Section

I.

An Overview of Multicultural and Social Justice Counseling

Chapter 1

Multiculturalism and Social Justice: A Revolutionary Force in Counseling and Psychology

There is a growing sentiment in the counseling profession that hegemonic counseling theories do not adequately address the needs of historically marginalized populations. Predominant theories in counseling do not take into account the unique needs of people of color; women; lesbian, gay, bisexual, and transgender individuals; socioeconomically disadvantaged clients; religious minorities; and other oppressed client populations. Predominant counseling theories, which we illustrate in detail in Chapter 2, tend to discount the importance of cultural factors, place excessive weight on individual change, blame historically marginalized clients for their predicament, and ignore the relevance of external factors to clients' health and well-being. Despite the growing body of literature (Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue & Sue, 2013) indicating the importance of cultural factors in counseling and the need to contextualize client problems and interventions (Ratts, Toporek, & Lewis, 2010), counselors continue to use archaic counseling practices that are remedial at best.

Consider the following examples:

- After seeing several counselors in his community, Victor, a 36-year-old African American gay male client, decided to travel more than 100 miles each way once a week to see a counselor who specialized in gay and lesbian issues. The counselors in his rural community were not able to address the struggles he was experiencing with family and work regarding his sexual identity. Victor was shunned by his family after telling them he was gay. They had cut off all communication with him. He did not "come out" to his colleagues at work for fear of losing his job. His colleagues often made anti-gay jokes, which made him feel uncomfortable. He could not speak out mainly because he did not want them to know that he was gay and because his work's anti-discrimination policy did not include sexual orientation.
- At one campus, most students of color preferred to see the staff at the Multicultural Affairs center on campus instead of the counseling staff at the university counseling center. Although the Multicultural Affairs staff were not trained counselors or psychologists, they often talked with students of color about such issues as racial identity, relationships, college transition, and other personal or social concerns. The

counseling center staff did not approve; they believed that students of color should be referred to them because they were trained to provide clinical services. The Multicultural Affairs staff reported that students of color regarded the counseling staff as insensitive to their cultural concerns. For example, many students of color reported that counselors seemed "distant" in sessions and appeared hesitant to share about their background. Many students of color, who are collectivistic in orientation, also reported that counselors lacked an understanding of how family played a role in their career choices. Students of color also reported that counseling staff, unlike Multicultural Affairs staff, were rarely present at student functions, which made them seem distant.

- Steven, a 19-year-old transgender male client, was recently diagnosed with depression. His family had become distant from him ever since he told them he was intending to transition from female to male. He spent a majority of his time home alone and reported not having any friends. Steven did not agree with the diagnosis of depression; he believed that his struggles were due to his family's inability to accept his gender identity. After 2 months, Steven realized that the majority of time in therapy was spent educating his therapist on the issues experienced by transgender people; for example, his therapist did not know what needed to be included in a letter he was going to write to Steven's physician so that he could receive hormone medication. Steven decided to terminate therapy; he wanted a counselor who could address his concerns and not someone who he paid to educate.
- Yen, a 35-year-old Vietnamese female client living in poverty in a major urban city, received a letter in the mail from her therapist who decided to terminate their relationship because she was late for therapy a third time without calling 24 hours in advance. Because she relied on public transportation to get to her counseling sessions, it often took about an hour to get from home to her counselor's office. The therapist had a 15-minute no-excuse late policy. Yen was unable to afford a cell phone (or a car, for that matter), so she was unable to call her therapist to inform her that she was running late on the three occasions that she was delayed by heavy traffic.

In each of these examples, the counselor failed the client. Equally unfortunate about each of these situations is that the failure often goes unnoticed. The counselors in the rural community will continue practicing without realizing that they cannot provide adequate clinical services to gay clients. The counselors in the university counseling center are likely to remain entrenched in what they have been trained to do, which is to require students of color to adapt to their own theoretical orientation. The therapist working with the transgender client likely feels that she is providing the client an affirming clinical environment. Yen's therapist may never realize that requiring her client to come to her office without being flexible regarding appointment times is an added structural barrier to accessing therapy.

These examples illustrate real-life multicultural interactions that occur every day between clients and counselors. These situations highlight how inequitable social structures contribute to client problems. Each example demonstrates how race, ethnicity, gender, and social class influence the therapeutic relationship, and each example reflects the harm that well-intentioned but ill-equipped counselors have on clients when they are unable to address multicultural issues and systemic barriers.

We hope this book helps to clarify, explain, and expand on the importance of multiculturalism and social justice in counseling. Multicultural and social justice counseling have transcended the field of counseling and psychology in ways its founders could not have

imagined. These changes highlight the need for all counselors to possess multicultural and social justice competence. The issues that clients bring to therapy cannot be understood simply by exploring client cognition, affect, and behavior. Understanding people's lived experiences is not possible without a grasp of the larger cultural and social context.

The purpose of this book is to help counselors develop both multicultural and social justice competence and to understand its application with clients and communities. Both multicultural and social justice perspectives are crucial to effective and ethical practice. For this reason, we attempt to bridge these two complementary perspectives by shedding light on the distinctions, and the symbiotic relationship, between the two. We begin this chapter by providing an overview of the flaws in psychology and its impact on counseling. An overview and history of the multicultural and social justice counseling perspectives is offered along with important events that shaped both perspectives.

Promotion of the Status Quo

The failure of the counseling profession and (more broadly) psychology to respond to the needs of historically marginalized client populations has received considerable attention. This failure can be attributed to a variety of factors. One, counseling continues to use theories that minimize clients' cultural background and that discount the influence of contextual factors on human development. The lack of attention to cultural factors and the larger sociopolitical context has to do in part because psychology, and by extension counseling, is in direct competition with the natural sciences. Both the natural sciences and the social sciences are in direct competition to be at the top of the "food chain" in the helping professions. It is this competition that leads to counseling theories and practices that lack an adequate epistemology (Martin-Baró, 1996). Two, the prevailing belief that counseling is an office-bound profession is also a constraint that limits what counselors can do. By virtue of the very system they have helped to construct, such as managed care, counselors have limited their own ability to address oppressive systemic barriers impacting clients. Three, another factor contributing to the failure of counseling in this respect is the flawed practice of having counselors align with a theoretical counseling orientation prior to working with clients. For example, graduate counseling students are often taught that they need to affiliate themselves with a particular counseling theory before they are to work with clients. This approach to counselor training leads to a counselor-driven model of helping that does not sufficiently meet the needs of oppressed client groups. We discuss each of these factors below.

Psychology's Inferiority Complex

The need for the social sciences to be on par with the natural sciences contributes to the inability of psychology to address the needs of oppressed groups. In order to be viewed as equals to scientists, psychologists adopted concepts and methods from the natural sciences. For example, an important aspect of psychotherapy stresses the need for counselors to be objective and value neutral. Like scientists in a lab, counselors are trained to maintain professional distance from clients so that the therapeutic process can unfold without counselor bias. We believe that objectivity and value neutrality in counseling are impossible and that they mystify the counseling process. Counseling is a value-laden experience to which clients and counselors bring their own biases, values, and experiences.

The need of social scientists to be viewed as equals to natural scientists is also seen in counseling and psychology's acceptance of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The *DSM* is largely created by psychiatrists to promote the practice of psychiatry. Counseling and psychol-

ogy have little to no say in the development of the *DSM*. When helping professionals uncritically accept the *DSM-5* as dogma or rely solely on it without considering cultural or systemic factors, they are essentially relying on psychiatry to define what is normal and abnormal. This practice is both dangerous and careless. It places the profession in a predicament where psychiatry dictates psychological practice and determines the value and worth of psychological practice in ways that serve its own interests.

There is an inherent flaw in applying methods and concepts from the natural sciences in the social sciences. Both are completely different disciplines with unique rules, variables, and nuances. Concepts and methods established in one discipline do not necessarily apply to another. By uncritically incorporating methodologies and concepts from the natural sciences, counseling and psychology assume lesser significance as disciplines.

Lack of an Adequate Epistemology

Martin-Baró (1996) discussed five assumptions inherent in psychology that limit its ability to address the needs of marginalized client populations:

- *Positivism*, the belief that knowledge should be based on logic, facts, events, and empirical research. The assumption is that society, much like science, operates according to general laws. These general laws are often based on dominant value systems and tend to place value of quantitative research over qualitative research. That which cannot be measured quantitatively (e.g., client and community voices) is rejected.
- *Individualism*, the belief that human behavior can be understood separate from the social context. Values such as independence, self-reliance, and autonomy are promoted over those of the group. Structural problems are perceived as being rooted in individual problems. Not all cultures value individualism. For instance, many Asian cultures place high value on collectivism and making decisions that promote the larger group (e.g., family). Psychology's promotion of individualism creates a hierarchy whereby collectivism is devalued.
- *Hedonism*, the belief that all human behavior is a never-ending quest for pleasure. Human beings seek happiness over pain. All theories are imbedded in hedonism in that they strive to help people achieve full pleasure. This perspective ignores alternative perspectives. For instance, within the Buddhist perspective suffering is considered a natural and healthy aspect of human development.
- The *homeostatic vision*, whereby human beings endeavor to have balance in life. Disequilibrium, change, crisis, or anything that ruptures this ideal balance is viewed negatively. This explains why social change is difficult for many in society to accept—it often leads to disequilibrium in the sense that it changes the status quo.
- *Ahistoricism*, a core tenet of science that all humans are the same regardless of race, gender, sexual orientation, social class, disability status, and religion. The assumption that predominant theories and concepts can be modified to make them applicable to all groups is an example in psychology. This belief often leads to the application of dominant cultural theories and concepts on cultures and groups that hold differing worldviews and perspectives, which in turn can lead to labeling marginalized communities as abnormal.

For psychology, and thereby counseling, to truly be appropriate to historically oppressed groups, such issues need to be addressed. To ignore these issues would mean running the risk of doing harm to clients from oppressed groups and communities.

Office-Bound Profession

Students often enter graduate counseling programs with a predetermined idea of what counseling entails. Many begin their training with the idea that counseling is a one-on-one process that takes place in an office setting. Their notion of counseling, formed well before they take their first class, is based on personal experience as clients or is formed through popular culture. They hold the belief that clients come to counseling seeking insight, guidance, and direction. Clients enter therapy hoping that counselors can help them feel better by resolving their problems.

The belief that counseling is an office-bound profession is further reinforced in counselor training programs. Students are told throughout their training that they need to maintain "professional boundaries" and preserve their "professional identity." These are code words for "Don't leave your offices." "Don't question the status quo." "Systems work is social work." This message is both subtle and direct. Students who question the social order of things are threatened with failing grades or placed on remedial plans. Because students do not have power, most choose to say nothing. Some decide to leave their programs because they are frustrated by the lack of support. Some graduate, enter the field, and eventually leave, unable to loosen the shackles of their training.

Counselor-Driven Approach

Determining the origin of client problems should begin with the client (Lewis et al., 2011). Unfortunately, prevailing practice has it that counselors enter the counseling relationship with a predetermined theoretical orientation and idea of how they intend to work with clients (see Figure 1.1). When this occurs, counselors risk doing things that are not consistent with the client's cultural background. This approach may also disregard important social factors that contribute to client problems. Such counselors risk missing the mark because they come with a preconceived notion of client needs before they even establish a working relationship with the client.

