Practice with Diverse Populations: Tools for Cultural Competence

Course Overview

Over 13% of the U.S. population is foreign-born and millions more are the children of immigrants and refugees. Immigrants and refugees of the 21st century are more diverse than ever before, presenting a unique set of challenges for practitioners. This course provides an introduction to the information and skills necessary for practice with diverse populations. The course is designed to help the learner develop knowledge regarding the contextual factors which affect immigrants' and other diverse populations' well-being, and build practice skills to respond to their needs and particular patterns of help seeking. Although some of the course examples may be focused on specific immigrant or refugee populations, the course aims to provide a non-essentialist perspective on practice with diverse populations. Knowledge objectives of the course include the ability to: understand the contextual factors which influence the well-being of immigrants and refugees, and other diverse populations, and resources to help organize those factors in client assessment, understand the different ways in which the value systems of immigrants and refugees, and other non-dominant populations influence their definition of needs and patterns of help-seeking behavior and ways to elicit help-seeking behavior, and appreciate the importance of self-awareness and self-understanding for successful practice with diverse populations.

Introduction

For over a century, the clinical and counseling professionals have been committed to the provision of services to immigrants and refugees to help them overcome the structural and cultural barriers that impede their integration into mainstream communities (Iglehart & Becerra, 2011; Stern & Axinn, 2012). Since the 1970s, professional's commitment to these populations has inspired practitioners to revise existing models of practice to incorporate greater attention and sensitivity to the impact of cultural differences on people's conceptions of need and helping (Lum, 2007). In the 21st century, this issue has become even
more important as the U.S. population has become increasingly diverse as a consequence of global migratory patterns and domestic demographic trends.

The U.S. Census Bureau (2012) estimates that 13% of the population is now foreign born; millions more are considered first generation, the children of immigrants and refugees. This emerging demographic reality, with more diversity than ever before, creates new and unique challenges for the development of effective clinical and counseling practice that promotes the overall well-being of individuals in their environments at the individual, group, and community levels.

Clinicians, counselors, and practitioners, including but not limited to social workers, licensed counselors, therapists, and psychologists, are committed to social justice. Discrimination and prejudice directed against any group are damaging to the social, emotional, and economic well-being of that specific group and of society as a whole. For example, as codified in section 4.02 of the NASW Code of Ethics (1999), “Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.” The NASW Standards often refer to these abilities as ‘Cultural Competence’ and (2001) expand on the Code to delineate the organization’s position with regard to cultural competence. Standards One (“Ethics and Values”) and Two (“Self-Awareness”) direct practitioners to evaluate and understand their own values and beliefs as a precursor to cultural competence, and to
adhere to the values and ethics of the profession, acknowledging that conflicts may arise.

Similarly, in its ‘Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists’, the American Psychological Association (APA), requires that psychologists appreciate and practice “multiculturalism against the damaging effects of individual, institutional, and societal racism, prejudice, and all forms of oppression based on stereotyping and discrimination” (APA, 2003, p.15). Further, Standard 2.01 of the Ethical Principals and Code of Conduct for Psychologists outlines that it is essential for practitioners to have an understanding of factors associated with “age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status” to practice effectively.

Although attention to diversity has been a part of the helping professions for many years, the approach clinicians and practitioners have taken towards it has shifted from an emphasis on knowledge about specific groups to a focus on attitudes and behaviors that reflect appreciation and respect for, and the ability to practice competently with difference (Jani et al., 2011). This shift reflects the movement of practitioners from an outlook of “colorblindness” (in the late 1960s) to one of ethnic sensitive practice (Devore & Schlesinger, 1999) and multiculturalism in the 1970s and 1980s, to today’s emphasis on cultural competence (Lum, 2007). Today, the intended outcome of practice with diverse populations is cultural competence, a concept that is loosely defined in the literature and, therefore, challenging to carry out in practice.
There is general consensus that the ability of clinicians and practitioners to be “culturally competent” or practice competently with diverse client groups is a process that includes three components: (1) the development of an awareness of one’s own cultural values, biases, power, and position, and how these factors affect a helping professional’s relationships with clients; (2) the development of the ability to acquire an understanding of the client’s world view (including the ability to elicit the client’s cultural beliefs); and (3) the development of culturally appropriate interventions (Green, 1999; Lum, 1999, 2007; Sue & Sue, 2012). Although this process may seem linear, learning to understand and work effectively with difference is not straightforward. The acquisition of cultural competency, therefore, often requires the use of practice methods and tools other than traditional approaches. It is also important to note here that this process continues throughout the professional life course. This course will attempt to foster competency in working with difference by addressing the three components listed above: Self-awareness, understanding of diverse clients’ worldviews, and developing culturally relevant interventions.

**Self-Awareness in Culturally Competent Practice**

In order for helping professionals to be effective to working with difference, it is extremely important for them to first be aware of their own culture, value and beliefs and to understand where they came from. Often, practitioners do not realize they have a culture simply because they are ingrained in the dominant culture, whose values, norms, and beliefs are embedded in everyday life in America. However, everyone has a culture, and it must be recognized and examined in order for a practitioner to be
aware of her own biases, stereotypes, assumptions, and pre-conceptions. If the
counselor or clinician is not aware of these limitations, he/ she will not be able to
recognize them in practice, which can result in prejudice against a client who is from a
different culture.

Take a moment now to brainstorm some values, norms and beliefs that are
 ingrained in the dominant culture. What did you come up with? Some examples of
values that are common in mainstream American life and are underpinnings for values
and norms here are:

• Achievement & Success
• Activity & Work
• Moral Orientation
• Efficiency & Practicality
• Individual, not Group, Orientation
• Progress and Promotion
• Material Comfort
• Equality
• Freedom
• External Conformity
• Science & Secular Rationality
• Nationalism/ Patriotism
• Democracy
• Individuality and Individual Personality

Underlying cultural values such as these vary widely from culture to culture, and
have a great impact on human behavior, and expectations for behavior. Take a
moment to add to the list and consider ways that these values might impact your assumptions, expectations, beliefs, and values. Think about your assumptions about other groups of people and try to identify where they came from and how you learned them. Were they directly taught to you?

There are several exercises you can do to help you reflect on biases and deepen your self-awareness. Several methods and tools have been proposed and designed to enhance practice competence in diverse cultural contexts. Examples of such tools include the Multicultural Inclusionary Model (Nakanishi & Rittner, 1992), the Cultural Genogram (Hardy & Laszloffy, 1995), and the Intergenerational Family Map (Satir, Banmen, Gerber, & Gomori, 1991), and any combination of approaches (Freeman, 2013).

These approaches usually involve some sort of family mapping which can be an important tool to help practitioners understand themselves and gain self-awareness, but can also be used to help clients understand family dynamics and the impact of culture on their family. Mapping can be used as an assessment, intervention, or evaluation tool in practice. It involves an analysis of a person’s cultural identity through exploration and recognition of family patterns and themes regarding such identifiers as race, ethnicity, religion, spirituality, and class. Next, the person completing the map evaluates how these different identities impact their families, values, beliefs and underlying assumptions and expectations of behavior in terms of relationships and help-seeking. Specifically, they might assess how this impacts conceptions of gender roles and marriage, relationships to and beliefs about authority, how affection is expressed, traditions, help seeking behavior, intergenerational relationships, religious beliefs,
educational goals, and attitudes toward career and material success (Nakanishi & Rittner, 1992).

