidence, particularly in decisions made at the university (the university fired the coach and expelled a number of students). Such adjudication and due process is necessary even in claims regarding microagressions, privilege, coded speech, hate speech, homophobia, racism, sexism, and the like.
5. In understanding these matters, a careful analysis of the situation may need to address the multiple complex dimensions involved in the case, including (1) what is known about the facts of the matter (who said or did what), (2) what laws and particularly civil liberties apply in this situation, (3) what is the actual evidence for claims of harm (e.g., trauma, uncomfortableness, fear), and (4) what political ideologies may be in play here, e.g., is this

an example of intolerance of free speech expressing divergent views.

6. This does not entail that it is impossible for "reverse racism" to occur, i.e., it does not entail that no discriminated minority member can say or do anything toward a member of the majority culture that would in any way reflect a prejudgment or an irrational negative attitude toward that majority member. For example, the following would not be justified: the claim that "All men are rapists," advanced by the radical feminist Catherine MacKinnon (1987) is not justified even by recitations of past and current misogyny, sexism, and patriarchy. Or "Jews are responsible for slavery" said by Elijah Mohammad is not seen as not anti-Semitic or in any prejudicial even given the slavery, Jim Crow, and current prejudicial conditions toward African-Americans. Or "That bitch is crazy" said by a male African-American in a film depicting a white woman allegedly stating macroaggressions in a film on the Black Lives Matter website is again not unproblematic and innocuous even given legitimate listings of past and current wrongs associated with the African-American community.

Let us examine some of these instances of reverse prejudice. First, on Christmas Eve 2016, Drexel University Associate Professor George Ciccariello-Maher posted a message to his Twitter account reading, "All I Want For Christmas is White Genocide." Ciccariello-Maher posted a follow-up tweet the next day reading, "To clarify: when the whites were massacred during the Haitian revolution, that was a good thing indeed." The tweets prompted condemnation by the university and the promise of an investigation into Ciccariello-Maher's actions.

Next, statements made by Catherine McKinnon a University of Michigan Law Professor and well-known radical feminist:

- "The common erotic project of destroying women makes it possible for men to unite into a brotherhood; this project is the only firm and trustworthy groundwork for cooperation among males and all male bonding is based on it." *Our Blood* (1973) p. 16
- "Under patriarchy, every woman's son is her potential betrayer and also the inevitable rapist or exploiter of another woman. "*Our Blood* (1976)

Surely, these are pejorative broad brush unjustified claims against all males that are the epitome of prejudice.

Next, let's consider some of the statements made by Louis Farrakhan who is often embraced by Black Lives Matter activists:

> The Jews, a small handful, control the movement of this great nation, like a radar controls the movement of a great ship in the waters … the Jews got a stranglehold on the Congress. (Louis Farrakhan, Saviour's Day speech, Chicago, Feb. 25, 1990)

> We can now present to our people and the world a *true*, undeniable record of the relationship between Blacks and Jews from their own mouths and pens. These scholars, Rabbis and historians [that Nation of Islam researchers studied] have given to us an undeniable record of Jewish anti-Black behavior, starting with the horror of the trans-Atlantic slave trade, plantation slavery, Jim Crow, sharecropping, the labor movement of the North and South, the unions and the misuse of our people that continues to this very moment. (Letter sent by Louis Farrakhan to Jewish leaders and the Southern Poverty Law Center, June 24, 2010)

The so called "progressive" movement that is associated with the cultural sensitivity movement can be associated with a form of prejudice in which majority group members are demonized. This needs to be both recognized and rectified.

Conclusions

The following are recommendations for improved cultural sensitivity training:

1. Cultural sensitivity will attempt to honor all civil rights including the rights of the individual to free speech, freedom to practice his or her religion, as well as due process.
2. Problematic and restricted definitions of prejudice and discrimination are eliminated.

Cultural sensitivity training will attempt to identify and ameliorate all forms of prejudice and discrimination. Prejudice and reverse prejudice both will be identified not be tolerated in professional behavior. Prejudice is a prejudgment—usually a negative one (although interestingly Asian-Americans have expressed concerns about positive prejudgments such as all Asians are smart or Asian-American women are beautiful). What is uncontroversial is that age old prejudices are harmful. No one is contesting that these attitudes are problematic and ought to be identified and dealt with for any prospective therapist. But the question is, are the prejudices targeted by cultural sensitivity training comprehensive? There seems to be three problematic restrictions in standard training. (1) There are some prejudices against minority groups that are simply not addressed, for example, typically anti-Semitisms is given short shrift. (2) The problem of inter-minority prejudice is also given short shrift, e.g., African-Americans viewing Korean-Americans as greedy might be an example. Being a minority seems to have some sort of strange immunizing function in this training. (3) Prejudice against perceived minority members is allowed. All males are rapists is an example. All Christians are homophobic, another. Any white male who has accomplished x is always due to white privilege another.

3. Cultural sensitivity will honor the value of tolerance for political and viewpoint diversity: it will not pathologize political positions. There will be due concern that the entire movement has been dominated by a Leftist political ideology (Redding, 2015) and attempts to ensure that other political opinions will not result in harm done to those who hold these. Of course claims can be made that these are "wrong" or "false"; these are wrong based on reasoned argument and debate. However, political power held by the majority will not be used to suppress the rights of the political minority in the field. At times, as was seen by the treatment of the two sex researchers, it can also be the case that any political position taken that is not consistent with a fairly Far Left political ideology is taken as prejudice—thus CS training can become a political indoctrination rather than a more ameliorative process or one that truly celebrates and promotes diversity. In the future cultural sensitivity training needs to be more sensitive to political and intellectual diversity and to take more safeguards to assure that it does not become a political indoctrination.
4. Cultural sensitivity training will embrace a thoroughgoing rational and scientific epistemology. All claims will be evaluated by the quality of the arguments and evidence for these. Careful sociological data ought to be gathered regarding cultures instead of a glib reliance on stereotypes—even positive ones. Ad hominem arguments will be critically evaluated as such as opposed to be seen as some sort of trump card. Open debate and counter-viewpoints will be allowed and rationally appraised, consistent with both freedom of speech and academic freedom. Real tolerance of diversity will recognize that well-meaning individuals can agree to disagree.
5. Cultural sensitivity training will commit to due process for all. Any charge of prejudice or discrimination or oppression are serious charges—both because these are seen as serious infractions and also because these often violate institutional regulations or state and federal laws. As such these can have serious penalties such as dismissal, fines, and so on—not to mention a ruined reputation and the cost in time and money of defending oneself in these often onerous institutional adjudication processes. It would be ironic and hypocritical if a movement such as cultural sensitivity which is founded on notions of justice would violate fair and just treatment of individuals accused of inappropriate behavior. It is fair to say that it is unclear if these institutional adjudication processes are rational, fair, comprehensive, and just (see Bowers and O'Donohue (2016) for a critique of sexual harassment adjudication processes). The Duke Lacrosse team having their seasoned cancelled, the

coach fired, and then having members expelled from the university—all before any proper due process took place—is a case in point. Rushes to judgment regarding need to be avoided. This needs to occur even in cultural sensitivity training, if someone's utterance or attitude is ascribed the property P—such as prejudicial or discriminatory or insensitive—a rational case needs to be made and the person has to be able to be free to defend themselves against such accusations.

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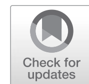

28 From Theory to Evaluation to Instruction: Toward an Ideal Cultural Competency Course in Applied Psychology

Craig L. Frisby and William O'Donohue

The impetus behind cultural competence advocacy comes from a mixture of real pressing problems that grow organically from practice, and sociopolitical concerns among advocacy groups that may or may not have anything to do with conditions observed in practice (see Patai Chap. 17, this text). It is difficult to clearly untangle these forces; hence, the response within applied psychology has been to forge ahead under the assumption that cultural competence is a clearly defined and empirically validated construct (that enjoys professional consensus), with professional guidelines, mandates, and initiatives running far ahead of the data (see Cummings & O'Donohue Chap. 8, this text).

Despite its significant problems, cultural competence is a popular area of advocacy and publishing in applied psychology, but the term remains "aspirational" more than it is substantive. We retain the phrase "cultural competence" in this course proposal from our strong sense that this phrase will not be going away any time soon in applied psychology. As discussed in the History and Development of Cultural Comptence Advocacy chapter (chapter 1, this text), the term "cultural competence" is ubiquitous not only within applied psychology but in health care, education, business, and other fields that involve managing racial, ethnic, linguistic, and cultural differences. Although the phrase can mean different things to different people (as well as across different situations), most people have a general (though vague) sense that the phrase is meant to improve the quality of caregiver's professional services when serving clients who are demographically different from themselves or from the majority cultures (assuming, of course, that professional challenges are related to these differences).

We also recognize the debate over whether or not cultural competence is best accomplished through individual "stand-alone" courses versus an infusion model where cultural competence topics are integrated into all aspects of a training curriculum (LaFromboise & Foster, 1992; Ponterotto & Austin, 2005). Our proposal for an ideal course includes innovative topics that do not fit neatly into other kinds of courses necessary for training; hence, a "stand-alone" course will serve as the model discussed in this chapter.

We also acknowledge that different branches of applied psychology have unique needs and traditions involving discipline-specific training content that is not easily translatable across specialty areas. As examples, psychodynamically oriented therapist training emphasizes mastery of different skill sets when compared to school psychology

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training, which in turn requires mastery of different skill sets when compared to chemical addiction counselor training. It comes as no surprise that many resources for cultural competence training are targeted for specific niche areas within applied psychology.

We argue in support for a universal set of principles that transcend differences across specialty areas, which in our view are considered foundational for all applied psychology training programs. These foundational principles honor the spirit of cultural competency advocacy, while being careful not to stray beyond the current state of the best available evidence and writing on the inherent limitations of cultural competency research. In addition, we argue that this training should be consistent with the meta-principles of our fields: i.e., that rational argument and critical analysis is paramount; that empirical questions should be addressed with carefully designed research instead of by authoritarian pronouncement; that competing hypotheses need to be fairly evaluated instead of ruled out because of a priori biases; and that (consistent with the general notion of diversity) there may be competing visions of the good or how the good ought to be achieved. These need to be rationally appraised and not decided by ad hominem arguments. In short, an ideal course on cultural competence needs to embody these general epistemic and moral principles instead of being a departure from these.

What Is Meant by "Ideal?"

We are keenly aware of the questions that naturally arise from our characterization of a proposed course as "ideal." A pervasive challenge that faced both the editors and authors of this text is the recognition that when reviewing the cultural competence literature, hard science is either missing or hopelessly intertwined with sociopolitical ideology. Sometimes it was easy to tell the difference between these two perspectives, but more often than not, it was quite difficult. Thus, the ideal cultural competency course for one instructor or training program may not be considered ideal by another instructor or training program. Some instructors define an "ideal" cultural competency course as any course that engages students in social justice advocacy and activities (e.g., Aldarondo, 2007; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009; Smith, Jennings, & Lakhan, 2014; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). Other instructors may define an "ideal" course as one that ensures that whites are inculcated in "anti-racism" advocacy and are made keenly aware of their "white privilege" (e.g., Constantine & Sue, 2006; Kivel, 2011; Ridley, 2005). Others see a cultural competence course specifically, and applied psychology generally, as under an urgent, moral obligation to bring attention to groups that they feel have not received adequate attention (e.g., ethnic minorities, women, LGBT groups, or the disabled; Brown, 2006; Levant & Silverstein, 2006; Olkin & Taliaferro, 2006; Sue & Zane, 2006). Since none of these views effectively challenge scientific epistemology, our view is that it is important to remain at the "hard science" end of this continuum. For these reasons, we do not assume that our proposal will be persuasive or even minimally acceptable to all readers. Nevertheless, we outline general principles – gleaned from conclusions derived from many chapters in this text – that establish the foundation for more specific proposals for what we view as an ideal course in cultural competency.