In the multicultural and social justice approaches to counseling, counselors enter the counseling relationship without a predetermined theory or expectation of how to work with clients (see Figure 1.1). When counselors enter the therapeutic relationship without preconceived notions of what theory or approach to use, they are better able to see clients for who they are. This tactic can lead to counseling strategies that are more consistent with the client's cultural background, worldview, and lived experiences. We believe that the client's presenting problems should determine the theories and approaches counselors take in counseling. This is a perspective shared by Martin-Baró (1996):

> What is needed is a revision, from the bottom up, of our most basic assumptions in psychological thought. But this revision cannot be made from our offices; it has to come from a praxis that is committed to the people. (p. 23)

Unless fundamental change occurs in how to use psychology to help others in a different way, the status quo of how counseling is practiced will remain the same. Culturally

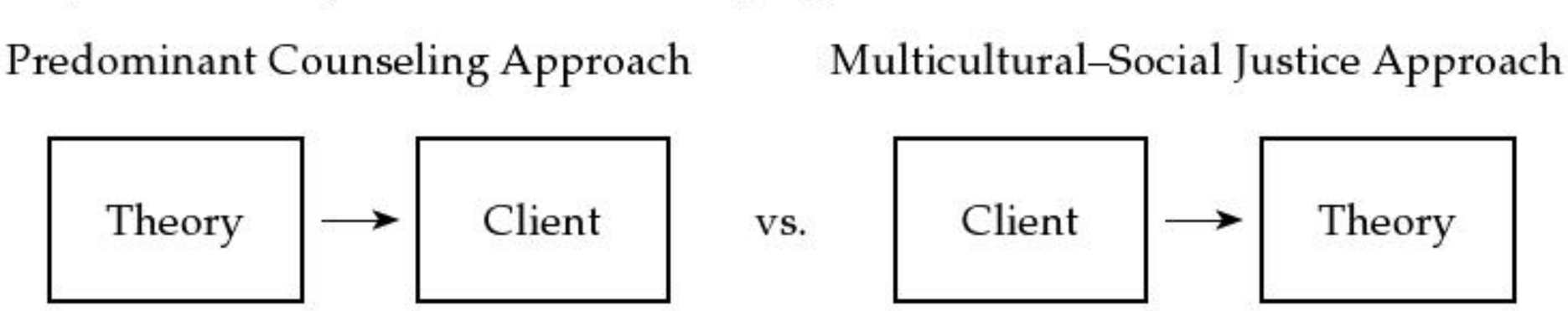

Figure 1.1 • **Approaches to Counseling**

diverse clients will continue to receive services that do not adequately attend to their needs because it overlooks cultural variables. Counselors will remain ill-equipped in their ability to address systemic issues experienced by clients.

Multicultural and Social Justice Counseling

The inherent flaws in counseling and psychology spawned the development of the multicultural and social justice perspectives in the field. The multicultural and social justice counseling perspectives are separate but equally important forces that have revolutionized the field of counseling and psychology. Both perspectives draw on the need to consider the relevance of cultural and sociopolitical contexts in counseling. Together, the multicultural and social justice perspectives help counselors develop into competent, ethical, and socially responsible helping professionals. Both approaches are described in this section.

Multicultural Counseling Perspective

Historical Overview

The multicultural perspective evolved in the 1950s during the civil rights era (Jackson, 1995). The 1950s was a time when overt racial segregation and systematic racial inequities were the norm in U.S. society. Professional counseling organizations were not immune from such racial biases in society. For example, the American Personnel and Guidance Association (later renamed the American Association for Counseling and Development in 1983 and the American Counseling Association [ACA] in 1992; Sheeley, 2002) has a history of racism. Racial and ethnic minorities, namely African Americans, were barred from leadership positions within the American Personnel and Guidance Association, the parent organization for those in the counseling profession (Jackson, 1995). Racial discrimination and exclusionary practices made it difficult for racial and ethnic minority counseling scholars and professionals to contribute to multiculturally oriented counseling research. The lack of multiculturally oriented research led to insensitive clinical practices that proved ineffective when counseling culturally diverse client populations. Instead, clinical practices focused on assimilating culturally diverse clients into White culture.

The prevailing belief at the time was that racial and ethnic minorities should adapt to White culture to survive in U.S. society. This belief was rooted in the "melting pot" metaphor, the notion that people from different cultures could co-exist by identifying and building on dominant similarities across racial groups. Unfortunately, this practice often came at the expense of minority individuals, who were expected to sacrifice their cultural identity.

In the counseling profession, the melting pot metaphor manifested itself in the belief that one theory or approach could apply to any client. As long as a theory was academically "sound" and supported by "research," it would be appropriate for use with any client regardless of that client's cultural background. Patterson (1996) argued against tailoring counseling approaches to specific client populations and promoted a universal approach to counseling that was applicable to all cultures.

The melting pot metaphor has never been an accurate descriptor of reality in the United States. Even when faced with pressure to assimilate, many immigrants and refugees maintain their cultural heritage and language. Many live in a bicultural world where they successfully operate in mainstream society at work and are able to maintain their cultural heritage by living in ethnic enclaves. Ethnic districts such as Chinatowns, Little Saigons, Jewish neighborhoods, Latino neighborhoods, and Black communities provide historically oppressed racial and ethnic groups a safe haven from the inherent racial and religious discrimination rampant in society.

In the United States, the 1960s were characterized by social unrest, political upheaval, and overt racial tension. Black and White Americans openly questioned the White establishment. Racist political beliefs, institutions, and policies were openly challenged and discussed. The social and political unrest in America served as an impetus for the emergence of the multicultural counseling perspective (Arciniega & Newlon, 2003; Jackson, 1995; Robinson & Morris, 2000).

Counseling professionals began to question White racist policies and practices (Pope-Davis, Coleman, Liu, & Toporek, 2003; Sue & Sue, 1977). For example, many African American counseling professionals called for the eradication of racist counseling theories and practices that dehumanized racial and ethnic minority clients (Robinson & Morris, 2000). As an example, many African Americans were viewed as "sick," "ill," and "abnormal" because theories that were based on White-dominant perspectives were being utilized to determine healthy development. In addition, African American psychologists were often excluded from positions of leadership, which made it difficult to integrate psychological theories and concepts that better reflected African American peoples in psychology. Multicultural counseling research also began to materialize in the counseling literature during this period (Jackson, 1995).

The multicultural counseling perspective led to the formation of the Association of Non-White Concerns in Personnel and Guidance in 1969. The creation of the association was spearheaded by William Banks, a professor at the University of California, Berkley (Jackson, 1995). The association began as a non-White caucus established by the American Personnel and Guidance Association, the organization now known as the ACA (McFadden & Lipscomb, 1985). The primary purpose of the Association of Non-White Concerns in Personnel and Guidance was to ensure that minority issues were being addressed in the counseling profession; in 1972 it launched a journal, *Journal of Non-White Concerns* (McFadden & Lipscomb, 1985), which has been influential in publishing scholarly work in areas relating to race and ethnicity. The first editor of the journal was Gloria Smith.

In 1985, the association was renamed the Association for Multicultural Counseling and Development and the *Journal of Non-White Concerns* was renamed the *Journal of Multicultural Counseling and Development* (Parker, 1991). The change in name reflected the growing need for multicultural counseling to be more inclusive of other underrepresented racial and ethnic groups such as Asians, Latino/as, and Native Americans (W. M. Lee, Blando, Mizelle, & Orozco, 2007).

Multicultural Counseling Defined

What exactly is multicultural counseling? Early definitions of the term were based on racial or ethnic identity:

> [It is] any counseling relationship in which two or more of the participants are culturally different. This definition of cross-cultural counseling includes situations in which both the counselor and client(s) are minority individuals but represent different racial/ethnic groups (African American counselor–Latino client; Asian American counselor–American Indian client, and so forth). It also includes the situation in which the counselor is a racial/ethnic minority person and the client is European American (African American counselor–European American client, Latino counselor–European American client, and so on). (Atkinson, Morten, & Sue, 1993, p. 15)

Jackson's (1995) definition of *multicultural counseling* is broad: "counseling that takes place between or among individuals from different cultural backgrounds" (p. 3). D'Andrea and Daniels's (1995) definition of *multicultural counseling* is more specific: it is "a process in which a trained professional from one culture/ethnic/racial background interacts with a

client of a different cultural/ethnic/racial background for the purpose of promoting the client's cognitive, emotional, psychological, and/or spiritual development" (p. 18).

Sue and Sue (2013) offered a more current definition of *multicultural counseling* that speaks to it as both a role and a process:

> . . . both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients; recognizes client identities to include individual, group and universal dimensions; advocates the use of universal and cultural-specific strategies and roles in the healing process; and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems. (p. 46)

In essence, multicultural counseling is based on the assumption that no two people are alike. We are all cultural beings who are exposed to a complex web of cultural influences that shape our worldview, behaviors, and lived experiences. How we see and experience the world is a result of cultural conditioning that begins at birth and continues throughout the life span. For this very reason helping professionals need to be committed to understanding the relevance of culture throughout the therapeutic process.

Seeing clients through a cultural lens has become increasingly important because of the diversity of the United States population. The need to frame counseling around a client's cultural background has led to a call to integrate multiculturalism into all aspects of counseling. The push for a more multicultural centered practice has increased the necessity for counselors to develop multicultural competence. The belief was that counselors lacked the requisite knowledge and skills to effectively work with culturally diverse clients. This belief led to the development of the multicultural counseling competencies developed by Sue, Arredondo, and McDavis (1992), which we highlight in subsequent chapters of this book; the competencies provide a framework that helping professionals can use to develop the awareness, knowledge, and skills needed to work with culturally diverse clients.

Social Justice Counseling Perspective

Historical Overview

When counselors develop multicultural competence, inevitably they begin to acquire an increased sense of social responsibility. As multiculturally competent counselors begin to see client problems more contextually, they gain insight into how oppression affects people's lives and the ways in which systemic inequities lead to internalized oppression (J. Lewis & Arnold, 1998). This awareness leads counselors to want to do something more because they see the struggles clients face and realize the limitations of traditional ways of helping. Dworkin and Dworkin (1971) observed that "counselors can sit on the sidelines and hope that everything turns out all right, or they can become actively involved and try to have an impact on the direction of the change process" (p. 749). Implicit in this statement is that counselors need to be more creative and proactive if they are to address the root of client problems. Specifically, counselors need to consider integrating social advocacy in addition to individual counseling in their practice.

The roots of social justice in counseling date to the inception of the counseling profession (Kiselica & Robinson, 2001). Although Frank Parson was not a counselor per se, his work in career development in the early 1900s has been credited with helping counselors today see the relevance in addressing the social and political barriers that hinder client development. Early evidence of social justice as a paradigm unto itself is reflected in the 1971 special issue of the *Personnel and Guidance Journal* (the predecessor to the *Journal of Counseling & Development*). The special issue, titled "Counseling and the Social Revolu-

tion" (M. D. Lewis, Lewis, & Dworkin, 1971), addressed the harsh realities of the world faced by historically marginalized client populations and the critical need for counselors to expand their role to include social advocacy. Counselor preparation programs were also challenged to consider how they prepare emerging counselors to be agents for social and political justice (M. Lewis & Lewis, 1971). Hutchinson and Stadler's (1975) book, *Social Change Counseling: A Radical Approach*, discussed using counseling and psychology as a vehicle to promote social change.

C. C. Lee and Walz's (1998) edited book *Social Action: A Mandate for Counselors* made a case for viewing social justice and advocacy as ethical issues in counseling. This book addressed why counselors who see an injustice and choose to do nothing may not be well-suited for the profession. The editors challenged counselors to build on the work of multicultural counselors by using advocacy to address systemic forms of oppression hindering client well-being and growth.