Before asking a client to do this, take some time and experience it for yourself. Gaining self-awareness is a key to competent practice with diverse populations. It will enable you to identify your culture as one of many, rather than the norm, and thus can help you avoid bias when working with clients from other cultures.

Practitioners often want to assess their self-awareness to make sure they have achieved an appropriate level as to avoid prejudice against any client or client group, and to ensure that they have the appropriate skill level to practice with difference. In addition to exercises geared toward creating self-awareness, there are also a multitude of scales and measures commonly used to evaluate competence with diversity. These include the Cross-Cultural Competency Inventory (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991), the Multicultural Awareness-Knowledge-Skills Inventory (MAKSS; D’Andrea, Daniels, & Heck, 1991), the Multicultural Counseling Awareness Scale (MACS-B; Ponterotto, Sanchez, & Magids, 1991), and the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Miville-Guzman Universality-Diversity Scale (MGUD; Fuertes, Miville, Mohr, Sedlacek, & Gretchen, 1992), and the Ethnic-Competence-Skill Model in Psychological Interventions With Minority Ethnic Children and Youth (ECSM; Ho, 1992). Although the latter four were recommended for clinical use (Krentzman & Townsend, 2008), there is not yet sufficient validation of these instruments to justify their use in the assessment of clinical outcomes.
demonstrate acceptable reliability, there is limited and/or unsatisfactory evidence regarding their validity, especially their construct validity (Kumaş, -Tan, et al. 2007).

These scales often measure awareness or knowledge about different ethnic or racial groups, but they do not necessarily reflect a person’s ability to practice. In addition, many of the scales ask about a practitioner or counselor’s confidence, or perceived self-efficacy, and reflect other underlying assumptions about the measurement of cultural competence. These include the notion that quantifiable knowledge and attitudes are sufficient to achieve skill competence, that a higher quantity of experiences, familiarity, communication, or engagement with a group leads to a higher skill level to work with difference, and that the practitioner is from the dominant group and, therefore, that the acquisition of culturally competence is largely a matter of obtaining knowledge about the ethnic “other” (Kumaş-Tan, et al., 2007).

In reality, one’s confidence about their ability to work with difference has actually been found to have an inverse relationship with the ability to work with difference (Alpers &Zoucha, 1996; Nokes, Nickitas, Keida, & Neville, 2005). Thus, the notion that practitioners should view themselves as perpetual ‘learners’ is important in work with diverse populations, and unfortunately, there are not yet a lot of ways to reliably quantify readiness or ability to practice with difference.

**Awareness of the Limitations of Theoretical Foundations**

Included in our self-awareness should be an awareness of where our assumptions regarding practice come from. We often forget that we base our practice on the theoretical foundations we learned while in school. While practitioners recognize and often celebrate the presence of cultural differences, in practice these differences
are largely assessed in terms of their relationship to a universal normative construct or to "mainstream" conceptions of human development. This is because theories that underlie our practice reflect fundamental assumptions about the relationship between the individual and the environment, the role of systemic and structural forces, and the nature of change have remained virtually unaltered (Dominelli, 2002; Lorenz, 1994).

These theories or theoretical perspectives often include conceptualizations or research that are based on white, middle class, male, Christian, heterosexual standards that can obscure the nature of the emerging socio-cultural environment in the U.S. Thus, even as practitioners have embraced diversity and rejected obviously discriminatory forms of practice, the assumptions of which underlie theories of human development and conceptions of deviance continue to reflect a subtle form of bias. Thus, it is important for helping professionals to become aware of the possible limitations of the theoretical foundations on which we base our practice.

It is important for practitioners to understand where the information they are taught regarding human behavior in the social environment comes from, and how it may work to foster subtle bias when working with clients of diverse backgrounds. Many of us are unaware that a classic text by Charlotte Towle, entitled *Common Human Needs* (1945), has framed the human behavior in the social environment discourse that has guided practice for the past 60 years.

The original edition of *Common Human Needs* (1945) was commissioned by the Social Security Administration for public assistance workers, was published at the end of a generation during which a growing number of “child saving” experts in helping professions sought to “use their expertise to remedy social ills and thus shape the future
of society” (Hawes, 1997, p. 2). The text was rooted in the futurist orientation that had initially appeared during the Progressive Era, which led to an emphasis on the behavioral problems of children and youth and their broader societal implications (Wollons, 1993). Yet, in their attempt to improve the social health of the nation’s youth, these “child savers” made two serious errors. One “was their seemingly innocent view that certain forms of behavior were normal and that any variation from them was therefore deviant” (Hawes, 1997, p. 9). They compounded this universalist fallacy by focusing solely on the needs of “normal” young white Anglo-Saxon males. Issues involving girls were virtually ignored unless they were sexually active, and immigrant families were largely regarded as pathological (Hawes, 1997; Wollons, 1993; Illick, 2002).

The varieties of normal adaptation have been largely ignored in the literature, although they were clearly expressed by Towle. Even as she focused on the range of universal human needs whose satisfaction was “conducive to the furtherance of physical, mental, and spiritual growth,” she also recognized the role of context and circumstances in shaping those needs. In fact, her book’s underlying premise is that there are universal needs and a universal order in which they are achieved, but that “since all our needs have varying importance at different ages under differing circumstances, it is essential that we consider them more specifically” (Towle, 1987, p.40). Therefore, although practitioners rarely are taught to understand human behavior outside of a universal normative construct, the bases for broadening universal assumptions were recognized by Towle from the inception of the human behavior in the social environment framework. This emphasis on normal adaptation, however, which
was part of Towle’s original framework, has been overlooked for most of the 60+ years since her book appeared.

Since the publication of *Common Human Needs*, many factors have weakened the notion that America’s children share a common experience (Illick, 2002). Some of these factors are the high proportion of children in poverty, particularly among the working poor, the increasing polarization of income and wealth, and the increasing racial and ethnic diversity of U.S. families as a result of global migration patterns. As a result, threats to children’s well-being are “built into the economic system” (Illick, p. 161), especially for children of color and those in lower income households. This alters their notion of needs and the opportunities they have to satisfy them. Thus, a theoretical foundation that assumes universal norms for behavior is flawed and must be considered in practice with diverse populations.

Most works on human behavior during the past sixty years, however, have overlooked the historical circumstances which shaped Towle’s framework or its subsequent adoption. They have largely ignored her assertions about the significance of context and explicitly or implicitly asserted that a universal normative standard exists against which all human behavior should be measured (Bronfenbrenner, 1979, 2005). The concept of “common human needs,” therefore, has been interpreted by helping professionals as the basis to create universal assumptions about who is a common person; what the needs of that person are; and how that person meets those needs (Zastrow & Kirst-Ashman, 2007; Dale, Smith, Norlin, & Chess, 2006; Hutchison, 2007). This universal standard is also predicated on the assumption that human behavior should be understood primarily as an individual phenomenon.
Most models of human development and behavior that are currently used (Bronfenbrenner, 1995; Karls & Wandrei, 1995) are based on the eight assumptions following, and are further reinforced by their graphic depictions (See Figures 1a & 1b):

Figure 1: Traditional Depiction of Person-Environment Relationship
1. Linearity between an individual’s biological, psychological, social, and spiritual needs. This further implies that there is a stable, coherent, knowable self that is conscious, rational, autonomous, and universal. Physical conditions or differences do not substantially affect how this self functions;

2. The existence of a universal and static hierarchy of needs (Maslow, 1954);

3. Rationality in the pursuit of means to satisfy those needs. That is, that the self knows itself and the world primarily through reason or rationality, which is considered the highest and only objective form of mental functioning and the ultimate judge of what is true, right, and good in the world. Conversely, in the West, “disorder” is constructed as “other” (e.g., non-rational, non-white, non-male, non-heterosexual);
4. The centrality of the individual and the primacy of the satisfaction of individual needs;
5. The existence of an essentially benign relationship between the individual and his/her social environment;
6. That well-being is a natural state of individuals and the social organizations they form;
7. That the social order (i.e., the environment) emerges out of efforts to satisfy individual and group needs, that all individuals and groups have equal opportunity and ability to shape it, and that the nature and boundaries of the systems which comprise the environment are essentially fixed; and
8. That individual behavior reflects a present and, occasionally, a futurist orientation which does not account for the influence of history on the individual or the group or community to which s/he belongs.

