A Brief Guide to Psychotherapy for Diverse Populations

1. African-Americans

African-Americans are the largest ethnic minority group in the United States and, in contrast to stereotypes, are diverse in terms of family structure, education, socioeconomic status, religious affiliation and spirituality, ethnic identity, reactions to racism, and other characteristics (Sue, Zane, and Young, 1994). When working with African-Americans, a therapist should be aware of the following (Paniagua, 1994):

- The African-American worldview emphasizes the interconnectedness of all things, and African-Americans emphasize group welfare over individual needs.
- The family is often an extended kinship network that includes both nuclear and extended family members as well as individuals outside the biological family. For many African-Americans, the church is an important part of the extended family.
- Roles within African-American families are flexible, and relationships between men and women tend to be egalitarian.
- Due to their history in the United States, African-Americans may exhibit signs of “healthy cultural paranoia.”

According to Boyd-Franklin (1989), African-American families respond best to a multisystems approach that addresses multiple systems, intervenes at multiple levels, and empowers the family by directly incorporating its strengths into the treatment. Systems that may be included in treatment include the extended family and nonblood kin, the church, and community resources. Family therapy, especially extended family systems therapy, is often the treatment-of-choice. General guidelines for working with African-American clients include the following (Aponte, 1994; Exum and Moore, 1993; Paniagua, 1994):

1. use a time-limited, problem-solving approach and directive techniques and focus more on concrete solutions to problems than on providing complex explanations about their origins;
2. be willing to adopt an ecostructural perspective that considers and addresses the social, political, and socioeconomic influences on behavior;
3. reduce status differences and foster empowerment by adopting an egalitarian approach;
4. recognize the importance of nonverbal behaviors and be sensitive to differences in communication style and language usage; and
5. avoid any attempt to maintain an “illusion of colorblindness,” or, at the other extreme, to attribute all of a client’s problems to racial oppression.

African-Americans are most likely to seek mental health services for practical problems – e.g., school, legal, and other administrative matters, medication, and to obtain answers to questions about community resources (Leong, Wagner, and Tata, 1995).
2. Native Americans

Native Americans include American Indians, Eskimos, and Aleuts. In contrast to members of the “mainstream” culture, Native Americans are more likely to:

- exhibit a spiritual and holistic orientation to life that emphasizes harmony with nature and regards illness as the result of disharmony;
- place greater emphasis on the extended family and the tribe than on the individual and adhere to a consensual collateral form of social organization and decision-making;
- perceive time in terms of personal and seasonal rhythms rather than in terms of the clock or calendar and be more present- than future-oriented;
- exhibit a strong sense of cooperation and generosity; and
- consider listening more important than talking.

Network therapy has been recommended as the treatment-of-choice for Native Americans since it incorporates the family and community into the treatment plan (LaFromboise et al., 1990). Walker and LaDue (1986) advise mental health practitioners working with Native Americans to become familiar with the historical events that have affected their lives and relationships with white Americans. One consequence of their history is that Native American clients may be distrustful of a therapist’s attempts to provide therapy in a “value-free” environment and prefer a therapist who helps them reaffirm the values of their own culture.

Additional guidelines for working with Native Americans include the following:

1. focus on building trust and credibility during initial sessions by demonstrating familiarity with and respect for the client’s culture and admitting any lack of knowledge;
2. adopt a collaborative, problem-solving approach that avoids highly directive techniques;
3. be sensitive to and respect differences in nonverbal communication (e.g., eye contact is considered a sign of disrespect);
4. recognize and respect forms of self-treatment and healing (e.g., responding to stress with passivity) and don’t assume that unfamiliar behaviors are signs of pathology;
5. approach sensitive topics with caution, model self-disclosure, and indicate the desire for reciprocity without pushing the client to self-disclose; and
6. consider incorporating elders, medicine people, and other traditional healers into the treatment process.
3. Asian-Americans

Asian-Americans include people of Chinese and Japanese heritage, Pacific Islanders, and Southeast Asians. When working with an Asian-American client, it is important to be aware of his/her country of origin and acculturation status since these factors will influence the client’s language and customs, social relationships, attitudes toward mental illness and psychotherapy, etc. In general, Asian-Americans:

- place greater emphasis on the group (family, community) than on the individual;
- adhere to a hierarchical family structure and traditional gender roles;
- emphasize harmony, interdependence, and mutual loyalty and obligation in interpersonal relationships; and
- value restraint of strong emotions that might otherwise disrupt peace and harmony and/or bring shame to the family.