What Factors Influence the Content/Design of Cultural Competency Courses?

The multidimensional factors that influence the content of graduate-level cultural competency courses for the training of applied psychologists are shown in Fig. 28.1. Such courses may or may not have the phrase "cultural competence" in their official titles, but can usually be identified by their references to "developing cultural competency" or "understanding multicultural issues" in the course description or outline of objectives in the course syllabus. We do not include within this category courses designed to help students develop concrete assessment and/or intervention skills, such as what would be found in courses

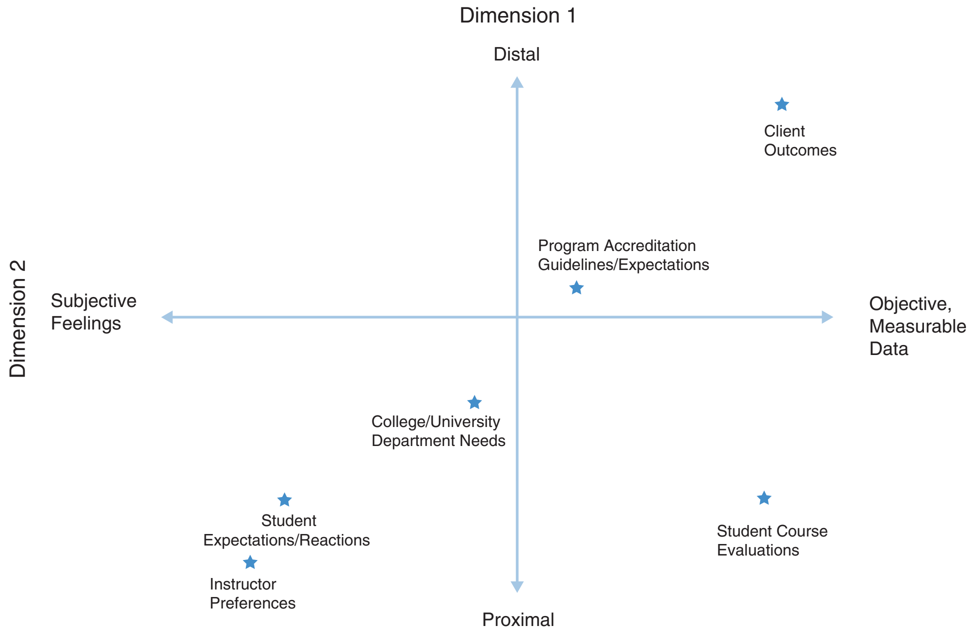

Fig. 28.1 Variables influencing the content and design of a cultural competency course in applied psychology

devoted specifically to bilingual psychoeducational assessment, dream analysis, crisis intervention, functional behavioral analysis, or motivational interviewing (to name a few examples). Rather, the kinds of courses to which we refer are those that traditionally advertise themselves as *broadly designed* to "increase awareness," "develop sensitivities," review theories and research, and/or expose students to experiences related to serving racially, ethnically, and/or culturally diverse groups.

The information in Fig. 28.1 is displayed like a multidimensional scaling plot of proximity data (Hout, Papesh, & Goldinger, 2013), although the "data" in the figure represent only conceptual categories, not actual empirical data. The six points on the plot represent variables that influence the content of cultural competency courses, and the latent dimensions reflect unobserved but inferred constructs that help to explain important similarities and differences among the variables.

Dimension 1 (proximity/distal dimension) represents a continuum that describes variables that are close, near, and immediate to the circumstances surrounding the creation of a cultural competency course, versus variables that are further away, distant, and removed from the circumstances surrounding the creation of a cultural competency course. We note that proximal variables tend to have a stronger influence on the choices that instructors make in designing a cultural competency course compared to distal variables.

Dimension 2 (subjective feelings/objective, measurable data) describes emotions, passions, and convictions that are felt by individuals, versus objective measurable data that a variety of different individuals can observe without being influenced by the biasing effects of any individual's subjective emotions.

Instructor Preferences Arguably the most important variable that tends to influence the content of a cultural competency course are the personal preferences of the course instructor. Instructors are chosen to teach university/college courses based on some combination of their personal research interests, personal demographics and experiences, publication record, history of success in teaching similar courses, and personal willingness to teach the course. This explains why this variable is closest to the proximal pole

of Dimension 1 in Fig. 28.1. Assuming some degree of leeway granted by department/college superiors, it is here where an instructor's personal and professional opinions as to what is most important for students to learn can be given free rein in influencing how a cultural competency course is taught. Such personal and professional opinions are often manifested in strong feelings about particular "hot button" topics involving a subset of issues regarding race, gender, sexual orientation, religion, and political ideology. This explains why this variable is closest to the subjective feelings pole of Dimension 2 in Fig. 28.1. If an instructor sees themselves as a committed "social justice warrior" or proudly self-identifies as a "radical feminist", and feels strongly that these perspectives lead to improved professional practice for certain classes of clients, then this orientation will more often than not have a direct influence on the pedagogical practices and instructional "tone" of the course.

Student Expectations/Reactions The content of cultural competency courses is also shaped by an instructor's anticipation of how students will respond emotionally (either positively or negatively) to course material and requirements. Some instructors know intuitively that cultural competence courses challenge students to think about issues that many students would prefer not to think about, which has the potential for stirring up strong opinions of which they might not have been previously aware. Some instructors see their role as confronting students with uncomfortable truths about themselves, the purpose of which is to presumably help students understand the experiences of cultural minorities and how their own actions may perpetuate societal injustices (Ridley, 2005; Sue & Sue, 2016). Other instructors may see their role as giving voice to or empowering students needing "allies" who can advocate for their group-based interests. In our combined professional experience, the reactions of students in cultural competency courses are often unpredictable and are as varied as there are wide individual differences among students. Some of the more typical responses that we have encountered are briefly described below:

Some students are privately uncomfortable talking openly about race, ethnicity, class, religion, or sexual orientation – simply feeling that such topics related to these categories are inappropriate or too sensitive and personal to discuss openly and honestly in polite company. Such students are terrified of voicing their true opinions on these issues because of fear that they will say the wrong thing or be misunderstood if they do not conform to "politically correct" orthodoxy – an error which has the potential to lead fellow students to mistakenly brand them as hostile, insensitive, stupid, or naïve. In addition, there is a realistic chance that these can also result in disciplinary action, including (although rarely) termination (see Cummings and O'Donohue Chap. 8, this text). Hence, these students are most likely to be the ones who rarely speak up in class discussions. Instructors mistakenly view these students as not having any relevant opinions on class topics, when in reality they do have opinions but are very reluctant to voice them openly (Jackson, 1999).

Some students enjoy frank discussions on topics of race, ethnicity, class, religion, or sexual orientation because it provides a rare opportunity for them to openly discuss deeply personal hurts or injustices that they have experienced or are currently experiencing in life. These students want the instructor or other students to empathize with them and may at times become visibly hurt, irritated, and openly vocal when they do not sense such empathy from either the instructor or fellow students. This, again, can result in various grievance procedures which may impact the instructor or fellow students.

Some racial or ethnic minority students find themselves as being the only visible member of a particular minority group in their classes. As a result, they sometimes feel embarrassed or extremely uncomfortable when well-meaning professors or other students expect them to be their groups' "representative voice" on discussions of hot topics. These students may dread certain class discussions, because it "shines the spotlight" on them when they would prefer to remain unnoticed. They can resent being seen not as an individual but rather as "tokens."

In some instances, students are quite hostile and resistant toward certain topics that they feel are unfairly negative toward a "politically incorrect" position on multicultural issues. These may be devout Christians whose faith teaches them that homosexual advocacy and behavior is sinful, whites who feel that nonwhite minority groups use racism and discrimination as crutches to excuse personal failures, persons with strong views on immigration enforcement who feel that all illegal immigrants should be deported for breaking the law, or persons who have no sympathy for chronic welfare recipients who are viewed as irresponsible and lazy for their economic condition. These students may be viewed by some training programs as "troublemakers" who require formal/informal sanctioning or further remediation for being open about their resistance to certain aspects of cultural competence training.

In addition, students may feel that their cultures are not adequately treated by the instructor – despite the instructor's best intentions. For example, a Chinese-American may feel that the broad Asian-American label the instructor is using does an injustice to their parents' and grandparents' feelings toward the Japanese treatment of the Chinese prior and during World War II. Or, an Hispanic student may feel that the instructor's claim that Hispanic-Americans believe in the "evil eye", or that all Hispanic males are "macho", are little more than lazy stereotypes of their culture. They may feel that these and other examples ironically reflect cultural incompetence – when the original intent is to teach cultural competence.

The point here is that strong student feelings can be quite influential in guiding instructor behavior, because these are what instructors must confront each time they hold class. Here, instructors may be prone to intentionally foster or suppress certain emotional reactions in students as an aid toward accomplishing course objectives. For these reasons, student expectations/reactions are variables that can be situated toward the "proximal" and "subjective feeling" poles of Dimensions 1 and 2 in Fig. 28.1.

Student Course Evaluations Instructors are sensitized to maximizing positive student course evaluations in order to be judged favorably by department chairs for tenure, promotion, and merit pay decisions. This is a source of much debate in scholarly journals, as some argue that the relationship between student evaluations and the actual quality of teaching is tenuous (Basow & Martin, 2012; Emery, Kramer, & Tian, 2003; McCabe & Layne, 2012; Pounder, 2007). Others have argued that teachers of cultural competence/multicultural issue courses are more vulnerable to lower course evaluations from students due to the anxiety-provoking nature of the subject matter (Rockquemore & Laszloffy, 2008; Samuels, 2017; Sue, Lin, Torino, Capodilupo, & Rivera, 2009). Although data from student evaluations may indeed be determined by emotional factors, the numerical data that are generated are nevertheless subject to objective, quantitative methods of statistical analysis. For these reasons, this variable is positioned closest to the proximal pole of Dimension 1 (due to its strong influence on instructor behavior) but is closer to the objective, measurable data pole of Dimension 2.

College/University Department Needs Each departmental unit within colleges and universities has their own history, climate, and "personality." Some departments are experienced by faculty as intellectually vibrant, highly collegial, and democratic. In contrast, other departments can be experienced by faculty as non-nurturing, tense, and/or highly competitive environments where colleagues rarely work collaboratively with one another (National Association of Geoscience Teachers, 2017).

When it comes to cultural competency courses, departments have their own idiosyncratic internal needs that may influence the content of such courses. For example, training programs differ considerably as to their geographical location within the United States. Training programs situated in the heart of the southwest find that their location fosters an acute awareness of multicultural issues involving Hispanics (particularly Mexican-Americans), while other training programs situated in the inner cities of northeastern states find that they must regularly confront multicultural issues involving African-Americans. Each of these sub-

groups have their own unique sociopolitical and sociocultural histories that shape the specific content of cultural competency classes. Programs geographically situated in certain locations have the advantage of providing practicum settings in which students can interact with specific cultural groups that other programs simply cannot provide.