These representations of the relationship between the individual and the environment and between the various dimensions of an individual’s needs have persisted in some form for nearly a century (Richmond, 1917). Although they portray the individual as embedded within the environment, they subtly imply the isolation of the individual from the environment and a sequential, rather than concurrent, impact of environmental forces on human needs and individual efforts to satisfy them. Furthermore, they emphasize the boundaries between individual and society and between various social systems, rather than their permeability and interaction (Gitterman & Germain, 2008; Bronfenbrenner, 1995; Karls & Wandrei, 1995).
More specifically, prevailing theoretical approaches which underlie practice – such as psychodynamic, developmental, systems, social behavioral/learning (including cognitive behavioral), conflict, rational choice (social exchange), and humanistic – primarily focus on individual behavior. This focus itself reflects an often unacknowledged dominant cultural bias, for example, by looking at conflict theory in terms of its impact on individual empowerment, or looking at social exchange as the exchange of resources between individuals. Another way in which these assumptions are reflected is in the presentation of universal, normative life stages and life stage challenges. Ironically, at the same time as the helping professions embrace the value of diversity this produces a perspective which equates difference with deviance (Fawcett & Featherstone, 2000). In other words, it leads to a more subtle form of discrimination which prevailing theories fail to elucidate.

Assumptions of commonality are present in the Ecological Perspective, often expressed as Person-In-Environment (PIE), through its conceptualization of micro, mezzo, and macro systems as separate entities (Gitterman & Germain, 2008; Karls & Wandrei, 1995; Hearn, 1979; Bronfenbrenner, 1979). The origins of this framework date back to Mary Richmond (1901). By viewing these systems as separate entities, practitioners can detach behavior from how it is impacted by differing individuals’ environments, thus creating a tendency to evaluate behavior against universal norms, standards, and values foreign to the context. Applying a critical lens to the Ecological Perspective rejects this decontextualization of behavior from its environment, thus precluding the application of universalist assumptions to clinical practice.
In addition, theories often used to guide practice accept as “givens” many of the structural and systemic features of society which shape and implicitly evaluate human behavior. These include the existence of a competitive market economy which permeates all aspects of our society; the separation of public and private spheres of life; traditional views of marriage and family relations; and the primary importance of material well-being as a measure of quality of life. While these assumptions provide the foundation for a “normative mainstream U.S.” worldview, they are not necessarily universally shared (Green, 1999). Although this diversity of norms and standards is acknowledged and even celebrated in the literature (Gitterman & Germain, 2008), the persistence of a bifurcated perspective diminishes the impact of this recognition on practice with individuals and families in a rapidly changing, diverse context.

These assumptions of commonality regarding human needs underlie the use of Eurocentric, individually-oriented theories to help practitioners explain and predict human behavior. The “Life Model” (Gitterman & Germain, 2008), which has been highly influential in shaping practitioners’ understanding of the relationship of human behavior and development to the environment for the past three decades, emphasizes the importance of diversity and the world views of different cultures. Yet, its stated purpose – “to improve the level of fit between people and their environments, especially between human needs and environmental resources” (p.72, emphasis added) – has inadvertently focused practice with individuals and families on the adaptation of people to their environments based on the assumption that the work of transforming the structural features of the environment will be addressed by others.
The most significant new features of the social environment include revised patterns of family and household structure, employment, and living arrangements; changing racial/ethnic/age composition of communities, schools, and the workforce; changing attitudes towards race relations, gender roles, gender identity, and disability; the changing nature of work; and changing expectations of the aging process (e.g., health, longevity, requirement to continuing working, etc.). As early as the 1960s and 1970s, social scientists recognized how all of these phenomena were influenced by factors of race, class, generation, and geography (Stack, 1974; Staples, 1986; Willie, 1985; Sennett & Cobb, 1972). Many of these changes are inter-related and thus emphasize the interactive nature of individual and societal changes and the shortcomings of applying universal constructs regarding human behavior and development.

Recognition of the absence of a universal normative standard for human behavior is particularly important for the helping professions as they struggle to address the emerging issues of the 21st century. The combined impact of immigration, mass migration, and economic globalization has rendered many long-standing assumptions irrelevant for practice in an increasingly diverse society. These factors lead to the need for an alternative critical framework to help practitioners work effectively in these new realities.

The gap between environmental realities and these assumptions produces significant problems for practitioners. It fails to provide you with an adequate theoretical underpinning to address the practice challenges you will face while working with diverse populations. It reinforces deeply entrenched assumptions about "normal" human
behavior which make it more challenging for practitioners to develop critical perspectives and practice without bias. While people may have common needs and life tasks, their definition of these tasks and their ability to accomplish them varies at different phases of their lives due to cultural, religious, historical, and structural factors.

**Use of An Alternative Critical Framework**

Practitioners should be aware of often unchallenged certainties about the life cycle, including the notion that development occurs only within certain stages and specific “normal” patterns, and the tendency to categorize human behavior and isolate it from its socio-cultural and historical context. An alternative theoretical framework should integrate several key features: (1) Recognition that all individuals share common life tasks but attempt to resolve them through uncommon solutions; (2) Acknowledgement of the role of institutional, cultural, structural, and historical forces in shaping people’s identity and, therefore, their ability to achieve lifelong tasks; and (3) Recognition of the importance of historical and cultural contextualization of the stages of development, (4) Understanding and application of a critical theoretical perspective which rejects universal and generalizable norms. For counseling practice, a critical perspective encompasses the ways in which concepts of power, oppression, and inequality influence interpersonal relationships, institutional arrangements, and individuals’ self-concepts, and recognizes multiple ways of knowing and the role of human agency in personal and social change (Adams, Dominelli, & Payne, 2009; Fook, 2002). Critical theory as an alternative explanatory and predictive framework encourages us to interpret the world through a different lens, one which integrates the
perspectives of vulnerable and marginalized populations that traditional theories often overlook.

The addition of critical theory to the “mix” of approaches used in practice facilitates the discovery of the hidden subtleties of power differentials which are socially constructed by encouraging the questioning of prevailing norms, values, and standards of behavior. To do this, practitioners need to focus on the entirety of a client’s life, and not assess components of their lives in isolation (Fook, 2000). This can help practitioners and clients because it contextualizes clients’ experiences and recognizes how prevailing norms, values, and standards are based upon practitioners’ assumptions regarding beliefs and sufficient access to opportunities and resources. Tools to help practitioners do this will be discussed below. The application of a critical perspective facilitates our understanding of the impact of power, oppression, and inequality on interpersonal relationships, institutional arrangements, and the processes of helping and learning by integrating such concepts as social construction, context, intersectionality, positionality, collectivity, agency, and historicity.