In therapy, a directive, structured, goal-oriented, problem-solving approach that focuses on alleviating specific symptoms is usually preferred. Asian clients expect therapists to give concrete advice and view the therapist as a knowledgeable expert and authority figure. General guidelines for working with Asian clients include the following:

1. Emphasize formalism in therapy (e.g., address family members in a way that reflects their status, respect conversational distances);
2. Keep in mind that Asians rely more on indirect and nonverbal forms of communication and refrain from open expression of emotion;
3. Be aware of the role of shame and obligation in Asian cultures (i.e., to reinforce adherence to prescribed roles and responsibilities) and that modesty and self-deprecation are not necessarily signs of low self-esteem;
4. Expect difficulty in discussing family matters, especially matters concerning parents and other elders and topics related to sex;
5. Establish credibility and competence early in therapy by, for example, disclosing information about your educational background and experience; and
6. To prevent premature termination, provide the client with an immediate and meaningful benefit.

Asian clients may regard their mental health problems as the result of a lack of will, physical disorder, or supernatural phenomena, and their symptoms often take the form of somatic complaints. A therapist’s response to somatic complaints should be to first acknowledge them and the possibility that medical consultation may be required and then to introduce statements that help the client make the transition from viewing their symptoms as having a physical cause to having a psychological etiology (Paniagua, 1994).

Research on Asian refugees and immigrants has produced social displacement theory, which proposes that these individuals typically experience an initial period of elation and optimism upon arriving in the United States but that this period is likely to be followed by frustration,
depression, and confusion. In other words, refugees and immigrants can be expected to exhibit the most severe mental health problems at the end of the first year through the third year after arriving in the U.S. An important source of stress among members of this group are intergenerational conflicts resulting from different degrees of acculturation by family members (with younger family members adapting more quickly and rejecting many of their family’s cultural traditions).

4. Hispanic-Americans

Hispanic-Americans include Mexican Americans, Puerto Ricans, Cuban Americans, and people from Spain, Central and South America, and the Caribbean. Casas and Vasquez (1989) note that Hispanics:

- emphasize family welfare over individual welfare;
- view interdependence as both healthy and necessary and highly value connectedness and sharing;
- consider discussing intimate personal details with strangers (e.g., a therapist) as highly unacceptable, and believe that problems should be handled within the family or other natural support systems;
- adopt a concrete, tangible approach to life (rather than an abstract, long-term perspective); and
- attribute the control of life events to luck, supernatural forces, acts of God, or other external factors.

When working with a Hispanic client, a therapist is usually best advised to be active and directive and to adopt a multimodal approach that focuses on the client’s behavior, affect, cognitions, interpersonal relationships, biological functioning, etc. Paniagua (1994) recommends family therapy for Hispanic clients because “it reinforces their view of ‘familismo’ and the extended family” (p. 50). When conducting family therapy, nonbiological family members should be allowed to attend family sessions. General therapy guidelines for Hispanic clients include the following:

1. Emphasize “personalismo” (except during initial contacts when “formalismo” is preferred) – e.g., recognize the importance of personal greetings, handshaking, the use of first names, and “small talk.”

2. Explore the client’s spiritual or magical explanations for his/her problems and be familiar with folk cures that are not recognized by the Western medical community.

3. Be aware that Hispanic families are basically patriarchal and that sex roles tend to be relatively inflexible. Avoid making suggestions that compete with the belief in “machismo” and “marianismo” (standards for masculine and feminine behavior).

4. Be aware that differences in degree of acculturation within a family are often a source of individual and family problems.

