Counseling in a Multicultural Society

Implications for the Field of Communication Disorders

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Presentation Outline

- Relevant Terms
- Practical Skills Model of Multicultural Engagement
- Hierarchy of Cultural Knowledge/Stages of Cultural Competency
- Cultural groups in the U.S.
- Cultural Competence
- Discussion

Relevant Terms

cross-cultural zone: space where the counselor takes into consideration the multiple identities of the client

ethnography: a method used in anthropology to gain information about a culture from the people who live in the culture

acculturation: explains the process of cultural change & psychological change that results following meeting between cultures

bicultural assimilation: relate to both their native culture and the mainstream culture

Broad View of Multicultural Counseling Example: Practical Skills Model of Multicultural Engagement

1) basic counseling skills
2) empathetic communication
3) relationship building
4) diunital reasoning
   - the act of validating & legitimizing other world views
5) attempt to understand the customs and traditions of clients

Review of Cultural Groups

- European Americans
- African Americans
- Hispanic Americans
- Asian and Pacific Islander Americans
- Native Americans
- Arab or Muslim Americans
- LGBTQ Americans

Hierarchy of Cultural Knowledge (Textbook)

- Value knowledge
- Event knowledge
- Peripheral communication knowledge
- Stereotypical knowledge

Stages of Cultural Competency (LGBTQ Article)

- Awareness (Knowledge)
- Sensitivity (Attitudes)
- Competency (Skills)
- Mastery

Hancock, A., & Haskin, G. (n.d.).
European Americans

- Embraces mainstream culture (middle-class values)
  - Competitive spirit
  - Individual unit
  - Direct eye contact
  - Focus on outcomes
  - Controlling emotions

African Americans

- Hesitancy to participate
  - Perception unequal roles
  - Unwillingness to share personal information
  - Discomfort in individual problem solving
- Group problem solving with family and community members (religious figures)
- Mothers often willing to seek help for children before themselves

Hispanic Americans

- **Strong religious influence**
  - Seeking counseling from religious figures (priests)
  - “God’s will” - explanation of disorder, not want to seek medical treatment

- **Gender differences**
  - Males - *machismo* - maintain pride through withholding emotions
  - Females - more likely to seek help for children before themselves
  - *Aguantar* - women’s suffering believed to be part of life

- **Bias against therapy being for “crazy” people *locos***
Asian and Pacific Islander Americans

- Varied group from many cultural groups
  - Five main groups in United States
    - Southeast Asian (Hmong) Americans
    - Korean Americans
    - Chinese Americans
    - Japanese Americans
    - Filipino Americans

- Reluctant to publicize problems- “model minority”, “silent minority”

- Power structure in family

- Group oriented therapy

Southeast Asian (Hmong) Americans

- Belief of cutting open the body during surgery will cause the release of spirits, resulting in death
- Touching the head of men/children is taboo
- Large extended family
  - Patrilineal society (women join husband’s family/clan)
  - Identify as part of family, clan, or community
  - Men given more power/status - roles changing from amount of assimilation to white-middle class values
  - Women traditionally run household and provide child care

- **Korean Americans**

  - In South/North Korea, women take care of domestic responsibilities, men take care of fiscal
  - In US, more women are working, causing tension in family
  - Conflict between children and parents over assimilation to US mainstream culture
  - Older Koreans may avoid medical help
    - Many living in poverty

Korean Americans (Shelton, 2008).
- **Chinese Americans**

  ● Traditionally male dominated, extended family homes - shift towards more equality between genders and nuclear family units
  
  ● Often influenced by Taoist medical practices (balancing yin and yang)

  ○ May seek traditional healing methods before Western methods
  ○ May be reluctant to discuss health problems and try to solve them before asking for medical assistance

- Japanese Americans

- Use indirect communication; direct communication is considered impolite
- Place importance on people’s feelings (more so than facts and opinions)
- High respect for others (e.g., will wait at a door until invited in)
- Self-esteem comes from belonging to a group
- Filipino Americans

- Family-oriented decision making
- Gender roles influenced by indigenous Filipino, Spanish and American cultures
  - Leads to many conflicting opinions on gender roles
  - Many are Catholic (after Spanish occupation) with smaller percentage Protestant