The social justice perspective is presented clearly in J. Lewis and Bradley's (2000) edited book *Advocacy in Counseling: Counselors, Clients, and Community*. This book frames what advocacy entails and how it aligns with the counseling profession. The contributors to this book discuss counselors as change agents in addition to their well-understood role as counselors. In 2000, Jane Goodman, then president of the ACA, commissioned a task force to develop a conceptual framework to help counselors implement advocacy strategies with clients. The task force created the Advocacy Competencies, which the ACA Governing Council formally adopted in 2003. Formal adoption of the Advocacy Competencies by the ACA's Governing Council helped add legitimacy to the social justice perspective. Toporek, Gerstein, Fouad, Roysircar, and Israel's (2006) edited book *Handbook for Social Justice in Counseling and Psychology: Leadership, Vision, and Action* provided a "road map" of sorts to understanding the relevance of social justice in counseling and psychology. In Summer 2009, the *Journal of Counseling & Development* published a special issue on the Advocacy Competencies, which further framed the relevance of the Advocacy Competencies in counseling. Ratts et al.'s (2010) edited book *ACA Advocacy Competencies: A Social Justice Framework for Counselors* offered practical ways to use the Advocacy Competencies across various counseling settings, client populations, and specialty areas.

Social Justice Defined

Many definitions of *social justice* exist in the counseling literature. C. C. Lee and Hipolito-Delgado's (2007) definition of *social justice counseling* promotes access and equity

> to ensure full participation of all people in the life of a society, particularly for those who have been systematically excluded on the basis of race or ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership. (xiv)

Fouad, Gerstein, and Toporek's (2006) definition of *social justice* within counseling emphasizes the redistribution of resources by altering social structures:

> [Social justice] focuses on helping to ensure that opportunities and resources are distributed fairly and helping to ensure equity when resources are distributed unfairly or unequally. This includes actively working to change social institutions, political and economic systems, and governmental structures that perpetuate unfair practices, structures, and policies in terms of accessibility, resource distribution, and human rights. (p. 1)

Counselors for Social Justice, a division of ACA, defined *social justice counseling* as follows:

> [It is a] multifaceted approach to counseling in which practitioners strive to simultaneously promote human development and the common good through addressing challenges related to both individual and distributive justice. Social justice counseling includes empowerment of the individual as well as active confrontation of injustice and inequality in society as they impact clientele as well as those in their systemic contexts. In doing so, social justice counselors direct attention to the promotion of four critical principles that guide their work: equity, access, participation, and harmony. This work is done with a focus on the cultural, contextual, and individual needs of those served. (http://counselorsforsocialjustice.net)

Ratts (2009) contended that social justice "is related to a growing need to connect human development issues with toxic environmental conditions" (p. 163) and added:

> Environmental factors, such as racism, sexism, heterosexism, and classism, can delay people's growth and development and hinder people's ability to reach their potential. This is especially true for clients who have been historically marginalized in society such as people of color, those in poverty, and individuals who are lesbian/gay/bisexual/transgender (LGBT). Helping clients recognize the presence of oppressive factors is important because it prevents them from blaming themselves for their plight. (pp. 163–164)

We add our definition to this list; we define *social justice counseling* as a role, a mutually collaborative process, and an ideal that counselors strive to achieve. Counselors can play a role in either maintaining or dismantling oppression. Those who seek a more just world actively work to ensure that high-quality resources such as education, health care, and employment are equitable and accessible to everyone. Such counselors strive to ensure that all people are able to live with dignity and respect so they may become participatory members of society. Social justice counseling necessitates that counselors embrace a certain role. Moyer, McAllister, Finley, and Soifer (2001) identified four different roles social activists play: (a) citizen (social activists must be perceived by others as responsible members of society who seek the common good), (b) rebel (social activists know when to speak up when injustices violate core societal values), (c) change agent (social activists actively collaborate with others to educate and change institutional barriers), and (d) reformer (social activists work to get multicultural and social justice ideas and concepts institutionalized into policy and laws). Each of these roles is equally important at varying points of social change.

The process of achieving social justice is a mutually collaborative one that involves counselors, clients, and community. Counseling is not a process where counselors act as experts imparting knowledge to passive and unaware clients. This perspective is similar to Freire's (1993) critique of the "banking education" model where students are sponges who uncritically soak up knowledge imparted on them from teachers. For clients to find therapy to be meaningful, they need to be active participants. Being active participants in therapy allows them to take responsibility and ownership of the counseling process. When they sense that counselors trust in their knowledge of the world, they begin to feel empowered. Accordingly, both counselors and clients are actively engaged in the process of exploring and gaining knowledge of how social structures influence client development.

As an ideal, the goal of social justice is to empower all individuals, regardless of background, so they may develop the knowledge and skills to achieve their full potential. Social justice counselors recognize that client problems can be attributed to oppressive structural factors. Accordingly, both counselors and clients are actively engaged in the process of exploring and gaining knowledge of how social structures influence client development. This process leads counselors and clients to consider whether interventions should focus on individual change or systems-level changes.

Social justice counseling recognizes the limitations of conventional counseling methods that place excessive weight on intrapsychic techniques to resolve problems that are systemically based. Using individual counseling to resolve systemically based problems is akin to a physician using a functional magnetic resonance imaging scan to treat a common cold. The physician who does so completely misses the mark! In counseling, too, some approaches completely miss the mark; this point is illustrated in the chapters that follow.

Distinctions Between Multiculturalism and Social Justice

There are fundamental philosophical and practical distinctions between the multicultural and social justice counseling perspectives. Multicultural counseling brought attention to the importance of cultural factors and the need to attend to cultural differences in counseling. Emphasis is placed on using culturally appropriate counseling strategies that align with clients' cultural background. Since its inception multicultural counseling has become more inclusive. Yet, its scope of practice continues to be too population specific as it tends to address racial and ethnic concerns over other dimensions of identity such as sexual orientation, gender, social class, religion, and disability (Pope-Davis, Ligiero, Liang, & Codrington, 2001). The practice of multicultural counseling tends to focus on individuals and interpersonal dynamics within the comforts of the office setting. Very little attention is given to working in communities to change oppressive structures that affect clients.

Social justice counseling addresses power dynamics, issues of equity, and oppression in all of its forms. Counselors operating from a social justice perspective realize that some situations require change at the individual level and other situations call for systemic-level changes. Such counselors seek to create a just world where resources such as education, health care, and employment are equitable and available to everyone. Social justice counseling also places equal weight on addressing the needs of all oppressed groups. All forms of oppression are harmful. Concentrating on one form of oppression while being neutral to other oppressive systems is harmful and creates a hierarchy of oppressions.

Multiculturalism and Social Justice: A Seamless Connection

Multiculturalism and social justice are seamlessly connected, in part because what counselors do in the traditional office setting can inform the advocacy work they do in the community (J. Lewis & Arnold, 1998). Through direct counseling intervention, counselors are able to recognize the relevance of cultural factors, and they can see firsthand the impact that oppression has on historically marginalized client populations. When counselors recognize this impact, they are faced with a decision to consider whether clients are best served through direct intervention or through advocacy on their behalf.

Both multiculturalism and social justice counseling highlight inherent flaws in psychotherapeutic approaches that discount the relevance of cultural and social factors. This realization led to important insights about counseling and psychotherapy:

- Not all counseling is good counseling.
- A "one size fits all" approach is harmful to culturally diverse clients.
- We are all cultural beings.
- Clients come to counseling with complex cultural backgrounds that require attention.
- Oppression is real and has devastating consequences if left ignored.
- Both individual counseling and advocacy counseling are essential ingredients to change.

To ignore the relevance of culture and sociopolitical factors would be a grave mistake. There are limits to what counselors are able to accomplish when they do not recognize the importance of cultural and sociological variables in counseling. These limitations, if not addressed, can have drastic effects on clients. Clients may leave counseling feeling that they are the cause of the problem. Counselors may mistakenly perceive cultural issues or responses to oppression as abnormal behavior. The lack of cultural empathy by counselors has been cited as a cause for the disproportionate number of clients of color who terminate therapy after the first session (Sue & Sue, 2013).

Conclusion

It goes without saying that multiculturalism and social justice have been instrumental in bringing counseling and psychology into the 21st century. Both perspectives have transformed the field in significant ways. Multicultural counseling sheds light into the dire consequences that occur when cultural factors are not considered in the helping process. Social justice brings attention to how oppression influences psychological health and the need for counselors to be social change agents. Both perspectives grew in response to the changing demographics of the U.S. population, the globalization of the economy, the harmful effects of oppression, and the increasing realization that predominant theories in counseling and psychology do not adequately prepare helping professionals to address these concerns.

The future of counseling and psychology rests on our ability to continue to change with the times. This means continuing to refine the multicultural and social justice counseling perspectives. We need to have the foresight to know where both perspectives are heading if counseling and psychology are to be sustainable resources. We must use research to improve our understanding of multiculturalism and social justice in counseling. Research provides the vision to sustain the multicultural and social justice perspectives. Clinical practices must also be informed by clients who seek psychological services. Clients bring with them a wealth of experiences and knowledge that should not be ignored.

As multiculturalism and social justice approaches in counseling continue to mature, there is danger in allowing complacency to set in. Stagnation and complacency can hinder innovation in counseling. When a profession becomes complacent, it runs the risk of becoming obsolete and irrelevant. We see this in the technology field, where companies fade into the background or become irrelevant because they are unable to change with the times or take risks to remain sustainable. Similarly, counseling must be dynamic and respond to the changing needs of society if it is to remain relevant.

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Chapter 2

Five Forces in Counseling and Psychology

As multiculturalism and social justice approaches in counseling gain ground, it is useful to clarify their complementary nature and relevance in the counseling profession. For readers to fully appreciate the significance of the multicultural and social justice counseling perspectives, we begin this chapter by providing an overview of the major paradigms or forces in counseling from its infancy. Understanding the profession's roots gives context for the evolution of multicultural and social justice counseling. Moreover, it provides insight into the limitations of previous theories, and it sheds light on the dire consequences when multiculturalism and social justice are not considered.

The counseling profession's continued evolution is reflected in the five counseling paradigms, which are also referred to as *forces*: (1) psychoanalytic, (2) cognitive–behavioral, (3) existential–humanistic, (4) multicultural, and (5) social justice (Ratts, 2009; see Figure 2.1). Each paradigm was developed to address perceived limitations in existing understandings, and each transcended explanations of human development and changed the rules of how psychology is approached. With each change, controversy and confusion brew because the new paradigm shifts prevailing beliefs and practices.

Each change in the field has brought new understanding of human development issues (see Table 2.1). For example, the psychoanalytic force provided a framework for exploring how the past shapes the present. The cognitive–behavioral approach brought attention to the importance of evidence-based practices. The existential–humanistic perspective led counselors to consider the importance of the therapeutic relationship. Multicultural counseling helped bring attention to the importance of culture in the therapeutic relationship. Social justice counseling addresses issues of injustice and calls on helping professionals to consider balancing individual counseling with systems work.