Hispanics are likely to be less interested in differentiating between emotional and physical problems and, consequently, to take psychological problems to a physician rather than a
mental health professional (De La Cancela and Guzman, 1991). In addition, psychological/emotional problems are often manifested as somatic symptoms.

5. Elderly Adults

Americans tend to maintain rigid, negative stereotypes of the elderly; and, unfortunately, therapists seem to hold similar mistaken notions. However, the elderly are actually a very heterogeneous group of people and may even be more cognitively and emotionally complex and diverse than younger adults as a result of differences in their individual experiences and backgrounds and responses to the physical and psychological impact of aging.

1. Treatment Issues: In the population of elderly adults, cognitive symptoms—which can occur alone or in conjunction with depression, delirium, dementia, or other disorders—are the most common problem. Myers et al. (1984) report that 14% of the elderly males and females in their sample had mild cognitive symptoms and another 5.5% of males and 4.7% of females had severe symptoms. The next most common problem is depression. It has been estimated that 15% of those aged 65 and older have depressive symptoms, although only 3% have symptoms sufficiently severe for a diagnosis of major depression (Blazer, 1993). In terms of other symptoms, about 11% of the elderly experience paranoid states, 7.5% progressive dementias, 4% anxiety disorders, 1 to 2% alcohol or drug dependence, and 0.5% symptoms of schizophrenia (American Psychiatric Association, 1991).

Issues of particular concern when providing mental health services to elderly clients include the following:

Identity Transition: The elderly often come to therapy because they are involved in an “identity transition” due to the many physical, psychological, and social changes they are facing. The first goal when counseling a client in transition is to empathize and help him/her cope with current circumstances. The second goal is to help the client adapt to new roles and changes in lifestyle.

Sexuality: Interest in sex continues for most elderly people into their 70s, 80s, and beyond. One of the most frequent sexual problems for elderly women is a lack of a socially-sanctioned partner; among elderly men, sexual problems are more likely to be due to impotence or other dysfunction that is related to a physical or psychological disorder. Overall, the best predictor of sexual behavior in old age is past behavior: The research indicates that sexual activity in mid-life and earlier is a good predictor of activity in old age, especially for males.

Depression: Among the elderly, loss is a common precipitant of depression: Widowhood, for instance, is associated with both increased risk for mortality and hospitalization for depression. When working with elderly clients, it is important to keep in mind that the symptoms of depression may differ from those typically observed in younger clients. Sadness, guilt, and low self-esteem are less common among the elderly, while feelings of uselessness, pessimism, apathy, and somatic complaints are more likely. It is also important to distinguish between depression and dementia, which share similar mood and cognitive symptoms.

Awareness and Acceptance of Death: A critical error made by mental health
professionals is to presume that the elderly are simply “preparing to die.” Although acceptance of death often emerges as a treatment issue, more often, elderly clients seek treatment to achieve a specific goal or a sense of meaning in their lives. To help clients deal effectively with death, therapists must be aware of their own feelings: One of the primary reasons why mental health professionals avoid treating the elderly may be the difficulty they have in dealing with their own fears and insecurities about death.

2. Treatment Approaches: When working with an elderly client, a therapist should not assume that certain types of treatment are necessarily inappropriate. The research has demonstrated that psychoanalysis, cognitive-behavioral therapy, and other traditional forms of therapy can be effectively used with older people. However, certain modifications in technique may be required:

- **(1)** Elderly people are often unfamiliar with and suspicious of therapy and may take somewhat longer to develop a working relationship with the therapist. Consequently, it is particularly important for the therapist to demonstrate genuineness, accurate empathy, and unconditional positive regard, which help foster the therapeutic alliance.

- **(2)** Assessment and treatment should reflect a comprehensive, multimodal approach that addresses physical, psychological, and social functioning and that entails reliance on a multidisciplinary team and involvement of the client’s family and other support systems.

- **(3)** Therapy is often more effective when it adopts a structured approach and a slower pace and when the therapist assumes a more active role.

