# **Clinical Application Paper**

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COUN 6150/8150: Multicultural Counseling & Advocacy

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This is a case of a Hispanic 13-year-old female with a past history of physical, verbal, and sexual abuse who is currently exposed to abuse by her grandparents. Her parents divorced when she was young and after spending some time in the custody of her mother, she and her three brothers moved to live with their paternal grandparents ten years ago. Her brothers have since moved out of the house but she still remains with grandparents who often call her “dumb ass”. Her biological father would like to give her a home but his girlfriend forbids it. Her 17-year-old brother would like to give her a home as well but the grandparents forbid it. In this paper I will discuss the various aspects of multicultural counseling and how the case study of this 13-year-old female and her family can be used as a lens to examine them.

**Theories and Models**

One major model of multicultural counseling is the racial/cultural identity development model that identifies five phases of acculturation: conformity, dissonance, resistance and immersion, introspection, and integrative awareness. The client is a 13-year-old Hispanic American who is raised by her Spanish-speaking grandparents. The differences in phases are likely to cause turmoil. The level of acculturation is how much of the dominant culture is taken up by another culture. Cultural identity development can also be viewed through the tripartite development of personal identity model. The tripartite framework separates identity formation into three levels: individual, group, and universal. At the individual level is genes and nonshared experiences, at the group level is culture, ethnicity, race, age, location, socioeconomic status, etc., and the universal level is what makes us human like self-awareness and the use of symbols (Sue et al., 2019).

 Traditional counseling comes from a EuroAmerican viewpoint. The theories and models of counseling are largely geared towards those who value individualism over collectivism, the self over the family, only relying on a small nuclear family, sharing of feeling and emotions, encouraging individual life pursuits, and the like. Many cultures such as the Hispanics in the case study have different viewpoints that must be acknowledged, respected, explored, and valued if we are to create a community of culturally competent counselors and consultants. A culturally diverse model of counseling appreciates differences rather than comparing cultures, legitimizes alternative cultures, and focuses on the advantages of being bicultural (Sue et al., 2019).

**Multicultural Counseling Competencies**

 Multicultural counseling is a way of incorporating the cultural values, beliefs, and behaviors of diverse clients into the counseling process from assessment to diagnosis to treatment. Traditional counseling theories stem from a EuroAmerican culture, the same culture that I identify with as a white, cisgender female from a middle-class family. It is crucial that I recognize my own values, beliefs, and behaviors and point out the distinction between them and those of my client’s. The 13-year-old has more of an individualistic point of view compared to her Hispanic collectivist beliefs that family, or *familismo*, has great influence over the self (Sue et al., 2019). She may feel empowered to speak of her dating life and interest in African-American males with me because I represent these ideals rather than her grandparents whom she describes as “old school”, homophobic, racist against African Americans specifically, and wanting to control her interactions with others outside of the home.

 To be culturally competent also means to be cognizant of the client’s cultural, ethnic, gender, and sexual orientation. As the consultant of the 13-year-old female in this case study, it is my job to discuss these elements so that I can give advice and suggestions that are effective for this client (Sue et al., 2019). From the case study there are clues: she is interested in males, she does not have the same “old school” views as her grandparents and her respect for the family hierarchy seems minimal. I must also be aware of the individual, group, and universal influences on the client. She has the genetics of her mother and father and her experiences of trauma from abuse, notably sexual, and she has had troubling life experiences throughout her young existence. Understanding the group aspect, not only of her Hispanic heritage, but her generational influences like being on her cellphone since she is isolated from the outside world, play a role in her beliefs and values. Despite only being a young adolescent, she has lived through many experiences and belongs to many different groups that influence her personality and mental health. I would also use universal and specific strategies throughout the consulting process that adhere to her individual and collectivist needs.

**Cultural Values and Acculturation**

The 13-year-old female client views her brother and biological father as possible saviors to her predicament with her abusive and controlling grandparents. She sees those men in her life as potential providers but her grandparents forbid her from moving out from under their guardianship. The cultural value of *familismo* again comes into play as despite being impoverished as well as possibly undocumented, the grandparents are still pushing to remain as caregivers. These are real obstacles to caring for a 13-year-old adolescent and despite these, they still insist that she stay with them, likely due to the Hispanic value that family bonds and hierarchy matter a lot.

 The client is in the stage of dissonance among the stages of acculturation according to the racial/cultural identity development model (Sue et al., 2019). This is evident by the awareness of the client’s grandparents’ racism towards African Americans. She is not entirely resistant to the dominant culture but she also is not fully sold on her Hispanic culture in determining her life choices such as dating. She also states that white people are crazy. A common sentiment regarding mental health stigma among Hispanics is that anyone who seeks or needs those services is just crazy or *loco.* It can be seen as hesitancy to seek help due to the belief that mental health is part of systemic oppression. It is skepticism that the system can help and understand their culture. The client’s skepticism towards the white, dominant culture as well as the rejection of her grandparents’ racism is evidence that she has overall mixed feelings about her cultural identity. Her confliction between her Hispanic culture and the dominant white culture as well as her identifying with aspects of African American culture is key to acculturation issues. Her bicultural issues of identity and acculturation are important because working with a consultant of a different racial/cultural identity automatically raises skepticism (Sue et al., 2019).