The integration of critical theory to enhance our understanding of human behavior through the inclusion of the following interrelated concepts (Adams, Dominelli & Payne, 2009; Payne, 2005; Ritzer & Goodman, 2004; Dominelli, 2002; Fook, 2002; Fawcett, Featherstone, Fook & Rossiter, 2000; Pease & Fook, 1999).

- **Social Construction** - That reality is socially constructed in a manner which creates preferred universal conceptions of what should be done and what is considered “normal” or ideal human behavior. One example of how social construction influences our perception of reality is the acceptance of binary
thinking in which concepts are divided into two mutually exclusive categories, such as white/black, man/woman, reason/emotion, and heterosexual/homosexual;

- **Context** – Based on the above assumption, it is important that practitioners avoid generalizations about groups and strive to understand how history, socioeconomic realities, and immediate situations (e.g., crises) affect people’s behavior. This rejects the essentialist tendency to regard individuals and groups as possessing inherent, unchanging characteristics rooted in biology or a self-contained culture that explains their status. At the heart of the emphasis on context is the idea that culture is dynamic, not static;

- **Intersectionality** – In addition to recognizing the dynamic qualities of culture, it is also important to acknowledge the range of cultural influences which affect people. That is, each person has multiple, intersecting dimensions and cannot be defined in terms of one demographic variable. Therefore, instead of viewing race, class, gender, sexuality, ethnicity, religion, nationality, age, ability, and other identifying variables as isolated features of social organization, it analyzes them as mutually constructed components which shape and are, in turn, shaped by individuals’ experiences;

- **Positionality** – A corollary to the notion of intersectionality is that people’s social position (e.g., class, race, gender, religion, age) influences their construction of reality and the ways they interpret other people’s constructions and behaviors. Standpoint theory, from which this concept emerges, further argues that the location of an individual or group in the context of hierarchical power
relationships produces common challenges for individuals similarly located. These shared challenges foster similar perspectives on history and current reality essential for taking collective action to alter that reality;

- **Collectivity** – Because of these diverse, multiple influences, individuals are not isolated, and do not act alone. They are affected by and have an impact on their communities. Often, this concept is expressed through the emergence of collective consciousness about a group’s social situation, the acceptance of a common paradigm or interpretive framework to explain social phenomena, or the development of oppositional knowledge which defends an oppressed group’s interests and fosters the group’s self-definition and self-determination. Together, these can produce a counter-narrative to the prevailing master narrative, which often serves to perpetuate dominant-subordinate relationships;

- **Agency** – As a result of the emergence of these counter-narratives, even people in desperate situations can possess a self-defining and self-determining will which enables them to maintain some sense of control over their lives. This concept is consistent with an empowerment perspective and a strengths-based approach to practice; and, lastly,

- **Historicity** – An important prerequisite for the implementation of agency is the growth of people’s awareness of their place and role in history, and affirmation of their ability to produce change over time. Since helping professions are unique because of their belief in the value and possibility of change, this concept is particularly valuable for today’s practitioners to embrace in the complex and rapidly changing environment (Hill Collins, 2009).
Different groups interpret and meet these needs in different ways - sometimes because of longstanding preferences (i.e., due to cultural norms) and, at other times, due to limitations created by structural barriers. If we incorporate critical theory into an understanding of common human needs, we are able to put behavior in context in our practice and to recognize that humans cannot be generalized by group membership. Rather, there is a need to understand how history, politics, economics, social realities, and immediate situations create unique behaviors.

**Applying an alternative framework: A Case Illustration (Adapted from Jani & Reisch, 2011).** Sammy, 13, and José, 12, live with their mother and two younger sisters in an urban neighborhood. Sammy is a good student, is well liked by his peers, and adored by his family. José has always exhibited behavioral problems and received low grades. On numerous occasions recently, he has been involved in fights at school and in his neighborhood. Sammy feels obligated to protect his brother and in doing so has gotten into trouble for fighting. The helping professional to whom Sammy has been referred thinks he is college material and has encouraged him to participate in special classes and after-school activities. Sammy is reluctant to do so, however, because he will not be able to protect his brother in the streets and will have to quit his delivery job which helps support his family.

How might you assess or ‘intervene’ in this case? What cultural values, norms and beliefs may impact your intervention plan? A more traditional framework would assess the needs of Sammy and his family based upon certain assumptions about “normal” developmental stages, definitions of such critical concepts as success, the role of institutions in identity formation, and mainstream cultural ideas about the relationship
between individuals and their families. The use of this framework would probably lead a well-intentioned practitioner to focus on how to help Sammy adapt to his environment and assimilate into the expectations and roles of the dominant culture by encouraging him to go to college and to make a successful transition to young adulthood. Such an intervention would not adequately take into account the competing pressures on Sammy which are the products of his culture, community, and family history, and which would have a long-term impact on his development and life chances.

Now, consider the critical theoretical perspective discussed above. How might that influence your understanding, assessment, or intervention plan for working with this case? Practitioners applying a critical theoretical perspective would approach this situation differently in both explicit and subtle ways. They would recognize the power of Sammy’s culture, context, and history in shaping his priorities, the nature of his needs and those of his family as they define them, and their historical patterns of help-seeking. Yet, they would avoid making broad assumptions about the family based on a static view of their culture, and rather focus on asking informed questions to understand the dynamic interplay of past and present in a holistic manner.

In addition, they would look to the community, and not merely the individual, for the type of supports which Sammy and his family require to address the complexity of their situation. Practitioners using a critical perspective would also be aware of how Sammy and his family regard the institutions in their community, such as the agencies in which they are employed, in particular the degree of trust which they have in such institutions. In other words, practitioners would understand how the perception of their agency’s priorities would influence the likelihood of Sammy and his family making an
effective use of whatever interventions they attempted. Finally, helping professionals using this perspective would take a longitudinal view of the consequences of their interventions – i.e., how short-term choices shape the nature, definition, and resolution of the needs which Sammy and his family will face in the future.

In sum, the inclusion of the role of institutional, cultural, structural, and historical forces as key elements that shape human behavior, the evolving definition of human need, and the means by which needs are met is crucial since different populations face different institutional barriers in meeting their needs. For example, resolution of Eriksonian conflicts such as industry vs. inferiority in middle childhood can be facilitated or impeded for different groups by such factors as how a child is treated in school, whether the child speaks English as a second language, and what are the expectations of the child’s parents regarding education. Consequently, children from different cultures or who live in poverty may have very different opportunities for identity formation – as defined by the mainstream culture – during this life stage.

**Understanding Clients’ Worldview & Creating Culturally Appropriate Interventions: Considering tools and resources to help practitioners elicit relevant information**

In the introduction, we established that to practice competently with diverse client groups is a process that includes three components: (1) the development of an awareness of one’s own cultural values, biases, power, and position, and how these factors affect a practitioner’s relationships with clients; (2) the development of the ability to acquire an understanding of the client’s world view (including the ability to elicit the client’s cultural beliefs); and (3) the development of culturally appropriate interventions (Green, 1999; Lum, 1999, 2007; Sue & Sue, 2012).
In the last section, we considered the development of one’s self-awareness, both from a personal, and theoretical/educational perspective. Now, we will focus on increasing the practitioner’s ability to acquire an understanding of the client’s world view, which, in turn, will lead to ideas and tools for intervention. As our discussion on theory highlights, it is highly important to consider context—including an understanding of a client’s beliefs, expectations, and assumptions regarding help-seeking—to understand his/her world view. In addition, we want to focus on knowing the “right questions to ask” rather than making assumptions regarding client behavior.