Decisions as to who teaches what courses are often influenced by internal department politics or the personal/professional qualities of individual faculty members as judged by their superiors and colleagues. A particular faculty member may be chosen to teach a course for no other reason than the fact that they are members of a certain minority group, have the "correct politics," or are exceptionally well-liked by students.

Program Accreditation Guidelines/Expectations In order to attract the best students, training programs in applied psychology and mental health counseling must be accredited by the American Psychological Association (APA, 2006), the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015), or approved by the National Association of School Psychologists (NASP, 2010). Each of these entities requires training programs to acknowledge multicultural and diversity issues in the recruitment of students and faculty, student training, and course offerings. Programs are visited by site accreditation review teams in 1–7-year cycles to evaluate the extent to which these and other goals are being met. Although review teams do not dictate the specific content of cultural competency courses for programs, there must at least be a minimum level of acknowledgment of diversity issues in order for programs to receive high marks necessary for accreditation renewal decisions. Accreditation review teams do not have a daily presence in academic departments, which is why this variable is more distal in its influence compared to instructor, student, and college/university department need variables. However, the *anticipation* of their future evaluation decisions (which are often summarized in quantitative terms) positions this variable a little to the right of the midpoint of Dimension 2 (subjective feelings/objective, measurable data) in Fig. 28.1.

Client Outcomes The *sine qua non* for determining the ultimate value of cultural competency course content is whether or not the knowledge, skills, and dispositions learned have any positive effect on the clients whom students will eventually serve. The paucity of hard data linking cultural competency classes with client outcomes represents the "Achilles' heel" of cultural competence advocacy (Frisby, O'Donohue, Benuto, & Casas, this text; Braden & Shah, 2005; Worthington, Soth-McNett, & Moreno, 2007; Yutrzenka, 1995). Since preservice students in training programs have not yet begun their professional careers, the effects of what they are learning on actual clients remain unknown unless such data can be collected in their practicum or internship settings. It is for this reason why this variable is positioned closest to the distal pole of Dimension 1 in Fig. 28.1. Since client outcome data is both observable and measurable, it is positioned closest to the observable, measureable data pole of Dimension 2 in Fig. 28.1.

Seven Foundational Principles for an Ideal Cultural Competency Course

Principle #1 ***The general purpose of an ideal cultural competency course is to increase the likelihood that preservice psychologists will be more knowledgeable about and effective in meeting the mental health, psychological, and related needs of vulnerable populations about whom they have limited information or exposure.***

We are not persuaded that a cultural competency course is the only avenue through which preservice psychologists will develop knowledge and skills to serve members from racially, ethnically, and/or culturally different population subgroups. Rarely are baseline measures collected to determine who needs how much of exactly what regarding cultural competence. Based on our evaluation of the cultural compe-

tency research literature, we do not subscribe to the view that racially and ethnically different groups can be automatically judged as so exotic, that "traditional" principles for meeting the psychological and mental health needs of such clients are unilaterally inappropriate or irrelevant for these groups. Since individuals are much more than their race or ethnicity (see Principle #5), the competencies that preservice psychologists learn in "regular" courses are just as potentially useful to these subgroups.

What an ideal cultural competency course uniquely provides that "traditional" courses do not is to increase students' knowledge and awareness of how "cultural" variables (e.g., race, ethnicity, language, social class) can impact service delivery. An ideal course also increases students' awareness of, and competencies in, situations where service delivery can be improved with cultural adaptations (see Principle #7).

Principle #2 ***Instructors model a deeper level of critical thinking and analysis applied to word meanings, concepts, research findings, personal assumptions, ideological presuppositions, and guild narratives.***

It is generally beyond dispute among educators that the fundamental purpose of a college education is to promote and assist students in developing critical thinking skills – despite contrarian evidence that this actually occurs (Arum & Roksa, 2011; Schlueter, 2016). Many cognitive scientists argue that thinking skills are best developed within the context of discipline-specific content (McPeck, 1990; Moore, 2011a, 2011b; Willingham, 2007). Regardless of the specific discipline, however, a critical thinking perspective is diametrically oppositional to thinking and reasoning based on unexamined and unchallenged assumptions, strong emotions, tradition, popularity, wishful thinking, sociopolitical ideologies, or appeals to authority (Chaffee, 2015).

A significant number of chapters in this text have argued directly (or at least implied indirectly) that the cultural competence movement is currently driven more by sociopolitical advocacy rather than by empirical validation of its real-world effectiveness. This in turn fosters an approach to the subject matter that can be casual, lazy, imprecise, and sloppy. That is, important words, terms, and concepts are not defined with care, precision, or accuracy. Ideas are assumed to be true or valid without any interest in, or serious attempt to, provide supporting data or evidence. Ideas that have been largely discredited are treated as if they are legitimate, while ideas that have a consistent record of solid research support are ignored. Due to sociopolitical advocacy, ideas that have not been supported by any serious history of empirical validation are treated as if they are beyond dispute.

An ideal course in cultural competence fosters an intellectual atmosphere where the instructor models a willingness to use critical thinking skills in carefully defining important terms, evaluating key concepts, judging the empirical soundness of published research, and encourages (challenges) students to do so as well (e.g., see Feltham, 2010). Examples of specific applications of this critical thinking attitude are given below.

Carefully Defining Important Terms One issue raised in previous chapters is the difficulty inherent in defining "culture" and its semantic derivatives (see "*History and Development of Cultural Competence Evaluation in Applied Psychology*" Chap. 1, this book). The cultural competence movement has short-circuited this difficulty by using race and ethnicity as a succinct proxy for culture, as well as building professional practice guidelines on the implicit assumption that racial and/or ethnic differences – by themselves – *automatically and unilaterally* connote important cultural differences. Serious scholarship underscores the truism that cultural differences are *multidimensional* in nature (e.g., see Frisby, 1996; Wood, 2003), such that two or more persons can be *both* culturally different and culturally similar simultaneously. Acknowledging this basic fact has important implications for understanding to what degree race, ethnicity,

and/or social class may or may not be relevant in their application to specific clinical situations.

Evaluating Key Concepts "Cultural sensitivity" is a concept that is repeatedly promoted in the cultural competence literature (e.g., see Butler, 2003; Foronda, 2008; Schnyder et al., 2016) as a disposition that clinicians are morally and ethically obligated to apply to culturally different clients. The Cummings and O'Donohue chapter (see Chap. 7, this text) applies a deeper analysis of this term than how it is typically handled in the cultural competence literature. They take a fresh look at this term in light of its application to the dynamics of the client/caregiver relationship, in addition to what is known about certain conditions in clinical psychopathology. The chapter shows that, contrary to a superficial understanding of the term, a deeper and more critical analysis reveals serious problems about which clinicians need to be aware.

"Stereotypes" are generalizations about groups which are often portrayed as something that right-thinking professionals ought to avoid, if they wish to serve culturally different clients in a manner that causes no harm. The Stevens, Jussim, Stevens, and Anglin chapter (Chap. 26, this text) shows that, contrary to popular opinion, stereotypes are often accurate when evaluated in light of actual empirical research. This deeper analysis suggests that stereotypes can be rationally and reasonably used in clinical practice when individuating information is absent, scarce, or irrelevant.

Challenging the Validity of Weak Arguments Based on Sentiment/Emotions Critical thinking would not be necessary were it not for natural human impulses that are contrary to a critical thinking perspective (Ruggiero, 2011). Cultural competence advocacy is notorious for infusing its arguments with glittering "virtue words" that undermine clarity in thinking (see Chap. 9, this text).

As an example, Frisby (2005, 2013) examined multiple meanings of the words "multiculturalism" and "cultural competence" and explicated the wide variety of ways in which these terms (in their various forms) distort an objective understanding of reality. In doing so, the effort is made to carefully distinguish between the components of multiculturalism and cultural competence ideology that are positive (i.e., appropriate for psychology training) versus other components that are negative (i.e., existing only to promote a sociopolitical ideology). When critical thinking is applied to the use of these concepts, they are revealed to be internally self-contradictory, at best, and logically incoherent, at worst in academic writing. Applied psychology must grapple seriously and honestly with these nuanced arguments. Instead of doing so, critics instead use vague and generalized "don't-throw-out-the-baby-with-the-bathwater" arguments to defend the virtue of these terms as indispensable necessities within applied psychology training (Li, Ni, & Stoianov, 2015, p. 89; Merrell, Ervin, & Peacock, 2012, p. 59). In making this argument, these critics never clearly define what they mean when they use the terms "multiculturalism" or "cultural competence." Instead, these concepts are assumed to be so inherently noble and virtuous on their face, that audiences are conditioned to be anxious whenever these terms are criticized or closely examined in any form.

This illustrates how the indiscriminate use of virtue words such as "tolerance," "equity," "diversity," "inclusive," "sensitivity," "anti-racist," "nonbiased," and "progressive" (among others) effectively puts the mind to sleep. The liberal use of such words immediately shuts down debate and marks an argument, viewpoint, or user that evokes these terms as good, virtuous, and noble. Some have even argued, for example, that words such as "diversity" represent "how we talk about race when we can't talk about race" (Berry, 2015). Calls for a close examination of such words are studiously avoided or viewed instead with fear and suspicion.

An ideal course in cultural competency pushes students to avoid vague, hackneyed, and ill-defined arguments, articulate clear definitions for terms used, and reason clearly and logically. This is crucial for topics that invite strong emotional reactions, as is the case with any subject matter involving sensitive issues related to race, religion, sexual orientation, social class, or ethnicity.

In our opinion, only then can meaningful classroom learning and discussion take place.

Principle #3 ***Significant attention and systematic instruction is given to an accurate interpretation of subpopulation differences, as well as giving students the proper analytical tools to accurately interpret meanings behind subgroup disparity data.***

In adhering to this principle, students in an ideal cultural competency class must carefully distinguish between the terms "difference" versus "disparity." The former term (difference) has a morally neutral connotation, and simply describes a difference between two or more groups. In contrast, the latter term (disparity) is a more emotionally loaded term that connotes a condition that is caused by an injustice (and therefore needs to be corrected). Herbert, Sisk, and Howell (2008) argue that a disparity cannot be measured directly but can only be inferred when there is a residual difference between two or more groups only after other factors that might contribute to differences have been statistically controlled for.

Instead of comparing broad groups (e.g., men vs. women) in searching for disparities, the more responsible statistical approach is to compare groups who are under the same life circumstances (e.g., men with a bachelor's degree in political science who choose to work continuously after graduating college vs. women with a bachelor's degree in political science who choose to work continuously after graduating college). If this is done, huge differences may disappear, as the more variables one holds constant, the more differences tend to shrink (Smedley, Stith, & Nelson, 2003; Williams, 1996). Unfortunately, if very few persons from one group fall into the category being used for controlling variables in comparisons (e.g., black males with doctoral degrees), overly broad group comparisons (without the use of controls) will almost always show a disparity in one group relative to the other.

One of the most fundamental, pervasive, and longstanding reasoning errors in the justification for cultural competence advocacy (see History and Development of Cultural Comptence Advocacy chapter, this text) is the gratuitous assumption that just because there are statistically significant differences in certain negative outcomes by race/ethnicity, such differences must necessarily be *caused* by race or ethnicity (e.g., see Dolan, 2016; Nolan, 2016; Roberts, 2012; Smedley, Stith, & Nelson, 2003) or by sinister outside forces that are treating persons differently *because of their race or ethnicity*. Thus, in the minds of many, a statistical difference between groups is *automatically* a "disparity," which *automatically* implies an injustice that is required by the standards of basic morality and ethics to be "corrected."