Each counseling force is considered a paradigm unto itself. A *paradigm* is an agreed upon set of practices and understandings that defines a scientific discipline and determines the scope of practice (Kuhn, 1970). For instance, in the medical profession a set of practices and norms shapes Western medicine and makes it fundamentally distinct from Eastern medicine. Paradigms are also culturally based because they evolve out of the social, political, and economic thinking of the times. The changes in the counseling profession are often a microcosm of social changes. For instance, multicultural counseling evolved in the 1960s because of the

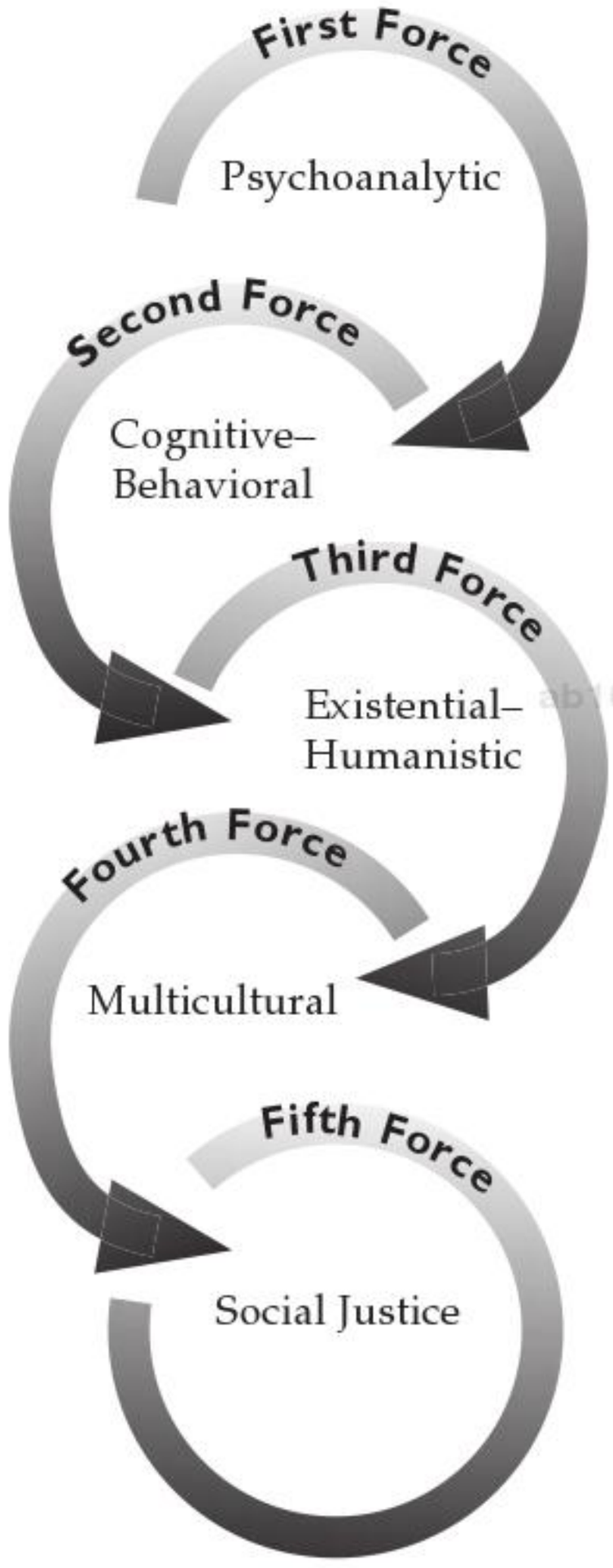

Figure 2.1 • Five Forces in Counseling

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racial oppression of African Americans in the United States (Jackson, 1995). Kuhn (1970) expressed the belief that a major paradigm shift occurs when scientific theories cannot adequately account for ideas, concepts, or data and when some new competing perspective better accommodates these data. In other words, paradigms are fluid and dynamic. They are constantly evolving as a result of new and emerging research, which often shifts the social order of things in a discipline. Often, resistance surfaces when changes occur in a paradigm. E. M. Rogers (2003) contended that new innovations, even when they have benefits, are difficult to adopt because they often require change in the structure of things.

Paradigms are useful in counseling because they provide a framework for working with clients (Barclay, 1983) and they help to connect theory with practice. For example, each counseling force is unique in its view of human nature, conceptualization of client problems, understanding of the role of the professional counselor and psychologist, goals of therapy, and types of therapeutic techniques used. In this chapter we discuss the five counseling forces in the profession. We illustrate the predominant thinking within each force, examine how each force has transformed current approaches to helping, and discuss

Table 2.1 • **Counseling Forces**

Variable	First Force	Second Force	Third Force	Fourth Force	Fifth Force
Paradigm	Psychoanalytic	Cognitive–behavioral	Existential–humanistic	Multicultural	Social justice
Key figures	Alfred Adler Erik Erikson Sigmund Freud Carl Jung Margaret Mahler	Albert Bandura Aaron T. Beck Albert Ellis Arnold Lazarus Donald Meichenbaum B. F. Skinner Joseph Wolpe	Victor Frankl Rollo May Carl Rogers Irvin Yalom	Patricia Arredondo Courtland Lee Cirecie West-Olatunji Paul Pedersen Joseph G. Ponterotto David Sue Derald W. Sue	Stuart Chen-Hayes Hugh Crethar Michael Hutchinson Judith A. Lewis Manivong J. Ratts Rebecca Toporek
Primary assumptions	Psychosexual and psychosocial development, biological and instinctual drives, and unconscious forces shape human behavior.	Cognitive processes and behavior influence the human experience.	Humans have the inner capacity to grow and the freedom to choose, and they possess personal responsibility over their own lives.	People are cultural beings who are influenced by larger social, political, and cultural context.	Client problems are connected to larger sociopolitical contexts. Problems are coping strategies to oppression rather than pathology.
Key concepts	Psychosexual development Psychosocial development Transference Unconscious drives Past oriented	Empirically based interventions Conditioning Present oriented	Genuineness Empathy Unconditional positive regard Present oriented	Universal and culture-specific strategies Individual, group, and universal dimensions of existence Identity development Multicultural competence Past and present oriented	Personal is political Critical consciousness Advocacy competence Past and present oriented
Therapeutic goals	Help clients gain insight Make the unconscious conscious	Change cognitive processes Measure outcomes	Help clients recognize factors blocking growth, become self-aware, and reach their potential through the counseling relationship	View clients in context Egalitarian relationship	Externalize oppression Connect client problems with systemic barriers
Techniques	Analysis of resistance Free association Interpretation Dream analysis Analysis of transference	Dispute irrational beliefs Change language Cognitive role play Desensitization Meditation Behavioral modification Education	Techniques are secondary to understanding and experiencing the therapeutic relationship	Education Culturally appropriate skills	Individual counseling and systems change
Critique	Medical model Culturally encapsulated Ignores sociopolitical context Diagnoses clients	Culturally encapsulated Ignores sociopolitical context	Culturally encapsulated Ignores sociopolitical context Lacks true techniques	Additive approach Ignores systems advocacy Exclusive definition of multiculturalism	Liberal bias Too political Doing social work Promotes notion of White guilt

the need for helping professionals to consider multicultural and social justice counseling as a generic helping modality. Considering the multicultural and social justice counseling paradigms as generic approaches in counseling is critical if counselors and psychologists are serious about working with culturally diverse clients.

First Force: The Psychoanalytic Tradition

One cannot discuss the impact of psychoanalytic theory without focusing on Freud, its founder. Although much of Freud's thinking on psychoanalysis is outdated, he remains an important figure. Freud's (1949) thinking about the human psyche was significant because he brought attention to the ways in which unconscious and instinctual sexual drives shape human behavior and lead to human psychosis. These topics were considered taboo at the time, yet Freud formulated a theory of psychoanalysis as a platform to discuss them, which made them socially acceptable. Freud's methods of treating the mentally ill were based on the use of interpretation, introspection, and clinical observations.

Freud's approach to the treatment of neurosis was progressive at the time. He believed that medical professionals, and psychiatrists in particular, relied too heavily on their eyes and their senses to explain physical symptoms in their patients. Freud (1920/2011) believed that psychoanalysis would be different and argued that it "must divorce itself from every anatomical, chemical, or physiological supposition which is alien to it. It must work throughout with purely psychological concepts" (pp. 9–10). A deeper understanding was needed to explain abnormal behaviors displayed by patients. According to Jones (1961), Freud reflected "a crusade of revolution against the accepted conventions of medicine," which at the time viewed "neuroses as mere abnormalities, as diseases that are deviations from the normal" (p. 163).

Freud's view on human psychosis and the way to treat it paved the way for the development of psychoanalysis as a paradigm. Freud's interest in clinical psychopathology led him to develop a comprehensive theory, which posited that psychosexual development, biological instinctual drives, and unconscious forces shape human behavior. Freud believed that the purpose of psychoanalysis was to bring the unconscious to the conscious mind and that this was best accomplished by having clients talk about their problems with a trained expert. Psychoanalysis was an emerging process involving "the interchange of words between the patient and the physician. The patient talks, tells of his past experiences, and present impressions, complains, confesses his wishes and emotions. The physician listens, tries to direct the thought processes of the patient" (Freud, 1920/2011, p. 8). Psychoanalysts were experts and authority figures who served as the guiding voice for patients. Freud's impact is evident through the many iterations of the psychoanalytic paradigm. Contemporary psychoanalysis includes ego psychology, object-relations approaches, self-psychology, and relational approaches. These approaches focus on development of the ego and differentiation of the self, whereas Freudian psychology focused on the id.

The psychoanalytic force is sometimes criticized for placing excessive weight on individual factors, pathologizing clients, and using androcentric concepts to explain female psychology. (*Androcentrism* is the use of male-oriented concepts to determine female development; Worell & Remer, 2003.) For example, psychoanalysis uncritically frames social issues from an intrapsychic lens. Rather than understand "the psychic processes and needs of man as a product of a social and historical development, psychoanalysis derives from instinct inherent in the organism, thereby, giving a narrowly biological interpretation to all of a man's psychic activity" (Cohen, 1986, p. 6). The decontextualization of human development frames social situations as being a direct result of internally driven unconscious drives and sexual libido.

The exclusion of social factors can be attributed to the reliance on the medical model. For example, in the late nineteenth century people thought that criminal behavior and neurosis were due to genetics. Socially unacceptable behavior such as prostitution or

abnormal behavior such as hysteria were often attributed to one's heredity (Brunner, 2001). Lombroso (2006), an Italian criminologist, posited that criminals could be identified by physical defects that were similar to those found in early humans and apes. In other words, biological factors were often used to explain abnormal and deviant behavior.

In the medical model perspective, clients are viewed as ill and needing to be fixed. Relying solely on the medical model approach gives an incomplete picture of the human organism. When only biological and individual factors are entertained, counselors risk using approaches that blame clients for their predicament. Often this approach leads counselors to consider solutions that focus only on change within the individual. The implicit message is that clients, and not their environment, must change.

Feminists have argued that psychoanalytic constructions of women's psychology are degrading because of their androcentric nature. Horney (1973) challenged androcentric concepts such as penis envy, a Freudian concept, because of the denigrating view of women implicit in their theoretical grounding and application. Horney argued that females did not desire to possess male genitals; rather, they envied the exclusiveness of male power and privilege (which inherently presented restrictions for women). Freud's (1930) perspective on gender was informed by the social and political climate of the times; he promoted traditional gender roles and viewed women as inferior and submissive to men.

> Women stand for the interests of the family and sexual life, whereas the work of civilization has become more and more the business of menfolk, setting them increasingly difficult tasks and obliging them to sublimate their drives—a task for which women have little aptitude. (p. 35)

Lerman (1986) called for a complete abandonment of the psychoanalytic paradigm because "assumptions about the inherent inferiority of women are embedded in the very core of psychoanalytic theory" (p. 6). Prilleltensky (1994) argued that using a helping model that denigrates women and ignores social context further promotes a status quo that benefits those in power. Similarly, Ratts (2011) contended that the psychoanalytic theory does not adequately equip counselors with the tools to address sociocultural factors.