In addition, although we often believe that cultural differences underlie assumptions in practice, we cannot overlook the importance of context, as critical theory points out. Other factors, not necessarily related to culture, or indirectly related, are also important to consider in practice with diverse populations. Consider this case, adapted from a case presented by Kleinman & Benson (2006):

*A counseling professional is asked by a pediatrician to consult in the care of a Mexican woman who is HIV positive. The woman’s husband had died of AIDS one year ago. She has a four-year-old son who is HIV positive, but she has not been bringing the child in regularly for care. The doctors explained to the practitioner that the lack of care is most likely due to a lack of cultural understanding surrounding HIV/AIDS and treatment options. The doctors assumed, then, that the problem was caused by a radically different cultural understanding. What the helping professional found, though, was to the contrary. This woman had a near complete understanding of HIV/AIDS and its treatment—largely through the support of a local nonprofit organization aimed at supporting Mexican-American patients with HIV. However, she worked under the table*
in a factory, a very-low-paid position, and often worked double shifts and late-night shifts to earn the money necessary to support her and her son now that her husband was gone. She had no time to take her son to the clinic to receive care for him as regularly as his doctors requested. Her failure to attend doctor’s appointments was not because of cultural differences, but rather her practical, socioeconomic situation. Talking with her and taking into account her “world” were more useful than positing radically different Mexican health beliefs. (Adapted from Kleinman & Benson, 2006).

This case brings up an extremely important point—we must consider a person’s entire life circumstance—not just their culture or any other single variable—when working with any client. Race, culture, or ethnicity do not account for a person’s entire being. Considering the concept of intersectionality may be of use as a practice tool to make sure to take into account a person’s whole being before over-considering one aspect of their lives. Intersectionality can be simply depicted like this (See Figure 3):
The identities listed above are just a FEW EXAMPLES of the multiple identities that should be considered when working with clients and understanding, assessing, and planning interventions. Take a moment now to consider other variables that should be considered among your own clients. Variables including gender, religion, ethnicity, sexual orientation, income, education, residency status, household composition, physical ability, health condition, language ability, and ethnic regionalism impact identity, and behavior, and access to opportunities and resources. Clinicians and counselors want to be able to analyze a client’s complete situation, and consider all variables—including those outside of “culture” or race. Consideration of intersectionality makes it difficult to generalize people and forces consideration of context.

By considering a person’s context, helping professionals will be able to make understand and make better assessments of client situations, which will
ultimately lead to the creation of more effective interventions. Over the last three decades, practitioners have attempted to enhance our understanding of the complexity of culture and expand our cultural awareness and sensitivity through the use of practice tools such as the Multicultural Inclusionary Model (Nakanishi & Rittner, 1992), Cultural Genogram (Hardy & Laszloffy, 1995), and Culturagram (Congress & Brownell, 2007; Warde, 2012; Freeman, 2013). Since the 1990s, there has been considerable discussion in the literature of social work, psychology, counseling and other professions about the effectiveness of these tools (Hardy & Laszloffy, 1995; Eldridge, 2001; Maudsly & Striven, 2000; Keiley, et al, 2002; Shellenberger, et al, 2007; Lim, 2008; Willow, Tobin, & Toner, 2009).

The use of culturally specific tools supplement two tools commonly used in practice: the ecomap, and the genogram. Based on General Systems Theory, the ecomap is intended to enhance practitioners’ understanding of the relationship between clients and their external environments and social support networks (Hartman & Laird, 1983). Similarly, the genogram, based on Family Systems Theory and Developmental Theory, seeks to help clinicians understand the dynamics of internal family relationships (Bowen, 1985; McGoldrick & Gerson, 1985). Each of these tools share a common theoretical underpinning: individuals cannot be understood in isolation, but rather as part of a family system and broad cultural environment. They also add a visual component to the application of various theoretical perspectives, which has been found to enhance the ability of practitioners to conceptualize client situations (Keiley et al., 2002). Use of such tools is based on Experiential Learning Theory (ELT) (Kolb, 1984),
thus the tools encourage practitioners to discover, through *doing*, how concepts such as culture functions to create diverse world views and impact behavior (Eldridge, 2001). Less experienced practitioners, in particular, often benefit from a concrete experience that can serve as a basis for future observation and reflection, ultimately resulting in heightened ability to conceptualize a situation abstractly, often through a subtle shift in their thinking (Kolb, 1984; Maudsley & Strivens, 2000). In addition, tools specific to culture provide a method of conveying information regarding for practitioners with varying levels of cultural sophistication.

Many recent studies have also focused on the use of practice tools, focused both on culture and other topics, in an educational context. During the past decade, research in the fields of family therapy and counseling has explored the use of visual mapping tools in education. Willow, Tobin, and Toner (2009) found that the use of a spiritual genogram among counseling students improved their ability to conceptualize the meaning and importance of spirituality, in part, because it encouraged self-awareness. The process of using the spiritual genogram expanded students' worldview by helping them explore their values and spiritual journeys and those of their clients'. It also increased their understanding of the spiritual realm in the therapeutic relationship and aided them in acquiring a better understanding of the worldview of others. Similarly, in her study of counseling students, Lim (2008) found that the use of genograms led to personal growth and even improved relationships with their families of origin.

Kosutic and Garcia (2009) evaluated the usefulness of constructing and presenting a Critical Genogram (CritG) on the ability of students in a course on family therapy to
develop critical consciousness. They found that the CritG exercise augmented students’ insight into the influence of social, political, and economic systems on individuals and families, and helped students find new ways of conceptualizing family processes and the meaning behind them.

With regard to cultural tools specifically, Keiley et al. (2002) found that a cultural genogram helped family therapy students increase awareness of their own cultural identity. This, in turn, helped them be able to ask clients about their culture and be more empathic. Two recent articles have explored the usefulness of the cultural genogram in the developmental process of the professional self and in formal education. Warde (2012) asserted that the cultural genogram is a useful tool to complement didactic instruction in clinical education. The author found that it encouraged students to take a more active role in the educational process and develop increased cultural awareness and sensitivity. He describes these outcomes, however, as prerequisites for the development of culturally competent practice, not in terms of their effects on students’ perceived ability to practice. Shellenberger, et al (2007) drew similar conclusions in their examination of the impact of the Cultural Genogram on the education of health care professionals.

While the Cultural Genogram (Hardy & Laszloffy, 1995), and older tools such as the Multicultural Inclusionary Model (Nakanishi & Rittner, 1992), focus on the development of awareness and sensitivity, the Culturagram also has the potential to enhance practice skills and, therefore, is presented in more detail here. The culturagram is not yet a widely used tool, but has the potential to inform the
process of enhancing practitioners’ practice skills at the micro, mezzo and macro levels.

The Culturagram

The Culturagram (Depicted in Figure 4) was introduced in the mid-1990s as a tool to aid practitioners in understanding, assessing, and planning in professional practice with immigrants and refugees (Congress, 1994, 1997). Its purpose is to help practitioners recognize the role culture plays in clients’ situations so that appropriate, accessible interventions can be planned and realized.