Race and ethnicity are correlated with a wide variety of variables associated with socioeconomic status and living conditions (Williams, 1996). Deciding which factors to statistically control for in multivariate data is challenging and involves a myriad of subjective decisions (Herbert, Sisk, & Howell, 2008). First and foremost, American racial and ethnic groups are not distributed evenly or randomly throughout the country or even within each state (see Frisby, 2013, Chapter 3). Depending on the specific region of the country, or the particular county within a state, psychologists are highly likely to have steady exposure to some groups while having minimum exposure (if at all) to other groups.

An ideal cultural competency course raises students' awareness of the geographical locations, service delivery settings, and psychological help-seeking situations in which significant differences in subpopulation outcomes will most likely be observed. As one among many examples, nonwhite groups are overrepresented in populations served by mental health and social service agencies, as well as the criminal justice system (Children's Bureau, 2016; Fong, Dettlaff, James, & Rodriguez, 2014; Nellis, 2016).

Racial and ethnic groups differ and are not comparable on a host of basic social, educational, and economic variables. American racial and ethnic groups differ in levels of educational attainment (Pew Research Center, 2016; Ryan & Bauman, 2016), life expectancy (Cantu, Hayward, Hummer, & Chiu, 2013; Cunningham et al., 2017) average measured cognitive ability (Herrnstein & Murray, 1994; Rushton & Jensen, 2005), marriage

and non-marital birthrate patterns (Pew Research Center, 2016; Raley, Sweeney, & Wondra, 2015), and employment wages (Patten, 2016) – just to name a few.

Klick and Satel (2006) show that factors that are *correlated with race* (and not race itself) are largely responsible for differences between racial groups in both health care and health-care outcomes. These authors show that when researchers employ statistical designs that properly control for the influence of correlated variables, "the magnitude of any race effect shrinks considerably, if it does not disappear altogether" (p. 4).

For example, patients from different racial/ethnic groups often do not visit the same population of physicians, which makes the argument for "physician bias" less compelling (since bias is most effectively proven when it can be shown that the same physician treats his/her patients differently due to their racial/ethnic group membership). If physicians who are visited disproportionately more often by one group are not in a position (for whatever reason) to provide the best care, then group disparities will result for reasons that have little or nothing at all to do *directly* with patients' race/ethnicity (Klick & Satel, 2006).

Second, the quality of health-care facilities differs as a function of differences in their geographical location of residence. Therefore, if one racial/ethnic group is overrepresented in geographical areas that have poorer health-care facilities, then poorer care will be evident as a *direct function of where patients live (or how they live)*, not from being *caused* by patients' race or ethnicity (Klick & Satel, 2006).

An illustration of this principle can be clearly seen from data published online by *24/7 Wall Street*, which is a corporation that publishes financial news, opinion articles, and commentaries over the Internet and in a variety of financial investment publications. The corporation recently published a list of the 50 worst cities in which to live (each having populations of more than 65,000 persons in 2015*;* Sauter, Stebbins, & Comen, 2017). In order to determine which cities to include on this list, data was collected in the nine major categories of crime, demography, economy, education, environment, health, housing, infrastructure, and leisure. Within each of these categories, a number of specific measures contributed to a city's overall category score. For example, the economic category score is determined from an examination of median household income, poverty and unemployment rates, and the city's 3-year employment growth.

We then consulted the American FactFinder online search tool to compile the most recent statistics on the proportions of persons living in these 50 "worst" cities who self-identify as non-Hispanic Caucasian, Black (African or African-American), Hispanic, Asian, and Native American (shown in Table 28.1). These cities are ranked from the "best-worst" city (50. Columbus, GA) to the "worst-worst" city (1. Detroit, MI). As shown in Table 28.1, only 15 cities have non-Hispanic Caucasian populations that exceed 50 percent. These data suggest that nonwhite minority groups are disproportionately affected by living in these cities, but their race/ethnicity status cannot be said to be the *cause* of any negative outcomes that may result from living in these cities.

Third, there are interventions that increase outcomes in a positive direction for all population subgroups unilaterally. However, differences between population subgroups can still remain. For example, it is undeniable that all Americans are exposed to better nutritional information and choices today than was the case 200 years ago. Currently, however, subpopulation differences continue to exist in risk factors for childhood obesity rates (e.g., see Dixon, Peña, & Taveras, 2012). The important questions here are, do these differences negate the tremendous strides achieved in nutritional literacy over the centuries? Is it appropriate or professionally responsible to automatically ascribe any stubborn subpopulation differences to malevolent forces (e.g., prejudice, discrimination, bias, racism, etc.)?

An academically and intellectually responsible course in cultural competence exposes students to the truism that some improvements in psychological services can indeed significantly impact racial

Table 28.1 Percentages of racial/ethnic groups living in America's 50 worst cities in 2015 (Sauter, Stebbins, & Comen, 2017)[a]

City, state	White (%)	Black (%)	Hispanic (%)	Asian (%)	Native American (%)
1. Detroit, MI	9.5	79.2	7.9	1.2	0.0004
2. Birmingham, AL	21.5	72.4	4.1	0.6	0.2
3. Flint, MI	41.7	52.5	2.6	0.2	0.1
4. St. Louis, MO	43.7	46.5	3.8	2.8	0.1
5. Memphis, TN	26.3	62.8	7.1	2.0	0.0004
6. Milwaukee, WI	36.1	38.5	18.3	3.7	0.4
7. Albany, GA	22.1	73.2	2.5	0.6	0.4
8. Hartford, CT	13.7	36.0	45.1	3.0	0.0
9. Merced, CA	28.5	4.8	52.9	9.8	0.2
10. Wilmington, DE	29.1	59.4	7.6	1.5	0.2
11. San Bernardino, CA	15.4	13.2	63.0	4.8	0.2
12. Springfield, MO	88.0	4.8	4.3	2.7	0.5
13. Stockton, CA	21.3	10.5	41.9	21.4	0.1
14. Baltimore, MD	28.1	61.1	4.8	2.7	0.1
15. Jackson, MS	16.1	81.2	1.7	0.4	0.0
16. Rockford, IL	55.0	19.1	19.3	3.1	0.2
17. Miami Beach, FL	41.9	2.9	51.3	2.6	0.0
18. Springfield, MA	31.2	18.0	44.8	2.9	0.2
19. Pueblo, CO	42.9	1.8	52.6	0.7	0.7
20. Canton, OH	63.5	25.6	5.4	0.4	0.0
21. Youngstown, OH	41.1	43.3	11.7	0.3	0.6
22. Buffalo, NY	43.7	36.5	11.4	4.8	0.3
23. Knoxville, TN	73.0	16.8	4.6	1.7	0.1
24. Fort Smith, AK	59.0	10.6	19.3	5.9	1.4
25. Cincinnati, OH	49.3	42.0	3.0	2.0	0.1
26. Little Rock, AK	44.4	42.0	7.8	3.7	0.0001
27. Paterson, NJ	10.3	24.3	57.9	5.3	0.0
28. Tucson, AR	44.7	4.6	43.4	3.0	1.8
29. Gary, IN	15.4	77.2	8.1	0.5	0.0
30. Chattanooga, TN	56.8	31.8	6.1	2.2	0.3
31. Syracuse, NY	52.3	27.3	9.2	5.8	0.6
32. Salt Lake City, UT	67.1	2.2	21.0	5.3	0.5
33. Reading, PA	24.1	8.0	64.9	0.9	0.0
34. Rochester, NY	36.3	38.6	18.1	3.6	0.2
35. Lansing, MI	53.6	22.8	12.4	3.4	0.2
36. Waterbury, CT	37.7	21.8	35.1	3.4	0.0
37. Atlanta, GA	38.1	51.5	4.0	4.3	0.1
38. Fall River, MA	79.0	3.1	10.2	1.8	0.0
39. Indianapolis, IN	56.5	27.6	9.8	2.9	0.2
40. Medford, OR	76.2	0.3	17.9	1.2	0.2
41. Lubbock, TX	51.4	6.9	36.4	2.5	0.3
42. Philadelphia, PA	35.1	40.9	13.9	7.1	0.1
43. Lawrence, MA	36.3	7.3	53.0	2.6	0.2
44. Albuquerque, NM	39.7	3.0	48.6	2.4	3.8
45. Gastonia, NC	57.6	27.8	8.9	3.0	0.4
46. Shreveport, LA	38.0	56.1	2.5	1.8	0.1
47. South Bend, IN	53.6	24.8	15.8	1.3	0.1
48. Camden, NJ	3.6	39.1	54.4	2.2	0.0
49. Kansas City, KS	39.4	23.6	29.3	4.3	0.3
50. Columbus, GA	41.7	44.7	7.5	2.2	0.3
United States	**76.9**	**13.3**	**17.8**	**5.7**	**1.3**

[a]Race/ethnicity breakdown data is from US Census Bureau (2015), US data is from US Census Bureau (2016)

and ethnic groups in a positive direction, but only because certain problems are more prevalent in one group compared to another (i.e., the services that lead to improvement may have nothing at all to do with race or ethnicity directly).

Principle #4 ***The interaction of real-world variables that influence caregiver/client outcomes is extremely complex, an accurate understanding of which is not well served by simplistic generalizations.***

As an illustration of this principle, Font, Berger, and Slack (2012) statistically analyzed a national sample of 1461 child protective services investigations in the United States, examining differences between black and white families with regard to caseworker ratings of risk and harm to the child and the probability that a case is substantiated for maltreatment. They found no differences in outcomes by the child's race after statistically adjusting for differences in case characteristics. They concluded:

> On the whole, these findings suggest that efforts to address racial disproportionality in [child protective services], which have predominantly focused on cultural competence training for caseworkers and recruitment of minority workers. .. are unlikely to reduce black-white gaps in [child protective services] outcomes, particularly if they operate under the assumption that such differences are determined by white caseworkers' assessments of black families. Rather, greater attention should be given to the geographic contexts in which families and caseworkers function, as well as to racial differences in sociodemographic and case characteristics that are associated with maltreatment. .. [W]e caution that the role of race within [child protective services] is complex and that there is likely a great deal of heterogeneity in case details as well as worker-family interactions. *(p. 2198)*

Because cultural competence advocacy is highly susceptible to ideological rather than scientific thinking (Frisby, 2009), and the very definition of ideological thinking involves the oversimplification of life's complexities (Frisby, 2013), cultural competence advocacy is often built on overly *simplistic narratives* that serve to reinforce a particular view of the world (see Chap. 9, this text).

A narrative is a story that weaves together a "cherry-picked" sampling of discrete observations or opinions for the purpose of supporting a particular conclusion or viewpoint. Audiences are not required to critically question, evaluate, or analyze the strength of narratives, but are only required to *accept them without question* (due to the ascribed value of the cause that the narrative supports). To illustrate, consider the following four distinct observations (discussed in the History and Development of Cultural Competence Advocacy chapter, this text):

1. American demographic changes reveal increasing numbers of racial and ethnic minorities relative to whites.
2. Disparities exist across racial and ethnic minority groups in mental health and mental health-related resources, indicators, and outcomes.
3. There is a shortage of racial and ethnic minorities who work as mental health or psychological service providers.
4. Most psychological theories used to understand and treat mental disorders were developed by white psychologists and researchers.