Second Force: The Cognitive–Behavioral Tradition

Cognitive–behaviorism grew in popularity because of its applicability across settings. The widespread acceptance of the cognitive–behavioral force is evident in its use in schools, hospitals, college counseling centers, and agency settings. Cognitive–behaviorists believe that human behavior can be measured and that psychology can be fully explained by the use of experiments and the scientific method. The focus on using the scientific method was in part a response to the call to be on par with the medical profession.

The cognitive–behavioral movement evolved in reaction to the psychoanalytic emphasis on exploring the unconscious and instinctual drives. Cognitive–behaviorism, which combines cognitivism and behaviorism, questioned the underpinnings of psychoanalysis. Rather than view abnormal behavior as a result of natural causes or unconscious drives, cognitive–behaviorists share the following elements: (a) a focus on cognitive processes to address mental health and well-being, (b) empirically based interventions that focus on measurable and concrete behavioral and cognitive change, (c) time-limited counseling sessions, (d) the use of education to help clients, and (e) a focus on the present.

Cognitive–behaviorism draws from the behavioral and cognitive schools of thought. Behaviorism, which became the dominant school of thought in the 1950s in part because of

the work of John B. Watson, evolved with the work of Edward Thorndike, Clark L. Hull, and B. F. Skinner. Watson, known as the founder of behaviorism, rejected the psychoanalytic perspective of studying the conscious mind and questioned the use of introspection in counseling and psychology. Watson's (1913) view of psychology is perhaps best articulated in what is known as *The Behaviorist Manifesto*:

> . . . a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behavior. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness. The behaviorist, in his efforts to get a unitary scheme of animal response, recognizes no dividing line between man and brute. The behavior of man, with all of its refinement and complexity, forms only a part of the behaviorist's total scheme of investigation. (p. 248)

Behaviorists such as Edward Thorndike and Ivan Pavlov further popularized behaviorism with their study of animals, which they used to explain human behavior. Their research helped lay the foundation for educational psychology and classical conditioning. Similarly, Skinner brought attention to the importance of studying observable behavior through his research. Skinner questioned psychotherapeutic approaches that use introspection and case history to explain human development because they lacked scientific rigor.

Cognitive theory is a branch of psychology that focuses on cognitive processes, learning, and how people recollect memories. According to Beck (1976):

> This new approach to emotional disorders changes man's perspective on himself and his problems. Rather than viewing himself as the helpless creature of his own biochemical reactions, or of blind impulses, or of automatic reflexes, he can regard himself as prone to learning erroneous, self-defeating notions and capable of *unlearning* or correcting them as well. By pinpointing the fallacies in his thinking and correcting them, he can create a more self-fulfilling life for himself. (p. 4)

Beck (1976) believed that psychotherapy should be focused on distorted thinking and on helping clients learn alternative ways to conceptualize their experiences. Implicit in this approach is that counselors help clients adapt to their environment rather than work to alter the environment to adapt to the client.

Aaron T. Beck, Albert Ellis, and Arnold Lazarus helped bring cognitive theory into the mainstream of psychology. Beck developed cognitive techniques through his work with clients with depression. Ellis founded rational emotive behavior therapy (REBT) in reaction to the psychoanalytic paradigm in the 1950s. He argued against psychoanalytic explanations of abnormality and posited that "at the heart of neurotic disturbance lies the tendency of humans to make devout, absolutistic evaluations of the perceived events in their lives" (Ellis & Dryden, 1997, p. 14). Ellis and Dryden (1997) further defined the focus of therapy in REBT:

> Unlike most other theories of therapy, which stress the impact of significant life events on the development of psychological disturbance, REBT theory hypothesizes that the biological tendency of humans to think irrationally and dysfunctionally has a notable impact on such disturbance. (p. 6)

The assumption in REBT is that much of human behavior and emotion could be managed if people could skillfully control their thoughts.

One critique of the cognitive–behavioral approach is that it places considerable weight on individual and internal factors while ignoring the sociocultural context. Little to no

attention is given to how cognitive processes may be influenced by such social ills as racism, poverty, and homophobia. Ellis and Harper (1997) contended that "When people and events are the way you would like them not to be, there is actually relatively little pernicious effect they can have on you unless you *think* they can" (p. 163). The underlying message is that if clients can change their thinking about events in their lives, they will feel better about their situation. In other words, it is not the event (e.g., oppression) that causes a client's problems but rather the client's perception of that event. This perspective tends to blame clients for their predicament.

Because it ignores cultural factors, decontextualization of client problems leads to limitations in a counselor's capacity to fully address a client's presenting issue and optimize client growth. Rather than examine how sociopolitical factors affect cognitive and behavioral processes, psychology is used to rid clients of "irrational" thoughts and behaviors. Human cognition and behavior are separated from contextual factors despite considerable research suggesting that oppression plays a significant role in human development. Cognitive–behaviorists view human beings as affectless organisms that control the experience of their own environments. When environmental variables are separated from cognitive–behavioral processes, counselors are forced to search for internal explanations to client problems. The belief that human behavior and cognition are internally driven and separate from the social context is grounded in the Protestant work ethic of individualism. In a classic analysis of individualism, Sampson (1977) noted:

> Our contemporary views of mental health emphasize a self-contained, individualistic ideal: The person who possesses all the qualities from whatever listing of positive traits we choose, for example, self-actualization, autonomy, or mastery. We have difficulty in thinking of these traits as functions that can be located within an interdependent collectivity rather than within the single individual. Thus, the burden for good health is the individual's; he or she must come to possess all that is good and desirable. (p. 775)

In other words, individuals and their environments are mutually exclusive. Positive mental health and success come through hard work and determination regardless of societal obstacles.

The lack of attention to cultural factors is an issue in cognitive–behavioral therapy. The promotion of European American values systems is seen in Western psychology's support of helping clients develop an internal locus of control. The concept of *locus of control,* developed by Rotter (1966), refers to whether people believe their fate is internally driven or a result of external factors. For instance, a client with high internal locus of control might attribute the lack of a promotion at work with needing to work harder as an individual employee. A client with a high external locus of control might believe that not getting a promotion is due to external factors such as racism, sexism, or heterosexism. Counseling and psychology tend to place value on developing one's internal locus of control.

Third Force: The Existential–Humanistic Tradition

The existential–humanistic force rejected both psychoanalytic and cognitive–behavioral explanations of human development. Existential–humanistic theorists saw limitations in viewing fragmented parts of a client's personality and in examining only client cognitions, and they questioned the validity of using experiments conducted on animals to explain human behavior. Carl Rogers (1951), a staunch critic of the psychoanalytic and cognitive–behavioral approach, believed that the improvements clients experienced from psychoanalytic and cognitive–behavioral treatment were temporary at best. He (1961) argued that "such methods are, in my experience, futile and inconsequential. The most they can

accomplish is some temporary change, which soon disappears, leaving the individual more than ever convinced of his inadequacy" (p. 33). C. Rogers saw potential in all people and believed that therapeutic techniques were secondary to the client–counselor relationship. His critique of the psychoanalytic and cognitive–behavioral forces is also seen in his use of the term *client* rather than *patients* because "it avoids the connotation that he is sick, or the object of an experiment" (1951, p. 7). Similarly, May (1961) stated:

> Psychotherapy is not a "problem" that the patient brings in, such as impotence; or a pattern, such as a neurotic pattern or sadomasochism or a diagnostic category of sickness, such as hysteria or phobia, ad infinitum; or a drive or pattern of drives. (p. 73)

These beliefs led to the development of the existential–humanistic force in counseling and psychology.

The existential–humanistic approach draws from the existential and humanistic traditions in psychology. Common to both traditions are the emphases placed on self–awareness, a belief in the potential of every human being, personal responsibility, the innate good in people, freedom, and personal insight. Within the existential perspective, helping clients develop awareness, find meaning and purpose, and become responsible for life choices is central to therapeutic improvement. Coming to terms with the idea that we all eventually face death is also a key concept in existential psychology.

The humanistic tradition sees the good in every individual and believes that the purpose of psychotherapy is to help clients reach their potential. An egalitarian therapeutic relationship between client and counselor is central. The role of the therapist is to model genuineness and authenticity and to accurately understand the subjective world of the client. The goal of therapy is less about solving problems and more about helping clients lead self-fulfilling lives.

Existential–humanistic counselors who operate from an intrapsychic perspective make what Prilleltensky (1994) referred to as a *fundamental attribution error:* They did not consider how culture shapes client experiences. For example, existential–humanistic concepts such as personal freedom and self-awareness promote individualism and autonomy. This approach works well with clients whose cultural backgrounds recognize independence as integral to healthy development. However, promoting individualism with clients from collectivist cultures (including people of color) can be misguided, because these groups generally place higher value on relationships, harmony, and group needs than on individual needs.

Another limitation of the existential–humanistic tradition is that it does not take external factors into account. The focus of this therapeutic approach is on helping clients understand the workings of their own inner world, which leads to self-awareness, congruence, and balance—all qualities that are considered necessary for healthy development. Although insight is important, it should not be examined without also exploring how cultural and sociopolitical forces influence the cultivation of this inner world. External forces and cultural factors are fundamental in shaping the ways in which clients experience life and construct meaning.

Fourth Force: The Multicultural Tradition

Up until the 1950s, the field of counseling and psychology was a monocultural science, even though, since its origin in Central Europe, it had spread throughout much of both the Western and non-Western world. Adler and Gielen (1994) were among the first to

document the trends suggesting that this monocultural emphasis in psychology was changing:

> Following a brief review of global society, it is argued that (a) at present American psychology routinely neglects perspectives and findings developed in other countries; (b) this is true even if foreign contributions appear in English; (c) this state of affairs differs from the situation prevailing in the hard sciences; and (d) in response to the multicultural movement and global developments, mainstream psychology in the United States and elsewhere will become less ethnocentric in the near future. (p. 26)

Contemporary global changes are having an increased influence in psychology and counseling, demonstrating the positive consequences of a culture-centered perspective.

- The ratio of non-American to American psychological and counseling researchers is gradually but steadily increasing (Rosensweig, 1992), suggesting that psychology and counseling are growing faster outside than inside the United States.
- All fields are becoming more globally focused as a result of technological innovations.
- There is a multicultural movement particularly in the social sciences that has raised sensitivity to cultural variables.
- The topic of cultural and multicultural issues is now mainstream in counseling and psychology.
- There is a reexamination of cultural bias in counseling and psychology so that instead of making assumptions about a client's values and beliefs, there is greater emphasis on discovering each population's unique explanation of its behavior and meaning.

Thompson, Ellis, and Wildavsky (1990) described cultural theory as providing the basis for a new perspective, dimension, or force in psychology and counseling:

> Social science is steeped in dualism: culture and structure, change and stability, dynamics and statics, methodological individualism and collectivism, voluntarism and determinism, nature and nurture, macro and micro, materialism and idealism, facts and values, objectivity and subjectivity, rationality and irrationality, and so forth. Although sometimes useful as analytic distinctions, these dualisms often have the unfortunate result of obscuring extensive interdependencies between phenomena. Too often social scientists create needless controversies by seizing upon one side of a dualism and proclaiming it the more important. Cultural theory shows that there is no need to choose between, for instance, collectivism and individualism, values and social relations or change and stability. Indeed we argue there is a need not to. (p. 21)

Multiculturalism has been described by Pedersen (1991) as a "fourth force" or fourth dimension, but neither of these terms is completely adequate. By referring to it as a fourth force, it is implicitly framed as being in competition with humanism, behaviorism, and psychodynamism, which is not the intent. Multiculturalism is a means of coping with cultural and social diversity in society.