Figure 4: Culturagram
As seen in Figure 4, the culturagram focuses on the interrelationships between client systems and other environmental factors that affect the lives of diverse families. The Culturagram especially focuses on work with immigrant and refugee families—those that have relocated. The interrelationships include the amount of time they have been in a community; the language spoken in their home and community; their health beliefs; the impact of trauma and/or crisis events; their connections with cultural/religious institutions (holidays, services received); the influence of oppression, discrimination, racism and bias; their values about education, work, and family structure, power, myths, and rules; their reasons for relocating; and their legal status.

By exploring these factors, the culturagram has the potential to assist helping professionals acquire a more in-depth understanding of the multiple dimensions of culture, the various ways culture affects clients’ lives, and the different ways it has an impact on the worker-client relationship. It can also help practitioners develop a more contextual and multi-dimensional understanding of clients’ situations in order to assess them more effectively and, in collaboration with clients, develop effective change strategies.

Several recent articles have discussed the applicability of the Culturagram to different practice settings and situations, including health care (Congress, 2005), domestic violence (Brownell & Congress, 1998, Congress & Brownell, 2007), adult protective services (Brownell, 1998), mental health care (Congress et al., 2004), and practice with people of color (Lum, 2007). In addition, the Culturagram has been found to impact the ability of helping professionals to understand, assess, and plan with clients.
from a non-dominant group (Jani & Okundaye, 2014). It encourages practitioners to challenge their own assumptions and heighten self-awareness by enhancing their capacity to consider clients’ relationship to their environments; by boosting their confidence to work with difference; and by altering the way they conceptualize client cases.

To practice using the Culturagram, we will now consider a case. First, consider this case adapted from Congress (2004) before trying to use the Culturagram:

Thirty-five year old Mrs. Carmen Perez was seen in an outpatient mental health agency in her community because she was having increasing conflicts with her fourteen year old son Juan who had begun to cut school and stay out late at night. She also reported that she had a twelve year old daughter Maria who was “an angel”. Maria was very quiet, never wanted to go out with friends, and instead preferred to stay at home helping her with household chores. Maria was often kept out of school to accompany and interpret for her mother at medical appointments. Mrs. Perez did express concern that Maria had recently begun to menstruate. Every month she became ill with severe cramps and vomiting. Mrs. Perez commented that this was women’s cross and that there was nothing to be done about this.

Mrs. Perez indicated the source of much conflict was that Juan believed he did not have to respect Pablo, as he was not his real father. Juan complained that his mother and stepfather were “dumb” because they did
not speak English. The past Christmas holidays had been especially
difficult, as Juan had disappeared for the whole New Years week-end.

At 20 Mrs. Perez had moved to the United States from Puerto Rico with
her first husband Juan Sr., as they were very poor in Puerto Rico and had
heard there were better job opportunities here. Juan Sr. had died in an
automobile accident on a visit back to Puerto Rico when Juan Jr. was 2.
Shortly afterwards she met Pablo who had come to New York from Mexico
to visit a terminally ill relative. After she became pregnant with Maria, they
began to live together. Pablo indicated that he was very fearful of
returning to Mexico as several people in his village had been killed in
political conflicts.

Because Pablo was undocumented, he had only been able to find
occasional day work. He was embarrassed that Carmen had been forced
to apply for food stamps. Pablo was beginning to spend more time
drinking and hanging out in the corner with friends.

Carmen was paid only minimum wage as a health care worker. She
was very close to her mother who lived with the family. Her mother had
taken her to a spiritualist to help her with her family problems, before she
had come to the neighborhood agency to ask for help. Pablo has no
relatives in New York, but he has several friends at the social club in his
neighborhood.
Ask yourself three basic questions regarding the case (PRIOR to using the Culturagram):

(1) What is your understanding of the client system dynamics?
(2) What is your assessment of the client system needs?
(3) What is your beginning plan for intervention?

Also, in an effort to increase self-awareness, consider some of your underlying assumptions regarding the cultural group at the center of the case—where did these assumptions come from? How do they impact your understanding, assessment and plan for working on the case?

**Understanding the Client Situation: Use of the Culturagram**

Prior to using the culturagram, practitioners frequently identify the clients’ immigration status and language barrier and the role that family members’ values play as significant problems in the case. For example, practitioners may assume that a major source of family conflict and tension results from the mother being the primary breadwinner in the family, since traditional gender roles are often assumed to be central to the Latino culture. In addition, it is often assumed that the mother’s frequent reliance on her son and daughter to help her navigate their complex environment was a source of the children’s problems both at home and in the community. This initial understanding of the client system situation may be a reflection of dominant cultural assumptions, overgeneralizations regarding the client system’s culture, and misunderstandings about the complexity of the family’s situation.

Now, take a moment and consider the additional information you might gather by using the Culturagram. What additional information would you ask the client? How
would you get to know the client in a different way? How would it change your session?
Your assumptions? How has the use of the Culturagram shifted your understanding of
the client situation?

Often, after using the Culturagram, practitioners have a somewhat more
sophisticated and contextually relevant understanding of the situation; they recognize
both the complexity of the clients’ situation and the interrelationship of the various
cultural, social, economic, and legal factors that affect the clients’ lives. They may also
become more aware of the impact of the clients’ cultural values, norms, and traditions
on the behavioral responses of individuals within the family to their specific
circumstances. Practitioners are also more able to revise their prior assumptions about
the family’s dynamics, which were often based on dominant cultural norms and/ or
overgeneralizations about the client culture, and demonstrate a more in-depth
understanding of intra-family relationships in the client system. The Culturagram also
encourages practitioners to consider the client’s relationship to different systems in the
environment.

In sum, after using the Culturagram, practitioners have often developed the
ability to begin to examine areas of clients’ lives that they had not considered before,
such as legal status, language barriers, healthcare-conventional vs. spiritual, religion/
spirituality, adolescence, blended family, school-truancy, loss of husband/biological
father, trauma in returning to Mexico, interpreter, and income. They are more likely to
ask the right questions rather than making assumptions based on generalizations, and
they enhance their understanding of the case by considering the effects of the
environment on the client system. Thus, practitioners are more likely to consider the
clients’ perspective while attempting to understand the case.

**Assessing the Client Situation: Use of the Culturagram**

Now that you have considered all aspects of the case and created a complex,
thoughtful understanding of it, what is your assessment of the case? How might your
cultural assumptions impact your assessment of the case? Despite a heightened
understanding, since many practitioners are part of the dominant culture, they have
difficulty recognizing and assessing the individual and family problems reflected in the
case which are influenced by external systems with which they (the practitioners)
seldom have had contact. This may be a consequence of the tendency within the
dominant culture to individualize the source of personal problems. Practitioners often
also have trouble assessing clients’ situations when the impact of environmental forces
on clients’ lives is mediated through a cultural lens different from their own. This leads
them to assess clients’ problems in a micro sense without connecting them to broader
systemic factors. Perhaps of greater importance is that it also leads them to assume
that traditional culturally dominant methods of intervention, such as family therapy,
would be equally applicable to clients from different cultural backgrounds.

For example, a common assumption in assessing this case is that a family
therapist would be useful to sort out any animosity and disagreements among family
members in a neutral setting. This assumption reflects a worldview very different from
that of the client systems’.