These observations – considered individually or as a whole – are frequently cited as a justification for the urgent need to infuse cultural competence training as a top priority for professional preparation programs (see American Psychological Association, 2003, 2008; Sue, Zane, Hall, & Berger, 2009). This conclusion is a *received wisdom*, not an empirically vetted conclusion that is necessarily supported from a close examination of the relationship between the content of cultural competence courses in training programs and client outcomes in the real world. There is no more evidence that the actions of individual practicing psychologists can reverse these national trends than there is evidence that cashiers working in grocery stores can reverse world hunger.

In the absence of objective evidence, simplistic narratives are used to ignite social passions, which in turn can be used to mobilize students in cultural competence classes to adopt certain values or serve certain sociopolitical agendas (Aldarondo, 2007; Constantine & Sue, 2006;

Kivel, 2011; Reynolds, 2017; Toporek et al., 2006). Such narratives portray racial and ethnic minorities as being profoundly "culturally exotic" at best or perpetual victims of ongoing societal wrongdoing at worst (e.g., see critiques in Bawer, 2012; Frisby, 2013, Chapter 2). Particularly within counseling psychology, the victimhood of minority groups is promulgated within the context of a morality play pitting oppressor groups (e.g., whites, males, the rich, heterosexuals, Christians) against oppressed groups (e.g., persons of color, females, the poor, LGBTQ groups, and Muslims; Ratts & Pederson, 2014; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016; Sue & Sue, 2016).

Therefore, the justification for cultural competence classes is seen as analogous to a flu vaccination required by public health agencies. Instead of being injected with a substance that will prevent flu symptoms in the future, persons from the "dominant culture" (whites, heterosexuals, males, the middle class, etc.) are exposed to an experience (cultural competence training) that will hopefully eradicate their hidden/unconscious racism, prejudice, and insensitivity, "wake them up" to the suffering of minorities, "open their eyes" to the ways in which "whiteness" oppresses minorities, and learn a special set of skills, knowledge, and dispositions that will invigorate and improve the effectiveness of service delivery for disenfranchised groups. As an added bonus, cultural competency training may energize the trainee to discover and apply his/her passion for social justice advocacy both within and outside of professional practice (Alvarez, Liang, & Neville, 2016; Goodman et al., 2004; Jun, 2010; Lee, 2007; Sue, 2003).

Real-World Complexities

What is lost, ignored, or purposely "kept off-stage" in all of this excitement are certain inconvenient truths:

First, to assume that individuals who belong to the same ethnic/racial group are influenced in the same way by their reference culture, or to assume that all individuals in a specific group adopt the same cultural norms in all environments in the same manner, is to commit the *ecologic fallacy* (Dreher & Macnaughton, 2002; Jargowsky, 2005; Piantadosi, Byar, & Green, 1988; Frisby, 2013). Stuart (2004) writes:

> When psychologists make inferences about individual clients from assumptions about the cultures that influence them, in effect they commit the logical flaw of basing ideographic predictions on nomothetic data sets. *(p. 5).*

Second, racial and ethnic minorities are just as susceptible as anyone else to being prejudiced, promoting racism, or to mistreat and victimize other persons from culturally different groups (Casale-Hardin, 2016; Estrada, 1999; Flaherty, 2013, 2015; Landis & Albert, 2012; O'Donohue, chapter 27 this text; Peschmann, 2013; Pierce, 2014; Sales, 2014).

Third, while we acknowledge that the "culturally insensitive therapist/culturally misunderstood client" narrative can be a potential problem, it is but one of many varieties of therapist/client permutations that exist in the real world. The therapist could be the most culturally competent caregiver on earth, yet the intervention may still fail due to clinical features of the client's presenting problem, clients' propensity to lie to their therapist, or simply from a lack of personal responsibility on the part of clients (see "*Cultural Competence and Sensitivity in Applied Psychology: Ethical and Scientific Problems*" Chap. 5, this book; Blanchard & Farber, 2015; Curtis & Hart, 2015; Moffatt, 2016; Overholser, 2005; Samenow, 1998, 2004). In fact, there can even be problems due to clients' overt racism/insensitivity toward the therapist (Rastogi & Wieling, 2005).

Fourth, human beings experience difficult personal trials and tremendous sufferings in life for reasons that have nothing at all to do with their race or ethnicity (Keller, 2013; Lemacks, Fowles, Mateus, & Thomas, 2013; Miller et al., 2012; Mu et al., 2015; Wozniak & Izycki, 2014).

Fifth, no matter how skilled a clinician is, there are natural limitations in the kinds of problems that applied psychology can alleviate (Dalrymple, 2015; Driessen, Hollon, Bockting, Cuijpers, & Turner, 2015; Dawes, 1994; Glenn & Raine, 2014; Gregory et al., 2015; Johnsen & Friborg, 2015; Lilienfeld, Lynn & Lohr, 2003;

Rogers, Blackwood, Farnham, Pickup, & Watts, 2008; Spitz, 1986; Werb et al., 2016; Wright & Cummings, 2005).

Sixth, competent psychologists and therapists often disagree among themselves as to which are the best interventions for treating particular problems (Marlatt & Donovan, 2005; Fassin & Rechtman, 2009; Feltham, 2010; Jaffe, 2010; Wampold & Imel, 2015). Thus, it cannot be assumed that clients who visit caregivers for the same problem will necessarily experience the same treatment interventions.

Seventh, applied psychologists – by definition – do not have expertise or training in political science, sociology, or theology. Nevertheless, academic psychologists continue to push the narrative that "social justice" can be delivered to society through the avenue of cultural competency training (Chen, 2013; Lyons & Bike, 2013; Nassar-McMillan, 2014; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009; Satel, 2000). Social justice advocacy has been shown to be little more than "Marxism-lite" ideology, where social class struggles have been replaced by racial, ethnic, gender, language, sexual orientation, or religious group struggles (Bankston, 2010; Church, 2017; Duigon, 2007; Haidt, 2016; Novak, Adams, & Shaw, 2015; O'Neill, 2011; Palumbo & Iacono, 2016; Young, 2016). The cold reality is that Marxism has utterly failed when applied to governments and societies (if it can be applied at all) and has even created more problems than it solves (Hardiman, 2016; Kolakowski, 2005; Novak, Adams, & Shaw, 2015; Salzman, 2016; Sowell, 2016).

Finally, each applied psychology training program needs to make difficult decisions as to which content (about which particular cultural issues and groups) needs to be included in a relatively brief semester-long course. These decisions are particularly challenging in light of the fact that training programs have limited information about where (and under what circumstances) their graduates will eventually practice. Once students graduate from a training program, and have been away from the program for a matter of months (even years), they will most likely forget half of what they learned. Some students may indeed devote their professional lives to serving cultural minority clients. However, it may be years before graduates encounter clients from particular groups that they studied in preservice classes (if they encounter such persons at all). The cultural issues discussed in any preservice course are maximally salient to students only while they are taking the course (unless they supplement their training with a regular program of in-service cultural competency courses). When they eventually face an actual client, however, they will need to simultaneously integrate many different pieces of stimuli, information, and observations that are being currently presented to them. What is salient are the *immediate conditions* within which they are working at any particular point in time – which is something that didactic lecture courses (taken many months/years in the past) are limited in simulating.

An ideal cultural competence course is led by instructors who model an appreciation of these and other empirical complexities in the real world.

Principle #5 ***Competence in effective service delivery is rooted in an understanding of the primacy of, and fundamental respect for, the uniqueness of the individual client.***

Although the impulse to educate applied psychologists about cultural characteristics in client/caregiver interactions (for the purpose of improving outcomes) is essentially well-meaning, it unfortunately leads to the tendency to view individuals as little more than stock representatives of their racial/ethnic group. The following direct quotes typify this impulse:

- "Because of their theoretical roots in Asian philosophies, mindfulness and acceptance-based psychotherapies or contextual therapies have promise for application with Asian Americans" (Hall, Hong, Zane, & Meyer, 2011, p. 216).
- "The underutilization of mental health services by African Americans may be due, in part, to their cultural mistrust" (Whaley, 2001, p. 513).
- "Latino culture has several normative values that must be recognized in clinical settings. These include simpatía (kindness), personal-

ismo (friendliness), and respeto (respect)" (Juckett, 2013, p. 52).
- "African American clients are more likely to remain in treatment when mental health interventions are based on Afrocentric values" (Griner & Smith, 2006, p. 532–3).
- "The Mexican cultural value of collectivism and communal orientation has the potential to serve as a protective factor in mitigating distress. The Mexican collectivist cultural value entails mutual empathy, deference to group interest over individual interests, and conformity to group expectations. .." (Furman et al., 2009, p. 171).

To be fair, many of these same sources also mention the importance of avoiding group generalizations and treating clients as individuals:

- "When colleagues and students ask if they can determine a client's racial identity by appearance, I strongly let them know that they can't and that they should not try to do so. .. Given the high numbers of multiracial individuals in this country, therapists are wise to refrain from guessing or assuming any client's ethnic identity" (Sanchez-Hucles, 2001).
- "As with any patient, Latinos should be treated as individuals first, while exploring possible cultural distinctions" (Juckett, 2013, p. 53).
- "[C]learly there is much variability within cultural groups. .. Thus, psychotherapy approaches that overly emphasize or rely on a single cultural frame or orientation to the self, coping, and communication may not be optimally effective for persons of Asian cultural origins. .." (Hall, Hong, Zane, & Meyer, 2011, p. 217).
- "It is important to recognize that Latinos are not a homogeneous group. In fact, it can be argued that the very concept of a singular Latino identity or ethnic group affiliation is problematic" (Furman et al., 2009, p. 168).

These quotes underscore the existence of a very real and palpable tension between two opposing forces: (1) the desire to improve mental health and psychological outcomes for "cultural" groups, versus (2) recognizing and being clinically responsive to the uniqueness of each individual client.

The history of applied psychology from the 1800s to the present highlights the struggle of applied psychologists to alleviate human suffering by first gaining a deep understanding of the nuanced complexities of individual human beings (Hothersall, 2004). Since no one school of thought can fully integrate all of these complexities, this history is marked by exciting movements that captured the attention of the psychological community for a short while, only to be eventually eclipsed by a new movement once the shortcomings and flaws of the previous movement have reached a critical mass. We have witnessed these cycles in the psychoanalytic psychology, behavioral psychology, cognitive psychology, and cognitive behavioral psychology movements (Hergenhahn & Henley, 2014). Unfortunately, the history of applied psychology has also witnessed the general public's fascination with academically dubious "pop psychologies" such as recovered memory therapy, herbal treatments for psychological disorders, primal scream therapy, matching teaching styles to learning styles, training for right/left brain functioning, hypnosis therapy, and subliminal self-help tapes – to name a few (see Lilienfeld, Lynn, & Lohr, 2003; Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010).

We are now currently in a phase where multiculturalism and skin color are now what many consider to be the most important variables that can determine the effectiveness of psychological services (Helms & Cook, 1999; Moodley & Palmer, 2006; Ratts & Pedersen, 2014). Here, individuals are viewed as little more than representatives of their racial/ethnic groups. Thus, cultural competence training is rarely (if ever) framed as "how to treat individuals who happen to have cultural issues in their presenting problems." Rather, articles, book chapters, and workshops are more often than not framed as "how to be culturally competent with 'X' racial/ethnic group" (e.g., Furman et al., 2009; Hall et al., 2011; Pederson, Lonner, Draguns, Trimble, & Scharrón-del Río, 2016; Whaley, 2001).