As mentioned in Chapter 1, the multicultural counseling force evolved during the civil rights era in the 1950s as a result of a lack of attention to cultural factors in counseling and psychology and the increasing diversity of the U.S. population (Jackson, 1995). Factors such as racial segregation, systematic discrimination, and prejudice led professionals in the field to help clients of color assimilate into the dominant White culture (Copeland, 1983).

The belief in racial integration and the denial of group differences was based on the notion that racial and ethnic minorities needed to adapt to White society in order to survive. Though professional literature at the time had begun to address these issues, predominant theories continued to view client problems through an intrapsychic lens, which often used biological and intrapsychic explanations to frame human development issues. Little to no attention was given to sociocultural factors, largely in part because people of color were underrepresented within the profession. The prevalence of racism kept many racial and ethnic minorities, namely African Americans, from being able to fully contribute to the counseling field. For example, many racial and ethnic minorities were excluded from holding leadership positions within the American Personnel and Guidance Association (now the American Counseling Association; Jackson, 1995).

Sue and Sue (2013) described the implications of rapid increases in racial and ethnic populations as the diversification of the United States or the changing complexion of society. Recent migrations are different from earlier White European migrations that were more oriented toward assimilation. According to the United States Census Bureau (2011), White Americans accounted for 72% of the population in 2010. All racial groups increased in number between 2000 and 2010, but they did so at different rates. Asian Americans experienced the fastest rate of growth because of higher rates of immigration, and White Americans grew at the slowest rate. The Asian population increased by 43.3%, Hispanic or Latino by 43%, Native Hawaiian and Other Pacific Islander by 35.4%, American Indian and Alaska Native by 18.4%, Black or African American by 12.3%, and White by 5.7%. An overwhelming majority of people (92%) reported being a member of two races, with White and Black being the largest multiple-race combination. The racial and ethnic data suggest that the United States continues to become a more racially diverse society.

Multicultural counseling stresses the sociopolitical nature of counseling and the need for predominant paradigms to view clients in context of their culture and environment (Sue & Sue, 2013). Clients and the problems they present cannot be understood in a vacuum. Social, political, and economic conditions often influence academic, career, personal, and social issues. For this reason, human development issues need to be considered from a biopsychosocial lens, which allows for a holistic understanding of client problems. The combination of sociological factors along with biological and psychological factors is considered in explaining mental health issues. In contrast, the psychoanalytic, cognitive–behavioral, and existential–humanistic forces use either biological or intrapsychic (biopsycho) explanations to frame client problems (Ratts, 2011). The popularity of the biopsychosocial perspective is reflected in its presence in such disciplines as psychiatry, counseling psychology, and social work and in the medical profession (Santrock, 2012).

Multicultural counseling brought attention to how culture shapes people's worldview, experiences, and need for culturally competent helping professionals. Culture is the "characteristic values, behaviors, products, and worldviews of a group of people with a distinct sociohistorical context" (Kehe & Smith, 2004, p. 329). Rubel and Ratts (2011) added:

> Cultural differences may be readily observable as differences in clothing, foods, customs or traditions, and languages, or as subtler but crucial differences in parenting beliefs, family structure, social hierarchy, gender role expectations, communication style, and relationship to time and space. (p. 49)

Multicultural counselors view the "one size fits all" approach, promoted by the psychoanalytic, cognitive–behavioral, and existential–humanistic forces, as ineffective because it discounts cultural variables. Both clients and counselors bring with them unique histories,

backgrounds, and cultural influences that affect the client–counselor relationship. The need to be cognizant of a client's culture and worldview led to the creation of the multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992), which provide a framework for developing cultural awareness, knowledge, and skills to effectively work with diverse clients. Counselors and therapists must be aware of their values, beliefs, biases, and worldviews as well as those of their clients; knowledgeable about their cultural background as well as that of their clients; and skilled using culture-specific counseling strategies. There are many sources of resistance to multiculturalism as a fourth force.

- Some view multiculturalism as competing with already established theories of psychological explanation in ways that threaten the professions of counseling and psychology (Weinrach & Thomas, 2004).
- The terms *multiculturalism* and *diversity* are closely associated with affirmative action, quotas, civil rights, discrimination, reverse discrimination, racism, sexism, political correctness, and other emotional terms (Goodman, 2001).
- To the extent that multiculturalism is connected with postmodernism (as in multiple perspectives and belief systems), the arguments against postmodernism as a valid theory would also apply to multiculturalism (Pedersen, 1991).
- Those favoring a universalist perspective contend that the same practice of counseling and therapy apply equally to all populations without regard to cultural differences (Weinrach & Thomas, 2004).
- There are still no accepted standards for describing multiculturalism as a theory in practice, and it is too loosely defined to be taken seriously.
- There are no measurable competencies for multicultural applications of counseling or adequate standards of practice.
- Multiculturalism is too complicated and it would be unrealistic to expect counselors to attend to such a range of factors simultaneously.
- More research is needed on multicultural competencies, standards, methods, and approaches (Ponterotto, Casas, Suzuki, & Alexander, 2010).
- Multicultural standards cannot be incorporated into the counseling profession until all groups have been included.
- Multiculturalism represents reverse racism and quotas and is anti-White.

A prominent debate within multicultural counseling concerns the scope and limitations of the movement. One criticism is that multicultural counseling overemphasizes the importance of race and ethnicity over other dimensions of identity such as gender, sexual orientation, economic class, religion, and disability status. The prominence given to racial and ethnic concerns in multicultural counseling is due to its civil rights origins. Lee (2006) made a persuasive argument against the broad definition of *multiculturalism*. Lee argued that the term *multicultural* is in imminent danger of becoming so inclusive that it renders itself to be almost meaningless. The broad definition includes all constituent groups that perceive themselves as being disenfranchised in some fashion. This has resulted in diffusing the coherent conceptual framework of multiculturalism in training, teaching, and research. According to Locke (1990, cited in Pedersen, 1997), "As the term has been increasingly stretched to include virtually any group of people who consider themselves 'different' the intent of multicultural counseling theory and practice has become unclear" (p. 7). Another critique of multicultural counseling pertains to its failure to adequately prepare counselors for the realities of social justice work. In their critique of the multicultural

counseling competencies, Vera and Speight (2003) argued that the competencies do not address issues of injustice and that a commitment to social justice requires more than individual counseling and psychotherapy. The lack of attention to community-based work stems from the belief that helping professionals should be apolitical.

Ratts, Anthony, and Santos (2010) added that counseling theories that purport to meet the needs of culturally diverse populations should be examined with a critical eye. Most counseling theories that are repackaged to meet the needs of culturally diverse clients take an "additive approach" to counseling (Ratts et al., 2010). This concept was derived from Banks's (2012) stages of multicultural education. An additive approach to counseling occurs when multicultural concepts are superficially integrated into predominant counseling theories and practices without changing the core tenets of an existing theory or practice. On the surface, it appears as if the theory or practice has evolved to align with the needs of culturally diverse clients. However, the central tenets of the theory or practice remain the same. For example, toward the latter part of his career Albert Ellis began to acknowledge the importance of cultural factors in counseling. Yet, the core tenets of rational–emotive behavior therapy did not change. This point is similar to renovating a house with a bad foundation by only painting the walls and adding new trim and then selling it without full disclosure: The structure of the house is still weak because the existing foundation has not changed. We acknowledge that it is easier to revise an existing theory than to create a new theory from the ground up. New theories take time to develop, require extensive research, and often require challenging the existing structure of practice.

Fifth Force: The Social Justice Tradition

Ratts, D'Andrea, and Arredondo (2004) classified social justice counseling as a fifth force in the profession. They argued for a more balanced perspective that includes individual counseling and systems-level advocacy. This approach is based on the belief that toxic environmental conditions influence human development issues. Ratts et al. recognized a need to change how counseling is practiced. Many counselors placed excessive weight on the need to help individuals and families gain insight or on behavioral change without regard to how oppressive social conditions influence human behavior. Thus, instead of actively seeking to change oppressive structures clients are often required to change and adapt to their oppression.

Ratts (2009) added that counselors cannot expect a different outcome if they continue to do the same things. Working harder at the same things will drive counselors to exhaustion. Instead, counselors need to build new theories and approaches to helping clients. This understanding requires a renewed commitment to the use of psychology. Ratts (2009) identified three ways in which social counseling shifted the helping paradigm in psychology: (a) the way in which client problems are conceptualized, (b) the counselor role and identity, and (c) the skills required by effective counselors. We describe each below.

Client problems are viewed through a social justice lens where oppression is assumed to affect psychological health. There is research suggesting the negative impact of oppression on mental health. Research by Whitbeck, McMorris, Hoyt, Stubben, and Lafromboise (2002) indicated that discrimination experienced by Native Americans is associated with increased depressive symptoms. Diaz, Ayala, Bein, Henne, and Marin (2001) have discussed how the combination of poverty, homophobia, and racism leads to social alienation, low self-esteem, and increased psychological distress such as suicide among gay Latino men in the United States. Similarly, the achievement gap between rich and poor schools is

attributed to generational poverty and racial segregation (Kozol, 2005). K–12 youth who identify as (or are perceived to be) lesbian, gay, bisexual, transgender, or questioning are also more likely to experience depression, drop out of school, and have lower grade point averages than their heterosexual peers as a result of feeling unsafe because of their sexual orientation, gender identity, and gender expression (Gay, Lesbian & Straight Education Network, 2011). These examples provide important research evidence of the harmful effects of living in an oppressive society and demonstrate how easily clients can internalize things that are external to them.

The shift in how client problems are conceptualized changes the counselor role and identity (Ratts, 2009). Conventional terms used to describe helping professionals such as *counselor, therapist, school counselor, psychologist,* and *family therapist* are being modified to include *social change agent, activist,* and *advocate.* We add the term *counselor advocate* because we feel that it better reflects the merging of counseling and community advocacy. When helping professionals identify as counselor advocates, they are called on to do more than provide traditional therapy.

Counselor advocates realize that individual counseling is not sufficient to address systemic-based problems. There is a limit to the impact individual counseling can have with clients whose problems are external to them. As counselors begin working in communities, address unjust systemic barriers, advocate for legislative change, and collaborate with community leaders, they begin to develop new skills: organizational development, negotiation, mediation, the art of persuasion, grant writing, community engagement, policy and legislative writing, lobbying legislators, forming rallies, and participatory action research. Such skills are informed by a deep knowledge and understanding of the inner workings of social and political conditions and their impact on human development.

Critics of social justice counseling argue that it is too political, has liberal undertones, and requires counselors to perform social work-related activities (Canfield, 2008; R. Hunsaker, 2008). We note that many detractors of the social justice counseling movement tend to be White heterosexual males who argue for maintaining tradition. They believe that advocacy and social justice are outside the purview of counseling and that counseling is a process where client and counselor come together within the comfort of an office environment.

Social justice critics question the need for counselors to work outside the office setting. These critics draw a line between counseling and social work. They argue that community-based work is an area that requires the expertise of social workers. Counselors work in the office setting providing psychological services, and social workers provide case management in the community setting. Blurring the line between these two professions clouds the professional identity of counselors within the field and among human services generally.

Dissenters of social justice also argue that counseling should be a "value-neutral" endeavor where counselors help clients achieve optimal health and well-being. Counseling should not be used as a forum to promote political agendas. Political bias, especially one steeped in liberalism, taints the "science" and purity of counseling. R. C. Hunsaker (2011) argued that social justice in counseling is actually liberal propaganda supported by activists who use counseling as a platform to further a political agenda.