Now, take a moment and consider how your assessment of the client situation
may be different after using the Culturagram. What additional information would you
consider? How would you incorporate the interaction of systems impacting the client in a different way? Does it help you map out client beliefs and values? Does it help you recognize assumptions and expectations underlying the clients’ thought system? Your thought system? How has the use of the Culturagram shifted your assessment of the client situation?

By using the Culturagram tool to aid in assessment, practitioners can gain not only a different set of information to inform their understanding of the case, and what systems are involved in the case, but also what value and belief systems the client is operating from. In addition, by mapping out or charting needs and interactions, and responses to questions, value systems, unspoken client assumptions and expectations, can visually be seen, making it easier for practitioners to identify clients’ needs. Thus, the use of the Culturagram seems to enable practitioners to grasp the complexity of clients’ problems to a greater extent and to recognize the relationships that exist in the complicated nexus involving the clients’ situation, the various systems with which the clients interact, and the conflict between the clients’ values and those of the dominant culture.

**Planning an Intervention: Use of the Culturagram**

Now, prior to consulting the Culturagram, consider what your beginning plan for addressing the clients’ needs might be. What interventions might be effective? What services could be put into place to aid the client system? Often, before consulting the Culturagram, practitioners consider the following interventions: Obtain a school counselor/ get a school counselor involved for the daughter and son who are missing school, look into getting interpreters for mother’s healthcare, propose family therapy for...
mother and children, begin couples therapy for mother and partner, have both Carmen and Pablo take community English classes so Pablo can communicate with future employers and Carmen can communicate to doctors during her medical appointments, have Pablo join community recreation centers so he can build positive friendships and not get caught up in the wrong crowd, educate Carmen on the many state resources to help her financially, and connect Carmen with local clubs or spiritual groups that share some beliefs so she can build social support.

Did you brainstorm some of these interventions as a beginning plan before considering the Culturagram? These are common solutions to the types of problems presented in the case. Although they may provide some relief to the family members, these interventions reflect assumptions based on a dominant cultural perspective regarding the factors that shape people's attitudes towards receiving and providing help. These interventions reflect no recognition of the various barriers, practical, legal or cultural, that would be involved in carrying out such plans. For instance, the idea that counseling, even if it were not a financial burden, could be utilized effectively by this family fails to acknowledge that the ability to obtain help from counseling or therapy depends upon one's socialization into the processes involved, such as the ability to seek assistance from outside the family system, the facility to recognize and verbalize one's emotions about a particular issue, especially in the presence of strangers, and the ability to overcome the status barriers involved in speaking about personal matters to a professional from a different socioeconomic situation and ethnic background. Practitioners often assume that the family in this case (and in their own cases) would be able to access and utilize mainstream services such as counseling without much
difficulty. In addition, many practitioners assume that all that is necessary for a family such as the one depicted in this case to access services is to obtain an interpreter or to learn English, neither of which is a simple task to accomplish.

Now, take a moment and take a look at the Culturagram. Consider all the information you would have gathered that you may not have otherwise become aware of, and how this has influenced your understanding and assessment of the case. How might this affect your beginning plan for intervention in the case? How might it impact what interventions you would consider/ and what might or might not be effective?

After considering the Culturagram, you may feel like you have more proposed questions than proposals for effective interventions. That is a good thing! It reflects a deeper consideration of the context of the client system. Often, practitioners responses after using the Culturagram are less specific, demonstrating a slight shift in thinking, and a heightened ability to understand the client’s perspective. This reflects a more nuanced understanding of the situation even if it does not always immediately lead to an instant, specific plan.

Consideration of the Culturagram often encourages practitioners to discuss more thoroughly intervention options with their clients and to negotiate mutually agreed upon goals with clients, rather than making assumptions regarding needs. Thus, after applying the culturagram, practitioners’ approaches to the case hinted at a growing level of uncertainty that is often needed in working with clients’ who are different from themselves (Jani, Pierce, Ortiz & Sowbel, 2009), and awareness that clients may possess a perspective different from their own that is important albeit still unknown to the clinician or practitioner.
Use of the Culturagram--Summary

Practitioners report that using the culturagram helps them gain greater sophistication in conceptualizing client cases—by considering different areas that may need to be addressed that would not have been otherwise considered, such as legal status or language needs, by allowing the worker to examine individual and family beliefs, values, norms, and behaviors, such as their attitude toward health care, relationships with extended family, and by broadening their viewpoint of the case through asking the right questions, a critical main component of conceptualizing the clients’ situation. In addition, the use of tools that translate systems into images and shows how these systems interact with individuals and families helps practitioners reconceptualize and develop a more in-depth understanding of aspects of a case they had not previously considered. As you may have experienced while completing this exercise, this could be because it aids practitioners in formulating questions about topic areas pertinent to the case that they would not have otherwise considered. In addition, the culturagram helps practitioners challenge their initial assumptions by forcing them to think outside of their original perspective—this is an important component of self-awareness, and part of the process of being culturally competent. This is consistent with research (mentioned above) that has focused on the use of mapping tools—that part of how they work is in helping to enhance practitioners' self-awareness (Keiley et al, 2002; Lim, 2008, Warde, 2012). Because the culturagram is a concrete tool that translates abstract concepts into clearly understood images, it may help practitioners, particularly less experienced practitioners, feel more confident about their ability to understand and assess clients’ situations effectively. The process of learning how to
work with diverse individuals and families is not concrete; yet, practitioners are always looking for a concrete tool to help them improve their practice. The use of this concrete tool not only encourages practitioners to challenge their own assumptions and heighten self-awareness, it helps them develop their capacity to consider the client’s worldview and relationship to their environment, which leads to an increased ability to conceptualize problems. In turn, this has the potential to revise their way of thinking about the client’s situation and ultimately enhance their ability to engage with difference and practice with increased confidence.

It is important to note, however, that little research has been conducted which demonstrates conclusively the effectiveness of these informal practice tools. There is some evidence that these tools aid practitioners in gathering more information, but there is no evidence to date of a direct relationship between the use of these tools and enhanced client outcomes (Sawin & Harrison, 1995; Rempel et al., 2007). It is still unclear, therefore, how tools such as the sociogram, ecomap, genogram, and Culturagram improve and practitioners’ skills in assessment, planning, and intervention. Although the specific contributions of the culturagram to the enhancement of practice with diverse populations have still not been determined, it remains a useful tool in improving certain aspects of practitioners’ ability to practice with clients from different cultural backgrounds. Use of the Culturagram underscores the importance of using methods that help practitioners not only build awareness and understanding, but actually begin to conceptualize different aspects of practice situations, and how difference may impact practice. Future research should examine how specific
assessment tools enrich practitioners’ ability to work with the different populations with which they will certainly interact in the years ahead.

**The Construction of Help-Seeking**

Using the Culturagram brought up some important points that may have escaped previous consideration regarding the complexity of working with people from diverse backgrounds. For instance, the idea that came up under the “Planning” section, that counseling, even if it were not a financial burden, could be utilized effectively by the family in the case, fails to acknowledge that the ability to obtain help from counseling or therapy depends upon one’s socialization into the processes involved, such as the ability to seek assistance from outside the family system, the facility to recognize and verbalize one’s emotions about a particular issue, especially in the presence of strangers, and the ability to overcome the status barriers involved in speaking about personal matters to a professional from a different socioeconomic situation and ethnic background. As stated above, practitioners often assume that the family in this case (and in their own cases) would be able to access and utilize mainstream services such as counseling without much difficulty. However, we must consider the construction of help and help-seeking when working with clients from a different cultural background.