Why Is Respect for Individuality De-Emphasized in Cultural Competency Writing? Reasons behind this pervasive mindset in applied psychology are not difficult to grasp. For starters, most empirical research in the cultural competence literature is conducted on groups, not individuals. Counting persons by their group membership and placing persons into racial/ethnic categories is by far the easiest way to measure any ethnic/racial variable.

Second, a focus on groups more easily lends itself to political advocacy. The simple calculus of "Group disparities exist, therefore societal injustice" (Satel, 2000) is easiest for the lay public to grasp. Group data forms the basis for local, state, and federal statistical data to be collected and collated on race/ethnicity, for purposes of ensuring civil rights protections and enforcing nondiscrimination laws. The easy focus on group traits fuels the "grievance industry" in professional psychology (Satel, 2000) – where group disparities research provides the much needed pretext for charging "racism" in the mental health and healthcare systems (Bailey et al., 2017; Brondolo, Gallo, & Myers, 2009; Feagin & Bennefield, 2014; Gee & Ford, 2011; Levin, 2013; U.S. Department of Health and Human Services, 2001). The never-ending focus on group disparities research energizes political lobbying efforts in Washington, drives grant funding for advocacy groups, and energizes multicultural advocacy in academic departments, journal editorial boards, and professional organizations (Satel, 2000).

Third, it is one short step from these realities to the gratuitous assumption that the basic principles for understanding the workings of the human mind must also be "color coded" as well. Visit any university library, and one can easily find numerous racial/ethnic minority specialty journals devoted to each groups' psychology (e.g., *Mexican Journal of Behavior Analysis*, *Journal of Black Psychology*, *Hispanic Journal of Behavioral Sciences*, *Journal of Psychology in Chinese Societies*, *Philippine Journal of Psychology*, etc.). Some training programs no longer make any pretense that cultural competence has anything to do with understanding the human mind, as this has taken a back seat to skin color and its relationship to social justice (Satel, 2000).

In contrast, it is much more difficult to train practitioners to be responsive to individual differences, in our opinion. In many statistical designs, ironically, individual variability is referred to as "error variance" (e.g., in **AN**alysis **O**f **VA**riance designs; Turner & Thayer, 2001). No two individuals are exactly alike, no matter how similar they are in their racial, ethnic, or language characteristics. Understanding individual uniqueness requires the skillful integration of wide range variables that impact the individual, an undertaking that is maddeningly complex. Whereas group stereotyping provides psychologists with a predigested set of expectations about clients, caregivers are encouraged to avoid prejudgments when respecting individual differences (see Stuart, 2004). In fact, numerous sources warn audiences of the dangers of committing the *ecological fallacy*, which is generally defined as making assumptions about individuals from knowledge of groups (Dreher & MacNaughton, 2002; Jargowsky, 2005; Piantadosi, Byar, & Green, 1988). On this point, Stuart (2004) writes:

> . . . [E]very individual is a unique blend of many influences. Whereas culture helps to regulate social life, specific beliefs are products of individuals' minds. Because of this complexity, it is never safe to infer a person's cultural orientation from knowledge of any group to which he or she is believed to belong. *(p. 5)*

Even for cultural competence classes, we argue that practitioners must learn to closely observe clients, listen more than they talk (at least during the initial stages of a therapeutic relationship), and ask insightful and probing questions. Information gained in sessions are treated as ongoing hypotheses that are continually subject to confirmation or disconfirmation.

We do not retreat from the firm conviction that the foundation of all applied psychology training, as well as its ultimate goal, is for caregivers to best serve the mental health needs of the individual. Whether the context is school functioning, relationship issues, managing substance abuse, or dealing with the criminal justice system, psychologists must use all of the skills at their disposal to (1) first do no harm to the individual, (2) understand how the individual views the world

and their place in it, and (3) effectively treat their needs.

In our view, Stuart (2004) effectively articulates a grounded perspective on the relationship between a focus on the individual in relationship to group characteristics. On this issue, he writes:

> There is a very fine line between sensitivity to the implications of a person's membership in a particular group and losing sight of that person's individuality. Linguistic convenience can easily give rise to stereotyped thinking that undermines respect for the uniqueness of individuals. .. Awareness of different cultures does provide hypotheses about what the majority of some groups may believe, but it offers scant information about any given individual. *(p. 6).*

Satel (2000) writes:

> Culture, of course, has a considerable influence on personal identity, but it is only one influence among a great many, and it does not predictably determine the nature of one's distress nor the formula for its amelioration. By evaluating cultural influences the same way they evaluate every other influence – individually, one patient at a time – therapists can avoid the confusion that is the inevitable by-product of the group stereotyping found in various textbooks. *(p. 216)*

At the time of this writing, one of the authors teaches a graduate-level class for public school teachers on cultural diversity issues in education. One class assignment required students to interview two persons that are racially, ethnically, socioeconomically, or religiously different from the student and to each other and to understand how interviewees' previous educational experiences contributed to their life accomplishments. We end this section with a verbatim excerpt from one student's paper. Although the student who provided the excerpt is a professional educator and is not part of an applied psychology training program, the quote most effectively captures the spirit of Principle #5 for the training of applied psychologists:

> Interviewing these individuals also made me realize even more to not judge a person before you get to know them. Humans are so much more than just what they look like or what their culture says about them. Their culture may shape who they are, but it is not necessarily what defines them.. .. . Just because we see the color of our students' skin does not give us teachers the right to make judgements about our students and their families or assume we know what their culture is like. In order to fully understand who our students are, we need to build a relationship based on mutual trust, positivity, and warmth. When this happens, students are more likely to open up and share more about themselves. When students share about their life or their struggles, it makes it easier for us to fully understand them. *(Anonymous, personal communication, September 2017).*

Principle #6 ***The negative effects of contentious sociopolitical differences within the classroom can be disarmed to some degree by openly acknowledging such differences and treating such differences respectfully and as a serious topic of study within the context of understanding potential clients.***

Sociopolitical ideologues, whether they be on the political left or political right, are prone to see their worldview as "normal" and anyone who deviates from that view (no matter how slightly) as "radical" (Wright & Cummings, 2005). If the core of their personal and professional identities are deeply enmeshed with their worldview, then all professional objectivity is lost. In the context of academia, this simply means that any data that the ideologue does not like - or disagrees with - is summarily dismissed as being not just wrong but "harmful," "biased," "evil," or "dangerous" (see "*The Treatment of Race, Racial Differences, and Racism in Applied Psychology*" Chap. 13, this book).

Although this can happen to any academic on any side of the political spectrum (Haidt, 2012), it is only fair to point out that academia, generally, and psychology, specifically, is overwhelmingly dominated by politically "left" or "progressive" worldviews (see "*Viewpoint Bias and Cultural Competency Advocacy Within Applied Psychology*" Chap. 9, this book; Haidt, 2016; chapter on Cultural Competence, Identity

Politics, and the Utopian Dilemma, this text; Redding, 2001, 2012).

This creates the toxic conditions for potentially serious conflicts in cultural competence classrooms when the professor openly favors perspectives from one side of the political spectrum and the majority of students favor perspectives from the opposing side of the political spectrum. We argue that these conflicts, and the negative personal and professional consequences of them, can be neutralized to some degree by adhering to three main subprinciples:

First, inherent in cultural competence classes are topics that have the potential to ignite spirited debates (at best) or molten-hot conflicts (at worst). These are (but certainly are not limited to) debates over the validity of "white privilege" and the persistence of white racism; moral evaluations of racial/ethnic group behavioral traits, beliefs, and practices; opinions about the components of healthy vs. unhealthy racial/ethnic identity; debates over the importance of racial/ethnic matching in client services; the relevance of white racism in explaining past and current minority group inequalities; the causes and consequences of racial/ethnic group differences in crime/incarceration rates and out-of-wedlock birthrates; the causes for average racial/ethnic group differences in general intelligence and its social indicators; and differences of opinion as to the role of religious beliefs and the mainstreaming/acceptance of homosexuality.

If instructors feel that one or more of these topics will pose significant problems in the classroom, they would do well to administer anonymous attitude inventories (commercial or self-made) to their students at the beginning of the semester – then take the time to discuss similarities and differences in the survey responses and how these may relate to upcoming class topics. This assures instructors that they will not be "blindsided" later in the semester - which, if unanticipated, may derail student learning and the teacher's instructional effectiveness.

Second, and connected somewhat with the previous principle (Principle #5: Respect for individuality), within-classroom conflicts can be neutralized considerably by framing these issues within classroom instruction as "individual differences in what clients bring to sessions with the caregiver." No matter what a student's (or instructor's) political orientation is, nearly all of us can agree that our first priority is to understand our clients' worldview and to best serve them within the parameters of that worldview. This gives instructors a legitimate opening to discuss different sociopolitical worldviews, since students must understand worldviews that may be different from theirs in order to properly relate to clients.

Third, nearly all applied psychology courses are required to address professional ethics in training (Boyle & Gamble, 2014; Haeny, 2014; Jacob, Decker, & Lugg, 2016; Pope, Sonne, & Greene, 2006; Pope & Vasquez, 2016; Tien, Davis, Arnold, & Benjamin, 2012). If, in the course of problem-solving on a real or hypothetical case, the student inadvertently lets his/her sociopolitical orientation cloud professional judgment or clear problem-solving, the instructor has a legitimate reason to openly discuss the implications of particular sociopolitical convictions and/or biases.

Principle #7 ***A selective and judicious examination of cultural adaptations permits trainees to become well-rounded practitioners.***

The importance of Principle #5 (Respect for the individual) should not be mistakenly interpreted to mean that attention to cultural variables is downplayed or that cultural issues are unimportant in applied psychology training. The entire *raison d'être* for requiring a cultural competence course or workshop is to train pre- and in-service practitioners to be better prepared for serving populations with whom they have had limited exposure (Principle #1). Rather, the importance of the individuality principle lies in its ability to impose appropriate limits on which modes of service delivery labeled as "cultural adaptations" have real-world clinical significance and which do not.

One often hears the sentiment that racial, ethnic, and/or cultural minorities face "barriers to care" that are, in part, responsible for physical and

mental health disparities. As one example, Miranda et al. (2003) noted:

> Evidence-based interventions appear effective for poor and minority women if they are given support to overcome barriers to care . . . and using professionals sensitive to low- income and minority populations. *(p. 64)*

We do not interpret "barriers to care" as meaning that some outside force is intentionally working to erect roadblocks to adequate care for certain groups simply because of their race, gender, or ethnicity. To imply such an interpretation is intellectually irresponsible, in our opinion. Some "barriers" are due to internal characteristics having nothing at all to do with race or ethnicity – about which caregivers have little control. For example, Gottfredson (2004) stated:

> It is now amply documented . . . that equalizing the availability of health care does not equalize its use. Perhaps most important, less educated and lower income individuals seek preventive health care (as distinct from curative care) less often than do better educated or higher income persons, even when care is free. *(p. 181)*

Some barriers are social in origin, in the sense that the immigration and acculturation history, settling patterns, and cultural/language history of some groups cause them to settle in insular enclaves that are socially distinct from the broader surrounding community (see *Important Individual Differences in Clinician/Client Interactions* chapter, this text). These differences are so entrenched that in some urban areas, merely walking across the street from one neighborhood to another is analogous to stepping out of one cultural world into an entirely different cultural world. As a result of a long history of this cultural entrenchment, unfamiliarity and a lack of trust builds in cultural communities that makes it difficult to fully participate in health and mental health services dominated by the majority cultural group.