Toward an Interdisciplinary Approach

As mentioned, the psychoanalytic, cognitive–behavioral, and existential–humanistic counseling approaches place weight on the medical model and heavily promote intrapsychic explanations without critically exploring the significance of sociocultural factors on mental

health. Considerable weight is given to individual factors and biological determinism to explain client development. The use of the medical model and intrapsychic explanations are reflected in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the authoritative reference that describes and codifies mental disorders in the United States. Diagnostic labels were created to explain mental health problems. However, they are also used in child custody cases and to determine insurance premiums; they may also affect job prospects. However, questions abound regarding the reliability in diagnostic labels. In their critique of the Text Revision of the 4th edition of the *DSM* (*DSM–IV–TR*; American Psychiatric Association, 2000), Caplan and Cosgrove (2004) wrote:

> The terms "mental illness," "mental disorder," "abnormality," "normality," and even "insanity" are constructs, terms that do not correspond to clearly identifiable "real" objects. Constructs are defined by whoever does the defining, and the power to make a definition stick resides usually in groups that have the most social, political, and/or economic power. Beginning in the last twenty years of the twentieth century, the small number of primarily White, high status, male psychiatrists who make the ultimate decisions about what goes into the therapists' diagnostic "Bible," the [*DSM–IV–TR*], have had more power than any group to decide who is and is not psychologically normal. But the *DSM* authors are not the only creators of diagnostic categories, for drug companies and book authors with "M.D." or "Ph.D." after their names have also been granted authority. (p. xx)

The most recent iteration of the manual, the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM–5*; American Psychiatric Association, 2013), seems to indicate that things have not changed. *The Washington Post* highlighted a conflict of interest between pharmaceutical companies and creators of the *DSM–5* (Whoriskey, 2012). This article questioned the ethics of having a panel of experts who receive funding from drug companies (in the form of grants, stock options, and speaker and consultant fees) create diagnostic categories for the *DSM–5* that financially benefit pharmaceutical companies.

What is perhaps most interesting is that counselors and psychologists are one of the major consumers of the *DSM*, often relying on it for insurance reimbursement. Yet counselors and psychologists have little to no input in how diagnostic categories are developed within the *DSM*. It is dangerous to uncritically use diagnostic labels based on biological determinism and to have a small segment of the population determine what is healthy. When society gives power to a small group of professionals to determine normal and abnormal behavior without proper checks and balances, it opens itself to potential bias in diagnostic categories and raises concerns about unethical practices.

Counseling is becoming more interdisciplinary, drawing from such fields as biology, psychology, and sociology. Ratts (2011) added advocacy to the biopsychosocial helping paradigm to acknowledge that helping professionals should also integrate such disciplines as community engagement and activism. A biopsychosocial advocacy perspective is based on the belief that biological, psychological, and sociological factors all play a role in human development and that advocacy is necessary to help clients achieve optimal mental health and well-being. The biopsychosocial advocacy perspective is also reflected in such fields as engineering, medicine, social work, and family therapy.

Considerable debate remains as to whether mental illness is a result of biological, psychological, or sociological factors. The summer 2004 special issue of the *Journal of Primary Prevention* explored this debate. Agrawal and Hirsch (2004), both trained psychiatrists, argued that biological determinism is the root of mental health problems; they cited schizophrenia as a brain disease. They contended that mental illness such as schizophrenia is

a disease similar to cancer because of complex physiological abnormalities. Joffe (2004) questioned this assertion: "The claim that they are alike diminishes the likelihood of effective prevention by distracting attention from important social causes of a wide range of mental disorders" (p. 416). The belief is that clients and the problems they present must be understood within a larger context. Viewing clients solely through a biological lens limits our understanding of client problems.

Proponents of the psychosocial perspective attribute mental illness to stressful environmental conditions (Albee & Joffe, 2004) such as poverty (Silvestri & Joffe, 2004). What society may categorize as "pathological" is actually a healthy coping strategy to stressful environmental conditions. Unfortunately, counselors do not always explore whether clients have internalized their oppression for a couple of reasons: (a) The use of predominant theoretical paradigms ignores the connection between oppression and mental health problems, and (b) clients seldom indicate that they are experiencing internalized oppression. Instead, clients present with depression, substance abuse, low self-esteem, or relationship problems, to name a few of the issues that are typically expressed. These problems are often surface-level issues that can be attributed to larger systemic issues if counselors are willing to explore this possibility with clients. Exploring the connection between mental health and oppression can help rule out systemic barriers that hinder client development. A social justice oriented counseling professional will ask, "How is my client's issue influenced by oppressive sociopolitical conditions?"

We believe that taking a comprehensive approach to assessing human development issues is both ideal and ethical. Relying on biological, psychological, or sociological explanations alone is limiting. Clients come to therapy trusting that their counselors will be comprehensive in their approach. For this reason, it is critical that helping professionals consider multicultural and social justice factors in their work. When they do not do so, counselors run the risk of doing more harm than good. Clients may conclude that they are the problem and that they need to change.

Conclusion

Given the social ills in the United States, people are beginning to realize that there is a need to do things differently. The achievement gap in K–12 schools, the resegregation of America's public schools, the prevalence of racially segregated neighborhoods, the growing economic gap between social classes, the technological divide between rich and poor, anti-immigration sentiments, and homophobia across grade levels in education and in society at large all underscore the need for counselors to become involved with multicultural and social justice initiatives. Counselors can no longer ignore the cultural and societal realities placed on clients. The urgency to transform counseling practice may be considered a mandate for the field, given the harsh realities of the world in which we live. More than ever before, society needs counselors who are multiculturally competent agents of social change.

By virtue of their position in society, counselors have a personal and professional responsibility to promote a more just and humane world. Helping professionals who are unable to see the relevance of multiculturalism and social justice in counseling may need to reconsider their commitment to the profession. We know this statement may seem rather harsh. However, the stakes of maintaining the status quo in systems of oppression in counseling practice are too drastic for clients. Counselors need to develop a sense of urgency or run the risk of unethical practice.

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Chapter 3

The Complexities of Identity

Human identity is complex. How people identify themselves is shaped by "individual characteristics, family dynamics, historical factors, and social and political contexts" (Tatum, 2010, p. 5). In other words, people are not the sole determiners of their identities; society plays a role in the construction of identity and our beliefs about human diversity. Tatum (2010) contended that human identity is multidimensional rather than one-dimensional. Race, class, gender, sexual orientation, religion, age, and disability status are separate yet synergistic dimensions of identity that combine to make up the total human being. It is difficult, for example, to understand race without also examining its connection with other dimensions of identity such as class, gender, religion, and sexual orientation. Each dimension of identity influences how other dimensions are experienced. Together, each dimension of identity (race, ethnicity, gender, sexual orientation, economic status, religious status, age, etc.) combines to form a whole where one aspect of identity cannot be fully understood without the other.

The dimensions of identity are social constructs shaped and constructed by the dynamics of power, privilege, and oppression. To make sense of our world, we create social categories such as race, gender, sexual orientation, religion, disability, and class. Everything we do, how we experience the world, and how resources are distributed are based on these social categories. For example, students of color in urban schools tend to receive a lower quality educational experience than students in predominantly White affluent neighborhoods (Kozol, 2005). This experience leads to very different opportunities after graduation.

Counselors who are unaware of how dimensions of identity and oppression influence client experiences may inadvertently label clients with a mental illness when their behaviors are actually normal and healthy responses to a toxic environment. This carelessness on the part of counselors can have grave consequences for clients and their families. Misdiagnosing clients can mean an added financial burden for clients who opt for medication to cope with their "mental illness." Inaccurately labeling client problems can also lead clients to blame themselves for their problems.

In this chapter we highlight the most recent U.S. census data on the diversity of the U.S. population. We then discuss the dimensions of identity that form human identity; explain

oppressor, border, and oppressed group identities; and describe the way in which identity is tangled with interlocking systems of power, privilege, and oppression.

Diversity of the U. S. Population

The U.S. census data reflect the mosaic that makes up the U.S. population (see Table 3.1). The increasing diversity of the U.S. population also affects the counseling profession. Counselors can no longer ignore such important variables as race, ethnicity, gender, sexual orientation, economic class, religious status, and disability status. Both clients and counselors bring with them rich histories and personal experiences that shape the counseling experience.

Whites account for a majority of the U.S. population. However, historically underrepresented racial and ethnic groups are growing at a faster rate than the White population (Humes et al., 2011). Hispanics are the fastest growing population, increasing by 43% between 2000 and 2010.

The U.S. census data on gender suggest that males and females are equally represented. However, the data are misleading because information on transgender individuals is not

Table 3.1 • **Demographic Distribution of the United States**

Demographic Variable	% of the Population
Race (in 2010)	
Native Hawaiian and Other Pacific Islander	0.2
America Indian/Alaskan Natives	0.9
Asian	4.8
Some other race alone	6.2
Two or more races	2.9
Black/African American	12.6
White	72.4
Gender	
Female	50.8
Male	49.2
Poverty level by race (in 2011)	
Asian	12.3
White	12.8
White, not Hispanic	9.8
Hispanic, any race	25.3
Black	27.6
Age (in 2010)	
Under 18 years old	24.0
18–44 years old	36.5
45–64 years old	26.4
65 years old and older	13.0
Same-sex households	1.0
Disability	11.9

Source. Race data are from Karen R. Humes, Nicholas A. Jones, and Roberto R. Ramirez, 2011, *Overview of Race and Hispanic Origin: 2010* (2010 Census Brief, p. 2). Washington, DC: US Department of Commerce, Economics and Statistics Administration, US Census Bureau. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf. Poverty data are from Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica C. Smith, 2013, *Income, Poverty, and Health Insurance Coverage in the United States: 2010.* Current Population Report. 2013 (p. 22). Retrieved from http://www.census.gov/prod/2013pubs/p60-245.pdf. Age data are from Lindsay M. Howden and Julie A. Meyer, 2011, *Age and Sex Composition: 2010.* 2010 Census Briefs (p. 22). Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

collected. *Transgender individuals* are those who vary from culturally conventional roles of male or female. They may identify as male, female, transgender, or neither.

Christians make up the largest religious group (78.4%) in the United States. This is followed by unaffiliated (16.1%) and other religions (4.7%).

Blacks and Hispanics/Latinos account for a majority of those living in poverty. Individuals in the 18–44 year age range represent the largest age group. Same-sex households make up 1% of the population. However, the data are misleading because it does not consider lesbian, gay, and bisexual individuals who are single or living alone, which means that this group is much larger. Individuals with disability make up nearly 12% of the population.

Internal, External, and Sociopolitical Dimensions of Identity

Human identity exists on three dimensions: individual, group, and universal (Sue & Sue, 2013). The *individual dimensions of identity* refers to the unique characteristics of each person, such as personality, values, and belief systems. These characteristics and attributes distinguish people on an individual level and make each of us unique. The *group dimensions of identity* refers to the shared experiences people have as a result of being a member of a social group. As human beings we are all members of racial, gender, sexual orientation, social class, religious, and ability social groups. As members of these social groups we share certain things, such as language or a group identity, that shape our lived experiences. The *universal dimension of identity* refers to the universal aspects of human existence. Human beings need food, shelter, water, and safety for survival regardless of cultural background. How we achieve each of these survival resources varies for each person and social group.