We often fail to consider how help and asking for help are influenced by culture. Take a moment and consider your actions and thoughts when you realize you need help. Do you ask a friend? Family member? Do you feel comfortable going to a professional? Do you feel ashamed? Guilty? How do you decide that your problem warrants outside help? All of these things may impact clients’ feelings about and reactions to help. Understanding help-seeking behavior is a crucial component to
working with difference—whether your client is voluntary or involuntary. Let’s consider this exercise that can assist us focus on understanding help-seeking behavior:

HELP-SEEKING BEHAVIOR MODEL (Adapted from GREEN, 1999)

1. Think about a problem you have or have experienced. It can be anything. Here are some examples, but feel free to use your own:

   a cold       an obsession        contemplating divorce
   a hangover   a religious crisis  coming out
   scary dreams quitting smoking    unexpected pregnancy
   loss of a job chronic fatigue    low-grade depression
   insomnia     loss of appetite    a death in the family
   anorexia     fear of flying      failure in love

2. In this section, you will think about how you came to identify the symptoms you were experiencing as a problem, and how you call the problem, what you understand the source of the problem to be, how you will solve the problem, and how you will know when the problem is solved.
   a. Problem Identification—how did you decide that this was a problem you needed help with? Was it interfering with your functioning? Your relationships?
      i. How did you come to call this a problem?
      ii. When did you decide it was a problem?
      iii. Did you anticipate having this problem?
      iv. What are your symptoms?
      v. What feelings does this problem bring up?
      vi. What made you decide you needed help for this problem?
      vii. How do you explain the problem?
      viii. What caused it?
      ix. How long will it last, do you think?
      x. What will help you treat the problem?
      xi. Will you fully recover? What are expected outcomes?
      xii. How are people with this condition supposed to act?
      xiii. How are people with this condition treated?
         1. by friends
         2. by relatives/ parents
   b. Diagnosis/ Labels—What do you call this problem? Does it have a specific name?
i. How do you explain the problem to others?
ii. What words do you use to describe the situation?
iii. Do you explain it to everyone in the same way?
iv. Are there moral implications in the language you used?
v. How did you come to label the problem that way?
vi. Who else you know that has had this problem?
vii. What did they do to solve it?
viii. Who helped them?
ix. Would you do the same?
c. Client Utilization of Help Providers—How are you going to get help with this problem?
   i. Who did you go to for help with this problem?
   ii. Why?
   iii. What did this helper do for you?
   iv. What are the underlying assumptions the care provider had about the cause of your problem?
   v. Was it the same as your causal sequence?
   vi. What other strategies could you have used?
   vii. Why did you not choose them?
d. Criteria of Problem Resolution—How will you know when the problem is solved?
   i. How did you know when the problem was solved?
   ii. What do you expect from treatment?
   iii. How was your culture taken into account in problem resolution?
   iv. What cultural assumptions were made, if any?
   v. What cultural norms were at play?

Did you consider how your assumptions regarding you definition, label, help-seeking behavior, and problem resolution are impacted by culture?

Let’s take an example of a problem, insomnia. If a client comes you your office reporting her main problem as insomnia, what are your first assumptions? What are the first questions you might ask? Do you take the time to ask how she/he understands the problem, its source, and potential resolution? No matter what the background of the client is, understanding how the client is experiencing the problem will lead to a more nuanced understanding of what an appropriate intervention might be.

In our example of insomnia, what symptoms would we assume the client is experiencing in order to classify something as insomnia? A series of sleepless nights?
Our definition of insomnia, or a professional diagnosis, may be very different from what the client is experiencing. Would we ask what they believe to be causing the problem? This is a crucial question in working with difference—consideration of the client perspective. We might assume both a psychological and a biological cause to the problem. However, upon asking, a client may explain a more spiritual or ‘other-worldly’ cause—a curse, perhaps. Understanding the etiology, or cause of the problem will be critical in creating an agreed upon treatment goal. If you as the practitioner are working on treating the biological aspect, through educating the client on sleep hygiene, for instance, you may have ignored the client’s understanding of the problem. Thus, the problem will likely persist from the client’s point of view—even if some of the symptoms have gone away. Make sure to find out what the client’s perception of the problem is, how he/she believes it needs to be treated, and what it would look like to have the problem resolved from her perspective. Has she/he ever had this problem before? How was it resolved? How would the curse be reversed? Should an alternative health care provider be included in the treatment plan? How will SHE know when the problem has been resolved? Go back and consider your problem again, thinking about it specifically from your cultural perspective.

The following tool (Kleinman, 2006) may be useful in helping practitioners elicit culturally specific health and mental health beliefs. It helps practitioners consider unspoken assumptions and expectations regarding help-seeking and treatment outcomes of clients from different cultures.

**Kleinman’s Tool to Elicit Culturally Specific Health and Mental Health Beliefs**
• What do you call your problem? What name does it have?

• What kinds of symptoms (thoughts, feelings, behaviors) do you have?

• What do you think caused your problem?

• Why do you think it started when it did?

• What does your sickness do to you? How does it work?

• How severe is it? Will it have a short or long course?

• What do you fear most about your disorder?

• What are the chief problems that your sickness has caused for you?

• How does someone with that problem act?

• How does someone with that problem get treated by people in the community?

• What kind of treatment do you think you should receive?

• Where would you go to treat it?

• What are the most important results you hope to receive from the treatment?

• Would it be expected that those symptoms could go away or improve?

This tool may help you understand client expectations for treatment and help you know if you need to incorporate alternative, culturally specific treatment methods into your interventions.

Conclusion:
The emergence of the concept of cultural competence has reflected a significant advance in the thinking within the helping professions about practice in an increasingly multicultural environment. The concept has been well received in many human service professions and the American Psychological Association, the National Association of Social Workers, and most other professional groups have adopted comprehensive statements or policies promoting cultural competence in all areas of professional practice (2001). Scholars such as Lum (2007) and Green (1999) have expanded the field’s understanding of the role of culture in shaping the nature of help-seeking and helping, and the dynamics of the relationship between workers and clients, organizers and constituents, and management and staff.

Through the discussion and cases presented in this course, it is intended that practitioners gain a sense of the complexity of working with difference. Part of this complexity is in understanding that the practitioner is an important part of the partnership—so self-awareness is a key component to culturally competent work. We have discussed both personal self-awareness, of values, norms, and beliefs, and gaining an understanding of what any of your underlying assumptions may be and where they may have come from. We also discussed your educational self-awareness—gaining an understanding of assumptions underlying mainstream theoretical foundations and how those may impact work with clients from non-dominant populations.

Building on self-awareness, we explored how practitioners could enhance their understanding of the client’s worldview. We discussed the use of the Culturagram, and how visual mapping tools could enhance practitioners understanding, assessment, and
beginning intervention planning with diverse clients. We then explored other tools that could be used in practice—Green’s Help Seeking Behavior exercise, and Kleinman’s Tool for Eliciting Culturally Specific Health and Mental Health Beliefs—to help practitioners expand their understanding of clients’ situations—from the client’s perspectives. In all of the exercises and cases, it is noted that there is no such thing as “becoming culturally competent”—it is not something that can be achieved—rather something that is a lifelong learning process. This process is focused on gaining a complex, nuanced understanding of clients’ experiences, being tuned in to asking the right questions, and being comfortable with uncertainty.
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