**Power and Privilege**

According to the American Counseling Association’s Multicultural and Social Justice Counseling Competencies (MSJCC), there are four main relationships between client and counselor that affect power and privilege but that one that affects this case study, is that of privileged counselor working with an oppressed client. As a white consultant working with a Hispanic client, the relationship corresponds with historical and sociopolitical racial roles and structures in society (Sue et al., 2019). The client does mention looking more white as a light‐skinned Hispanic person so she may not experience as many elements of oppression that her grandparents do. This is another reason for division between the client and her guardians as the oppression is not the same for her and she may not feel/understand the impact of systemic racism. If the client’s last name has Hispanic origins, she may still experience racism despite her appearance.

Social justice counseling acknowledges that there should be equal access and opportunity for mental healthcare to all cultures but that it is not always evident. There is an uneven distribution of power and resources towards the dominant culture in regards to mental health. Microaggressions are a large part of the oppression that Hispanic cultures experience in their daily lives. It is important as a consultant to be aware of the microaggressions that I am guilty of committing. The working alliance between myself and the client must build trust through vulnerability and compassion. Microaggressions undercut the work done to build that trust by making the client feel oppressed and invalidated. I can also aim to use open discussion to speak on issues of power, racism, and inclusivity.

**Help-Seeking Behaviors**

There is a cultural stigma among Hispanics associated with seeking help. The aspect of *familismo* means that help-seeking behaviors should first be directed within the family before reaching outside the familial resources (Sue et al., 2019). Close friends and extended family should first be exhausted before other avenues. With the 13-year-old client’s mother out of the picture due to drug and alcohol abuse, it is likely that help-seeking behaviors were not conducive to her healing. It is not mentioned whether she sought out mental health services for addiction and patterns of abusive behavior.

The grandparents would likely be hesitant to reach out for help considering their sociopolitical issues of poverty and lack of English-speaking skills. The respect and reputation of the family in Hispanic cultures can also cause families to be reluctant to reach out for help out of fear that the family will be blamed. The legal status of the grandparents could also be a hindrance in their seeking out help because they fear deportation. Another common obstacle in seeking help is that mental institutions are seen as a representation of the dominant culture and unable to understand the cultural impacts for Hispanics. According to Morales and Norcross (2010), there are no programs in the United States that offer courses on teaching clinical counseling skills in Spanish. The lack of programs geared towards cultural competence is another hindrance for help-seeking behaviors.

**Spiritual Beliefs**

There is no indication of specific religious and/or spiritual beliefs within the case study but for Hispanic cultures the predominant religion is Catholicism. Many Hispanics rely on their religious beliefs to provide certainty and comfort in distressing times. It is also a fact that younger Hispanics place less importance on religion as opposed to the older generation (Sue et al., 2019). The 13-year-old client makes no mention of spiritual beliefs but likely conflicts with her grandparents’ “old school” beliefs including religious beliefs. This is another way in which the turmoil between the generations continues. There is potential for the client in her young age to have a belief in fatalism, where things happen because they were meant to out of fate. If this were true, I would focus less on changing the client’s mind about her beliefs and more on the controllable and giving her actionable steps to remedy the situation with her family.

**Countertransference**

At this point in my career I have a lot of experience with Hispanic or Latinx populations. I grew up in Los Angeles County where Hispanics are the most populous ethinic/racial group (U.S. Census Bureau, 2021). I have spent the last ten years training, competing and teaching Brazilian Jiu Jitsu. I am knowledgeable in the language of Brazilian Portuguese, have many different hierarchical relationships with Brazilians, and have spent months in Brazil amongst the locals. I consider myself to be well-versed in Latinx cultural beliefs but my experience has been specifically with one kind of Latinx ethnic population. The case study does not note what racial background the client is and so I cannot assume to know about every Hispanic culture. There are many differences among the cultures depending on factors like age, location, language dialect, etc. (Sue et al., 2019).

In order to minimize countertransference in the consulting relationship I must acknowledge my own white privilege. There are multiple layers of oppression by the dominant culture that are embedded forms which as a member of the dominant group one is taught not to see (McIntosh, 1990). Those include the luxuries of having people who look like me well represented in the media and history books, the likelihood of people acting pleasant towards me versus hostile or disrespectful. As a white person I must acknowledge that although I have not asked for this privilege nor avoided hard work of my own, minorities like the 13-year-old Hispanic female and her Spanish-speaking grandparents experience oppression because of it.

**Conclusion**

As Peggy McIntosh (1990) wrote in light of recognition of her own white privilege, I intend to use my unearned advantage of being white to weaken hidden systems of advantage. As I have learned in this course and assignment, I cannot rid myself of my white privilege but I can continuously work on my lifelong cultural competence to do my part in erasing cultural stigma against mental health. Plenty of obstacles for cultures to seek mental healthcare exist already and I aim to work as an ally to understanding different cultures and acknowledging my own biases and prejudices. It is my job to do my research to understand the major cultures in the population of which I live so as not to burden my clients with the education about their cultures and how their values and beliefs affect the consulting process.

**References**

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