- **(4)** When working with elderly clients, the therapist must be aware of his/her own stereotypes and biases to ensure that they do not have a negative impact on treatment.

6. Gay Men and Lesbian Women

Although society is becoming more tolerant of gay men and lesbian women, prejudice and discrimination are still common. Moreover, there is evidence that members of this population are not adequately served by the mental health community. For instance, a survey of 1500 gay, lesbian, bisexual, and transgendered individuals found that one-fourth of those who had seen a mental health professional said they had, at some time in their lives, received poor or inappropriate services because of their sexual orientation (Nystrom, 1997).

1. Treatment Issues: Research on mental health service utilization by gay men and lesbian women indicates that members of these populations are more likely than heterosexuals to consult with a mental health professional. Morgan (1992), for example, reports that 78% of the lesbians in her study versus 21% of the heterosexual women had seen a mental health professional. In addition, the lesbian women expressed more positive attitudes toward seeking psychological counseling. In a more recent survey of 600 gay, lesbian, and bisexual individuals who had received psychological counseling services at least once, Jones and Gabriel (1999) found that the majority (86%) believed that therapy had a positive influence
on their lives. The authors note that this finding contradicts earlier research indicating that gay and lesbian clients are often dissatisfied with therapy.

The research on reasons why homosexuals seek counseling is very limited. Jones and Gabriel report that one-third of the adults in their sample entered therapy for reasons related to sexual orientation, while the remainder began therapy for other reasons. In another study, Hetrick and Martin (1987) looked at reasons given by gay and lesbian adolescents for seeking psychological treatment. Their results indicated that social and emotional isolation was the most frequently-mentioned problem, followed by family difficulties.

2. Identity Development: Several experts have proposed models of gay/lesbian identity development. A frequently-cited model is Troiden’s (1988), which proposes the following four stages:

   Stage 1: Sensitization; feeling different. During this stage, which is usually characteristic of middle childhood, the individual feels different from his/her peers. For example, the individual may realize that his/her interests differ from those of same-gender classmates.

   Stage 2: Self-recognition; identity confusion. At the onset of puberty, the individual realizes that he/she is attracted to people of the same sex and attributes such feelings to homosexuality, which leads to turmoil and confusion.

   Stage 3: Identity assumption. During this stage, the individual becomes more certain of his/her homosexuality and may deal with this realization in a variety of ways – e.g., by trying to “pass” as heterosexual, by aligning him/herself with the homosexual community, or by acting in ways consistent with society’s stereotypes about homosexuality.

   Stage 4: Commitment; identity integration. Individuals in this stage have adopted a homosexual way of life and publicly disclose their homosexuality.
References


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Examination

Please answer these questions on the separate response sheet that is provided. Then mail or fax your response sheet to AATBS so you can receive course credit.

Learning Objectives:
1. Review key characteristics and issues for various populations.
2. Review effective treatments and interventions for these populations.

1. When working with African American families, you should keep in mind that the relationship between men and women is ________ and the family network involves ________.
   a. male-dominated; the nuclear family only
   b. male-dominated; an extended kinship network
   c. egalitarian; the nuclear family only
   d. egalitarian; an extended kinship network

2. Native Americans tend to more ________-oriented and ________ therapy is often considered the preferred treatment.
   a. present; insight-oriented
   b. present; network
   c. future; insight-oriented
   d. future; network

3. In the elderly, sexual problems are most often attributed to:
   a. a lack of available partners for women and men.
   b. a physical or psychological disorder for women and men.
   c. a lack of available partners for women and a physical or psychological disorder for men.
   d. a lack of available partners for men and a physical or psychological disorder for women.
4. The research on mental health utilization by gay men and lesbian women indicates that:
   a. gay men are more likely than heterosexuals to consult with a mental health professional, but not lesbian women.
   b. lesbian women are more likely than heterosexuals to consult with a mental health professional, but not gay men.
   c. gay men and lesbian women are more likely than heterosexuals to consult with a mental health professional.
   d. gay men and lesbian women are less likely than heterosexuals to consult with a mental health professional.
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