Native Americans

- Depends on acculturation type and degree
  - traditional
  - bicultural
  - assimilated
- Use of storytelling
- Parenting by grandparents
- Rituals associated with the body
- High incidence of otitis media/hearing impairments
- Use of power - passive & subordinate
  - Reduction in questions
  - Silence to show disagreement

Arab or Muslim Americans

- Level of acculturation/assimilation crucial
- Religious beliefs:
  - Wealthy and able-bodied should are for less fortunate
  - Avoid noon hour and Friday appointments
- Collective vs. individualistic societal view
- Less direct form of therapy
- Special education often not provided in Middle East-less importance compared to U.S. values (IDEA)
- Gender roles:
  - Males: authority in decision making
  - Females: responsible for carrying out home program

LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer) Americans

- 2 largest barriers of culturally competent healthcare providers:
  1) lack of awareness of LGBTQ needs
  2) inability to provide competent care despite awareness
- Homosexuality was not completely removed from the DSM until 1986 (before it was considered a psychological pathology)
- Mental health disorders, substance abuse, obesity, and tobacco use are disproportionately higher

Hancock, A., & Haskin, G. (n.d.)
LGBTQ continued...

- May be reluctant to seek care or disclose sexual or gender identity for fear of “homophobic reactions, confidentiality concerns, past negative experience with providers, and fear of being stigmatized.”

- Many LGBTQ patients report negative interactions with healthcare providers.

- In a survey of LGBT people with S&L impairments, only 35% reported disclosing their orientations and 43% reported perceiving a heteronormative bias.
Cultural Competence: Ethnicity vs. Culture

- People who share ethnic background do not always share cultural beliefs.
- Individual behavior is not determined by set cultural norms, race, or ethnicity.
- Culture is mutable and multiple.

Cultural Competence: Cross-Cultural Education

- Patients’ and healthcare providers’ interpretations of disease are often dissimilar - affects quality of care

- Biomedical culture, stems from “post-WWII explosion of science and technology, characterized by strong belief in value of newer, Western, and more technologically sophisticated treatments” (p. 543)

Cultural Competence: Stereotyping and Simplification

- All groups within the U.S. are affected by contact with other groups.
  - There are no distinct boundaries in groups.
  - Culture is not a *fixed* entity.

- Knowledge of culture does not predict behavior.

- Belief about disease/disorders can change over time.

Cultural Competence: Role of Poverty

● “Culture” is not always the only problem with people living in unhealthy conditions.

● Poverty is a major factor causing:
  o Limited access to health care
  o Little power to change circumstances

"...the danger of overly narrow and simplistic conceptualizations of culture is that they may reinforce stereotypes and contribute to, rather than reduce, cross-cultural misunderstanding. They may also then prevent in-depth exploration of the multiple, complex, and interrelated social, cultural, political, and economic factors that combine to influence patients’ behavior." (p. 544)
International Resources to Develop Cultural Competence (ASHA)

http://www.asha.org/Practice/multicultural/International-Resources-to-Develop-Cultural-Competence/
Discussion

1.) Rate your personal knowledge with the LGBTQ population. On page 181 in the textbook, which level of the hierarchy of cultural knowledge do you believe you fit? How could you raise your awareness and cultural knowledge (those within the chapter)?

2) Rate your personal comfort with the LGBTQ population. How could you increase your comfort with this population? What about other populations?

3.) How do you think your upbringing and where you were raised affect your opinions and bias? Now that you have reflected on your own personal opinions and bias, how do you plan on not letting these negatively impact your relationships with clients and future practice?

Hancock, A., & Haskin, G. (n.d.)
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a. Process of coming out for people who are LGBTQ

b. LGBTQ culture

c. LGBTQ healthcare issues

d. Role of SLP in LGBTQ healthcare

e. Voice feminization/masculinization services
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1---------2---------3---------4---------5
(uncomfortable) (very comfortable)
3.) How do you think your upbringing and where you were raised affect your opinions and bias? Now that you have reflected on your own personal opinions and bias, how do you plan on not letting these negatively impact your relationships with clients and future practice?
References