Finally, and somewhat related to the previous two points, physical and mental health disparities (e.g., Cunningham, Solomon, & Muramoto, 2016; Sakuma et al., 2016) are partly attributable to *personal choices* as these affect one's day-to-day lifestyle. Gottfredson (2004) quotes the 1996 Human Capital Initiative report on health (American Psychological Society, 1996):

> [S]even of the 10 leading causes of death have aspects that can be modified by doing the right thing; that is, by making healthy choices about our own behavior . . . and that mortality could be reduced substantially if people at risk would change just five behaviors: Adherence to medical recommendations . . . , [improve one's] diet, [reduce] smoking, [increase] exercise, and [decrease] alcohol and drug use. (Gottfredson, 2004, p. 181)

Understanding Cultural Adaptations

Although there have been numerous definitions for the term "cultural adaptation" (including using different synonyms such as "culturally informed," "culturally centered," "culturally grounded," "culturally attuned," or "culturally sensitive" interventions; see Bernal & Sáez-Santiago, 2006; Castro, Barrera, & Steiker, 2010), one of the most well-known definitions is "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jimenez-Chafey, & Domenech Rodríguez, 2009, p. 362). Some writers argue that culturally adapted interventions represent a middle ground in-between polar opposite "extreme" positions of (1) an "original" treatment viewed as applicable to all groups without adaptations vs. (2) a "culture-specific" approach that emphasizes "culturally grounded content and process" (Chowdhary et al., 2014). We favor Castro et al.'s (2010) depiction of cultural adaptations as:

> a continuum . . . that varies between the extremes of making no alterations to an original [evidence-based intervention] in its application to a subcultural group and the complete rejection of the [evidence-based intervention] in favor of a novel, culturally grounded approach that is developed in collaboration with the intended consumers. In between those two extremes are alterations that change few or many of the features of an intervention to affect engagement and/or the intervention's core components that influence mediating mechanisms of change. *(p. 219)*

Cultural adaptations are justified when (1) the adaptation has the potential to engage culturally different clients who typically would not be engaged in the culturally unadapted intervention, (2) there exist unique risk factors for harm that would be exacerbated with a culturally unadapted intervention but not so with an adapted intervention, (3) there exist culturally unique symptoms of a disorder that a culturally unadapted intervention is not designed to address, (4) the cultural adaptation is based on true claims about the cultural group and sound evidence is presented to evaluate the truth value of such claims, and (5) the cultural adaptation has the potential to yield better effectiveness and outcomes compared to unadapted interventions (adapted from Castro et al., 2010).

Although we support many of the illustrations these authors give of culturally adapted treatments, several challenges remain in digesting this literature. First and foremost, many meta-analyses of cultural adaptation studies do a technically impressive job of synthesizing large data sets of individual research studies using sophisticated meta-analytic reviewing techniques, yet leave undescribed the specific processes and/or nature of the cultural adaptations (e.g., see comments by Chowdhary et al., 2014; Zane, Bernal, & Leong, 2016). This is primarily because such literature reviews integrate results from heterogeneous populations, all of whom present with a wide range of heterogeneous mental and physical health problems, and report on heterogeneous cultural adaptations in different settings. Although these reviews conclude with generally positive testimonials that cultural adaptations are effective (e.g., see Barrera, Castro, Strycker, & Toobert, 2013; Nierkens et al., 2013), readers do not have the foggiest notion as to what *specifically* is to be done with this information (as large meta-analyses cannot specify the specific processes responsible for success).

Some cultural adaptations are extremely superficial in nature, as they do not require as a condition for their use any deep understanding of the confluence of the mind's functioning with serious scholarship in cultural socialization (see discussion of "surface structure" vs. "deep structure" adaptations in Resnicow et al., 2000). These adaptations are loosely based on how people look, the clothes they wear, the music they listen to, or the foods they eat. Superficial adaptations may include, for example, doctoring photos in an advertising brochure to give the impression that a crowd of people is composed of racially/ethnically diverse individuals (e.g., Wade, 2009) or serving Mexican-American food at a lunch buffet in order to appeal to Mexican-American diners.

Some adaptations that are labeled "cultural" are little more than creations that spring from the imaginations of their developers. For example, Belgrave, Chase-Vaughn, Gray, Addison, and Cherry (2000) report on a "culture-specific" intervention to increase resiliency among African-American preadolescent females. They employ a rating scale that purports to measure "Africentric" values based on the seven principles of *Nguzo Saba* (unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith; Karenga, 1965). When one looks past the exotic-sounding moniker, there is no discussion as to what makes these principles uniquely "African" – as such values are no different from the stated values of thoroughly Americanized groups such as the Boy Scouts. Furthermore, there is no discussion of how these "African values" harmonize with data showing that the African continent is the setting for some of the most horrific and long-standing instances of internalized tribal strife and political violence on the globe (Landau & Misago, 2016; Richburg, 1997; Straus, 2012).

Other cultural adaptations are depicted as incorporating sensitivity to group traits that are mislabeled as being unique to a particular racial/ethnic group, when in fact they are not. For example, a large literature describes Latino and Hispanic culture as being family oriented (*familism*), respectful of elders and authority figures (*respeto*), prone to relate to others in an informal and personal way (*personalismo*), and having a "present-time" orientation and worldview (*fatalism*; see Lopez, Lopez, Suarez-Morales, & Castro, 2005). Again, when we look

past the exotic-sounding labels, the same traits have been ascribed to Italian Americans (e.g., Sorrentino & Krase, 2000), Asians (Bankston & Hidalgo, 2007; Carteret, 2011; Sugie, Shwalb, & Shwalb, 2007), and African-Americans (Brown & Segal, 1996; Edwards et al., 2008).

Although scholars are no doubt quite sincere in their observations about cultural traits, we suspect that such conclusions are based partly on tradition (i.e., this is what is endlessly repeated in the multicultural literature) and partly on the basis of limited knowledge of or exposure to the wider research literature on a variety of different groups.

Varieties of Cultural Adaptations

We found Healy et al.'s (2017) conceptual scheme to be most useful for organizing the wide variety of cultural adaptations used to serve the physical health, educational, and mental health needs of diverse populations. We describe briefly some of these below:

Community Outreach and Involvement Some adaptation researchers find that it is useful to consult with community members and experts in designing interventions that are "culturally appropriate." This is accomplished through the creation of community focus groups and advisory boards that are helpful in identifying cultural themes, values, and preferences in communities (e.g., see Elder, Brasher, & Alexander, 2016). As one example, Grinker et al. (2015) describe the cultural adaptation and translation of the Autism Speaks First 100 Days Kit into Korean for the purpose of improving autism spectrum disorder (ASD) diagnosis, assessment, and interventions. The researchers conducted unstructured individual and group interviews with Korean child health and education professionals in Queens, NY, followed by structured cultural consensus modeling interviews with Korean mothers with and without children with ASD. Community outreach may also involve conducting community-based needs assessments (e.g., outlining the issue from clients' perspective), client involvement in the development of the adaptation, or client participation in the implementation/management/delivery of services.

Changes in the Structure and Process of Service Delivery Service delivery changes may involve a change in the location where services are delivered, primarily to facilitate convenience of access to clients. Instead of accessing services that require traveling long distances, home visits may be offered (e.g., Newton & Perri, 2004), or treatment centers will "set up shop" within the local community. If a change in location is not feasible, sometimes changes are made in the physical space of offices in which services are delivered (e.g., room or building design, altering pictures) or in the mechanism of service delivery (e.g., services are delivered electronically or by mail).

Some cultural adaptations match a service provider's race, gender, or language (within the contexts of one-on-one therapy or a didactic presentation to an audience) to clients/recipients in order to facilitate clients' personal identification with caregivers and/or more positive behavioral changes (e.g., Gondolf, 2008). Language has been described as a "carrier of culture," as skill in being able to speak a language often assumes greater cultural knowledge than someone who does not speak the language (Bernal & Sáez-Santiago, 2006, p. 127). This simply means, for example, that Spanish-speaking clients are best served by caregivers who also speak Spanish or who are bilingual (Miranda et al., 2003). Interacting with caregivers who speak the same primary language helps clients to relax, and clients are spared the difficult task of attempting to communicate awkward intimate personal information in a language (English) in which they have less-than-optimal competency (Bernal & Sáez-Santiago, 2006).

Sometimes what is defined as a cultural adaptation is merely a "tweeking" of an intervention in order to be more effective with a particular group. For example, Jandorf et al. (2013) describes the recruitment of "patient navigators" to facilitate urban African-American clients' participation in colonoscopy screenings. In the

context of this study, patient navigators are specially trained African-Americans who are skilled at using colloquial language and limiting the use of medical jargon when interacting with African-American clients (i.e., providing information to clients in layperson terms). Some patient navigators had personal experiences with colonoscopies and were skilled at discussing with clients helpful strategies for getting through these exams. Patient navigators were also skilled at engaging in non-threatening discussions with clients about their specific fears and concerns about colonoscopies (i.e., about the procedure or possible findings) or clients' more generalized concerns about their physicians and privacy issues.

Lee et al. (2013) describe a culturally adapted motivational interviewing (MI) protocol designed to reduce heavy drinking behaviors and related problems for a sample of lower SES moderately to highly acculturated Latinos. Here, "culturally adapted" meant that an unadapted MI protocol was slightly altered to incorporate social/contextual themes relevant to heavy drinking in Latino communities (e.g., see Lee et al., 2006). The authors found that the culturally adapted MI protocol was more effective than an unadapted protocol for reducing heavy drinking and its related consequences.

Provision of Supplemental Services, Resources, or Support Sometimes cultural adaptation means the provision of free services, such as vouchers that can be redeemed for free mammograms in order to boost participation in breast cancer screenings (Skaer, Robison, Sclar, & Harding, 1996) – which resulted in low-income Latina women being over 47 times more likely to receive a mammogram than controls.

Sometimes cultural adaptation means providing access to childcare, transportation, or accommodations for clients' work schedules (Lee et al., 2013). As an example of extra support services, Mohan, Riley, Schmotzer, Boyington, and Kripalani (2014) describe how clients were provided with a simplified and illustrated medication management tool to facilitate an understanding of pharmaceutical regimens.

Sometimes caregivers provide materials that are translated into the primary language of clients or provide materials that are modified to simplify the language in order to facilitate comprehension (see next section).

Adaptation of Content This category of adaptations modifies the content of the intervention to reflect cultural norms and values of the target population. Here, adaptations generally fall into two categories: "positive" cultural values, beliefs, and norms used to motivate behavioral change versus "negative" cultural experiences reflecting barriers to change that were targeted for modification (Healy et al., 2017).

Pan, Huey, and Hernandez (2011) describe a culturally adapted treatment for phobic (in response to crickets, worms, spiders, or dead fish) East Asian-Americans living on the West Coast. One cultural adaptation draws on research showing that Asian-Americans are more likely than European Americans to endorse the legitimacy of the social hierarchy of authority by preferring directive, solution-oriented counseling from more directive therapists. Another cultural adaptation draws on research showing that:

> Asian Americans are more likely to value calmness, to conceal 'disruptive' thoughts and feelings, and to consider emotional disclosure as inappropriate and less likely to disclose traumatic experiences to others and be emotionally expressive compared with other ethnic groups . . . . Verbal expression of negative emotions may be perceived by Asians as a counterproductive response that triggers social discomfort, whereas stoicism may help maintain harmony by avoiding the imposition of one's feelings on others. *(p. 13)*

As a result of this research, the study authors modified their one-session treatment to "better address potential concerns over inadequate emotional control" (p. 13).

There are some adaptations that are not necessarily "cultural" in content but are used to help groups better understand (cognitively or emotionally) intervention content. For example, Unger, Cabassa, Molina, Contreras, and Baron (2013) describe the use of "fotonovelas" (small

booklets that portray a dramatic story using photographs and captions) to increase knowledge of depression, decrease depression-related stigma, and increase intentions to seek treatment for depression in a sample of low-literacy Hispanic adults. Mohan, Riley, Schmotzer, Boyington, and Kripalani (2014) describe a method for providing illustrated, plain-language medication lists to Latino diabetes patients to help with increasing their diabetes treatment adherence.

We endorse an instructive experience that exposes students to a comparison of treatment manuals (as appropriate for the applied psychology specialty) that are not culturally adapted, with treatment manuals that are culturally adapted so that students can see and understand which specific components are adapted, for what groups, and why (e.g., see Hwang et al., 2015). This needs to be done with the proviso that students are properly educated as to the arguments for and against the use of such manuals (e.g., see Addis & Cardemil, 2006; Addis, Cardemil, Duncan, & Miller, 2006; Duncan & Miller, 2006).

Caveats

Although an important goal of an ideal cultural competency course is to increase knowledge and awareness of circumstances in which cultural adaptations are appropriate, this needs to be tempered by an acknowledgment that (1) cultural confounds exist that undermine easy interpretations, (2) cultural adaptations vary in their applicability/effectiveness, and (3) there are circumstances in which cultural adaptations may not be appropriate and need to be avoided. These issues are discussed briefly below.

Knowledge of Cultural Confounds Careful instructors are cautious in their interpretations of this literature. Often there are non-cultural confounds that may plausibly influence outcomes to a significant degree that have nothing at all to do with cultural variables (Healy et al., 2017). In addition, it would be incorrect to assume that nonadapted interventions, by definition, are *completely or 100 percent* insensitive (whatever this means) to a given cultural group (Healy et al., 2017). Although there is general support for the value of cultural adaptations in the applied psychology research literature, the specific adaptations themselves are sometimes difficult to isolate in appropriately controlled research designs (Healy et al., 2017; Huey, Tilley, Jones, & Smith, 2014). Cultural adaptations found to be effective with one specific population in a specific setting and for a specific presenting problem may not always be effective for the same population in a different setting and for different problems.

The determination of whether or not a cultural adaptation has or has not been successful is also deceptively complex. Outcomes can be distinguishable by the nature of the variables considered to reflect indicators of success (Healy et al., 2017). For example, is a cultural adaptation effective if it leads to better behaviors in service providers? Better numbers in simple intervention participation or completion rates of clients (regardless of symptom reduction)? Increased client awareness, beliefs, knowledge, and attitudes (independent of symptom reduction)? Or, should “effectiveness” be judged solely by improved behavioral or mental health outcomes for clients?

Sometimes Cultural Adaptations Do Not Work Consistent with Principle #4 (Respecting real-world complexity), the research literature on cultural adaptations does not always support their effectiveness. For example, Ard et al. (2008) compared a weight loss intervention group composed of all African-Americans to comparable groups that were mixed (i.e., composed of African-Americans and persons from other racial groups). The intent of this design was to determine if a weight loss group composed entirely of participants from the same racial group would create an advantage for weight loss goals. However, no differences were found in the average number of sessions attended by participants or changes in participants’ dietary intake as a result of the intervention. In a different intervention study designed to reduce smoking for African-Americans, Nollen et al. (2007) found that despite significantly greater usage of cultur-

ally adapted materials, there were no statistically significant differences in smoking outcomes. Finally, many cultural adaptation researchers caution audiences against the application of modifications if it undermines the fundamental goals of the intervention. There is evidence that when culturally modified interventions displace the core content of a training, outcomes can suffer (e.g., see Kumpfer, Alvarado, Smith, & Bellamy, 2002).

Some Cultural Adaptations Should Be Avoided The previous discussion assumes implicitly that all cultural traits and life experiences must necessarily be morally neutral. In multicultural settings, there is a skittishness against evaluating a group's cultural traits negatively, for fear that this will violate unspoken expectations of "cultural sensitivity" (see discussion on the sensitivity doctrine in Frisby, 2005, pp. 104–111; Frisby, 2013, p. 20). For example, in Mexican society, bribery involving everyday citizens of police officers and government officials is often viewed as "business as usual" (Archibold, 2012; Blears, 2013). If a Mexican-American immigrant suggests this as a way to cope with difficulties in American society, should the therapist endorse such thinking and behavior? Certain foods that are popular in African-American culture are high in fat, salts, and other ingredients that are not optimal for physical health (Collins, 2015; Edwards, 2003; Keyes, 2017). Is encouraging a reduction of these foods in one's diet a form of "cultural imperialism" for health educators to avoid? In inner-city schools, street gangs make life miserable for teachers, administrators, and non-gang-affiliated students who want to learn (Forrest, 2013; Martinez, 2017). High-performing charter schools find that they must ban all indicators of gang affiliation (in clothing, language, hand signals, etc.) in order to promote a safe, respectful, and orderly atmosphere in schools (Whitman, 2008). Since gang life is an integral part of many youth's "culture," are such restrictions wrong?

An ideal cultural competency course is led by instructors that have a deep appreciation for the complexity of the many factors that influence the ethical and moral implications of the conceptualization, feasibility, and efficacy of cultural adaptation research.

The point here is that, in a complex society, physical and mental health problems that disproportionately impact cultural groups, and strategies for addressing them, cannot begin to be comprehensively understood by resorting to lazy stereotypes, glib generalizations, and soothing bromides about "sensitivity" and "social justice." At minimum, instructors for an ideal course in cultural competence understand and appreciate the nuanced complexities inherent in the research literature. When this is done, instructors model for students a *deep humility* about the limits of our current knowledge of intervention strategies, as well as the cost/benefit tradeoffs involved in applied psychology's efforts to address these difficult issues.

How Should Cultural Adaptations Be Taught? By saying that "a cultural adaptation should be taught," we simply mean that, if students do not already possess certain skills (such as speaking a non-English language), then students should be taught how to refer clients to the appropriate caregivers who can apply these skills, or have the knowledge of what best practices are so that the optimal employment settings can be selected which match the students' interests (e.g., see Berger, Zane, & Hwang, 2014). This can be accomplished by exposing students to guest speakers whose applied psychological work includes experience in cultural adaptations. The specific content of these learning opportunities will quite naturally vary as a function of the applied psychology specialty within which the cultural competence class is offered. For example, a cultural competence class within a school psychology training program may emphasize cultural adaptations of psychoeducational assessment instruments (e.g., see Soto et al., 2015) or interventions that are carried out in schools (Johnson et al., 2005) compared to other applied psychology specialties. Another cultural competence class within a program that emphasizes one-on-one psychotherapy and

counseling may prefer to emphasize cultural adaptations that focus on issues of socioeconomic disadvantage (e.g., see Kim & Cardemil, 2012).

Regardless of the specialty areas, a list of general questions for guest speakers with experience in cultural adaptations would include (but certainly not be limited to) the following (adapted from Healy et al., 2017):

- What barriers made it particularly difficult for client groups to utilize services and how were you made aware of these barriers?
- What process did you go through to decide which cultural factors were important to use for adaptations?
- What specific things did you do to integrate cultural values and/or perspectives into your interventions?
- How were you made aware that the possible lack of trust in your client groups was an issue, and how did you or your organization build trust with groups served?
- What challenges did you face in implementing adaptations?
- What kinds of outcomes improved as a result of adaptations and what kinds of outcomes did not improve?

What kind of within-group cultural (acculturation) and/or individual differences did you observe in your work with clients?

Conclusions

In concluding this chapter, we begin with a quote that caught our attention, written by a physician on the topic of cultural competency:

> The bottom line is that I cannot be everything to everybody. If I am perceived by a patient as not communicating well with them, for whatever reason, because I'm culturally insensitive or because I'm just not nice enough, they have the opportunity to seek care elsewhere. If I find that a whole lot of patients are doing just that, I will have to find a way to change my behavior or go out of business. That is the American way. I don't need a Cultural Competency Czar making me sit in seminars and sing Kumbaya in Norwegian to understand that basic principle of life. (Like, 2010)

Three important points are implied by these comments that are germane to this chapter. First, as stated earlier at the beginning of this chapter, the construct of "cultural competence" is largely aspirational in nature. These comments acknowledge the humbling truism that no one clinician can realistically be "all things to all people." Thus, the objectives of any cultural competency course, symposium, or workshop need to be modest in scope and narrowly tailored to the specific needs of specific audiences. The different applied psychologies naturally promote different areas of emphasis; hence, the construct of cultural competence does not mean the same thing when used in different contexts. Even within the same specialty area, the research reviewed in this text underscores the truism that there is no one intervention that works the same way for all persons, under all circumstances, or for all problems. An ideal cultural competency course raises awareness as to circumstances that may require additional competencies and educates students as to what to do to seek out these competencies after graduation within in-service settings.

Second, these comments acknowledge, albeit satirically, the contentious politics and naked sociopolitical indoctrination that is hopelessly intertwined and embedded in cultural competence advocacy. Politics are evident despite the scholarly credibility conferred by publication in scientific journals, federal initiatives foisted on the general public by government agencies, compulsory initiatives promoted by "best professional practice" documents from applied psychology guilds, and keynote themes promoted in professional conferences.

The impetus for this text, generally, and from this chapter, specifically, comes from the simple conviction that applied psychologists need to be as well rounded as they can in learning how to provide the best services in a wide variety of situations in which they may find themselves. To its credit, the construct of "cultural competence" has been widely promoted as meeting this need; however, relatively little attention has been paid in critically evaluating this construct in the applied psychology literature. The original impetus for cultural competence began with the premise to improve practice for a wider variety of clients,

but this has quickly devolved into situations where science has been contaminated by sociopolitical ideology – so much so that training programs cannot even tell the difference between the two (nor do many programs even care that there *is* a difference).

When one reviews the academic landscape as it currently stands, cultural competence training is an ill-defined term representing an amalgamation of hard science, sincere efforts to meet real service gaps in underserved and/or vulnerable communities, sociopolitical indoctrination for groups perceived as "oppressors," racial therapy for groups perceived as "victims," and platforms for airing the sociopolitical grievances of groups thought to be previously neglected in the research literature.

We are encouraged by the recent growth over the past decade of scientific interest in the theory, research, and practice of cultural adaptations. It is indeed encouraging that many researchers do not shrink from asking the hard questions of what constitutes culture, what are the conditions under which cultural adaptions are (or are not) effective, and what outcomes validate the efficacy of cultural adaptations.

These comments suggest that there will always be effective professional practices that will only be discovered as a result of the harsh and unsentimental tutelage of real-world market forces. The real world is complex, and psychological interventions succeed or fail for a wide variety of reasons – cultural issues being only one among many variables that influence outcomes. Individual therapists, schools, clinics, and community centers must be open to collecting valuable information from the communities they serve, adapting services (when appropriate) to this information, carefully evaluating the results, and following the data where it leads. We hope this text contributes to these efforts.

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