People often focus on individual and universal dimensions of identity in the United States more so than group dimensions of identity. However, group dimensions of identity are just as important because they describe shared experiences that individuals have as members of a social group, and they offer explanations for the way in which people experience the world as members of various social groups.

We introduce the dimensions of identity model (see Figure 3.1) to explain group dimensions of identity. Group dimensions of identity are categorized into internal, external, and sociopolitical dimensions. All of these dimensions are linked with one another. Dimensions of identity closest to the center of the circle are those that are most salient for a person (i.e., dimensions that a person tends to be conscious of on a daily basis); they are referred to as the *internal dimensions of identity*. Dimensions of identity that are second furthest from the center of the circle are referred to as the *external dimensions of identity*. What is listed as an internal or external dimension of identity varies for each person depending on the degree of salience of that particular aspect of identity. Some people may list race as an internal dimension of identity. Others may list race as an external dimension of identity because they are not as conscious of their racial identity.

For purposes of illustration in Figure 3.1, we list internal dimensions of identity as age, race, ethnicity, gender, sexual orientation, and physical and mental ability. The circular arrows surrounding the internal dimensions of identity reflect both the forms of oppression related to that aspect of identity and the fluidity of identity and the connection between each dimension of identity and each form of oppression. We provide a more detailed overview of oppression in the section *Dynamics of Oppression*. Here we identify which internal dimensions of identity correspond to which system. (Note that each is associated with individual, social–cultural, and institutional levels of oppression.)

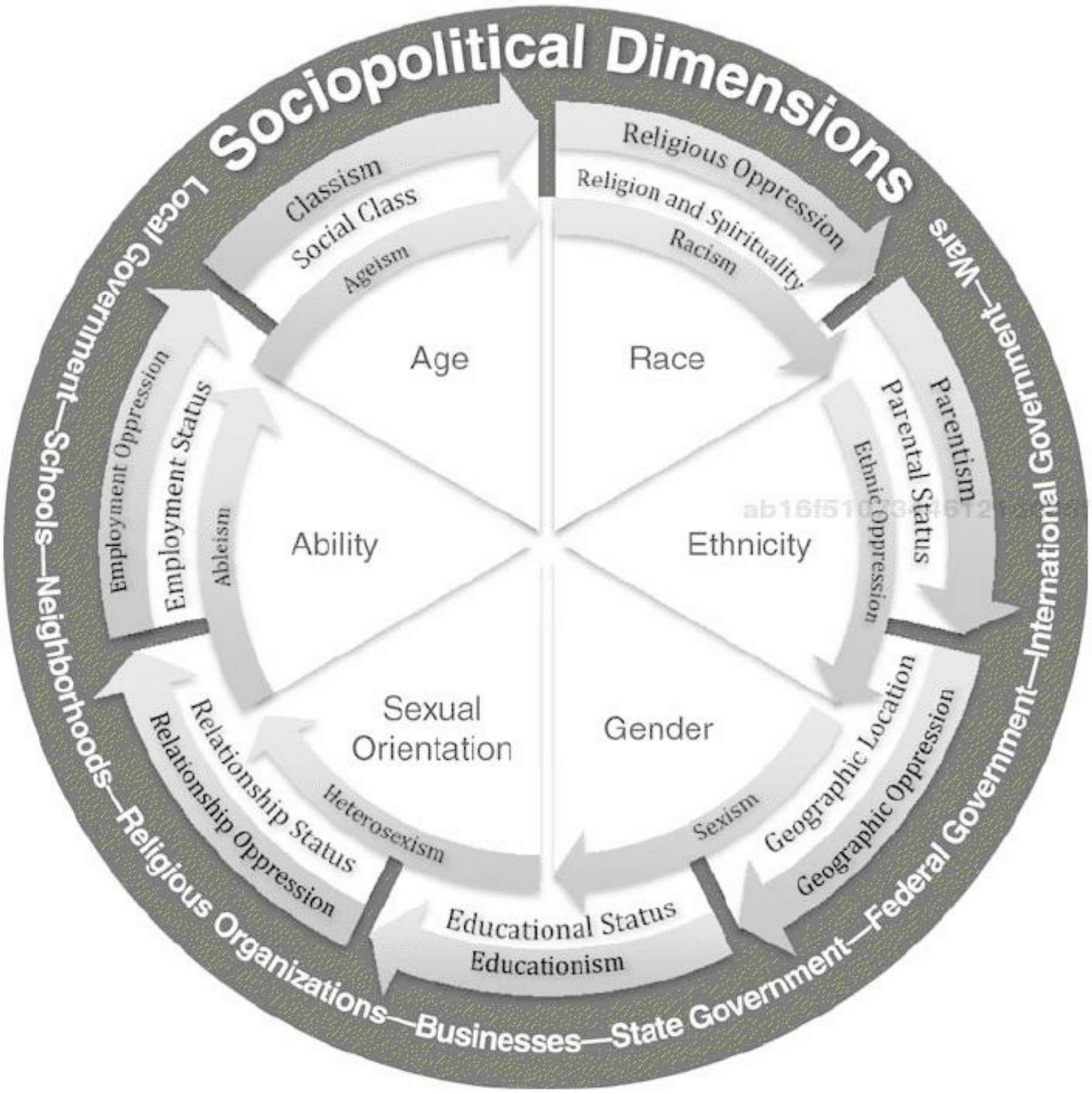

Figure 3.1 • **Dimensions of Identity Model**

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- race → racism
- ethnicity → ethnic oppression
- gender → sexism
- sexual orientation → heterosexism
- ability → ableism
- age → ageism

External dimensions of identity are aspects of human diversity that people tend not to be as conscious about as other dimensions. For instance, Whites tend to not be conscious of themselves as being members of a White racial group. For purposes of illustration we list external dimensions of identity as social class, religion and spirituality, parental status, geographic location, educational status, relationship status, and employment status. The arrows surrounding the external dimensions of identity reflect a form of oppression connected to that aspect of identity. Each bullet entry is associated with individual, social–cultural, and institutional levels of oppression.

- religion and spirituality → religious and spiritual oppression
- parental status → parentism
- geographic location → geographic oppression
- educational status → educationism
- relationship status → relationship oppression
- employment status → employment oppression
- social class → classism

The sociopolitical dimension of identity, which is furthest from the center of the concentric circle, is concerned with the social, political, and economic conditions that influence human development. This includes, but is not limited to, local government, schools, religious organizations, businesses, neighborhoods, state government, federal government, wars, and social policies. Each social system influences people's lived experiences and access to resources such as education, health care, and employment. For instance, religious institutions have historically been a barrier for sexual minorities. We see this in the Catholic Church's position against marriage equality. Another example is seen in America's education system where students who attend poor schools are more likely to have a less than ideal educational experience than students who attend well-funded schools. These examples reflect how people influence, and are influenced by, their surroundings.

Internal Dimensions of Identity

Age

Society uses age as a marker of time. Age is often used to determine biological effects of time on a person. It is also used to determine rites of passage in society. For instance, in the United States age 16 is often the marker for when people can legally hold a valid driver's license; at age 18, adolescents are generally viewed as legal adults.

Race

Race is a classification used to connote both biological and social differences in people based on historical geographic origins and physical attributes such as skin pigmentation. According to Pedersen (2000), the Caucasoid, Mongoloid, and Negroid races recognize racial differences among themselves and explain these differences in biological terms. However, this understanding does not explain differences in sociological behavior where patterns cut across racial lines. Race is a social construction with little or no biological basis. The U.S. census uses the following racial categories to distinguish people: American Indian and Alaska Native, Asian, Hispanic or Latino, Native Hawaiian and Other Pacific Islander, Some Other Race, and White.

Ethnicity

Ethnicity refers to an individual's identification with a cultural group and is largely based on culture, nationalism, religion, and citizenship. According to Pedersen (2000), the term *ethnic* is "derived from the social or cultural heritage a group shares that relates to customs, language, religion, and habits passed on from one generation to the next" (p. 54). African American ethnic groups include but are not limited to Nigerian, Kenyan, or Haitian. Asian American ethnic groups include but are not limited to Indonesian, Japanese, Korean, Laotian, Filipino, Taiwanese, Thai, and Vietnamese. Hispanic or Latino ethnic groups include but are not limited to Colombian, Cuban, Dominican, Ecuadorian, Honduran, Mexican, Peruvian, Puerto Rican, and Salvadoran. European American ethnic groups include but

are not limited to British, French, German, Italian, Polish, Spanish, Russian, Swedish, and Ukrainian. Native American ethnic groups are also referred to as *tribes*. There are 562 federally recognized tribes in the United States; the largest tribes are Navajo, Cherokee, Choctaw, Sioux, Chippewa, Apache, Blackfeet, Iroquois, and Pueblo. Pacific Islander ethnic groups include but are not limited to Hawaiian, Samoan, or Chamorro.

Gender

Gender refers to a range of social, behavioral, cultural, and psychological traits used to distinguish between girls–women and boys–men. Gender roles are ascribed within cultures. Society tends to view gender in binary terms, often equating it to either man or woman. This binary thinking of gender does not allow for gender diversity. Cultural practices and standards often determine how gender is viewed in society.

Gender should not be confused with biological sex, which is assigned at birth. Society uses *biological sex* to identify whether people are male, female, or intersex. It is determined by physiological factors such as internal and external sex organs (vulva, clitoris, vagina for assigned females and penis and testicles for assigned males), chromosomes (XX for females; XY for males), and hormones (estrogen and progesterone for females; testosterone for males).

Gender identity refers to whether people identify psychologically as male, female, both, or neither. People's gender identity often matches their assigned biological sex. However, this is not always the case; the gender identity one psychologically identifies with can differ from one's biological sex assigned at birth.

Gender expression refers to how people communicate their gender identity. Gender can be expressed through such things as clothing, hairstyle, or behavior. Cultural standards often influence the way gender is expressed. In Western society, males are expected to express gender in masculine ways (e.g., assertiveness and independence). Females are expected to express gender in feminine ways (e.g., nurturing and cooperation).

Sexual Orientation

A person's sexual orientation is related to, and yet distinct from, gender identity. *Sexual orientation* refers to the emotional, intellectual, physical, sexual, and spiritual attraction to members of a specific gender. Gay and lesbian people are attracted to members of the same gender. Heterosexual individuals are attracted to members of the opposite gender. Bisexual individuals are attracted to both genders. Asexual individuals are attracted to neither gender. It is important to note that the term *sexual orientation* is preferred over the term *sexual preference;* the latter is considered a derogatory term because it implies that being gay, lesbian, bisexual, or heterosexual is a choice, when research supports the claim that it is not.

Ability

According to the World Health Organization (2012), disabilities may be physical, cognitive, mental, sensory, emotional, developmental, or some combination that affects three areas: impairments (bodily functioning or structure), activity limitations (difficulty in executing a task), and participation restrictions (inability to obtain access). Disabilities are both visible and invisible. Visible disabilities are those that are typically noticeable and can be seen. Invisible disabilities are those that may not be readily observable, such as auditory, learning, and mental disabilities.

External Dimensions of Identity

Social Class

Clarifying what class entails requires an understanding of social status. *Social status* refers to the position, whether real or perceived, that society places people in based on economic indicators such as "prestige, power, income, wealth and property, in-group and out-group

behavior, lifestyle, and leisure and consumption behavior" (Liu, 2001, p. 129). The combination of socially determined societal markers (e.g., material possessions, education level) and a person's self-inventory of her or his economic status determines class status. *Class* refers to shared experiences, worldview, and life opportunities among people. Society in the United States is based on class stratification.

Adams, Bell, and Griffin (2007) categorize social class into the following: rich/upper classes, middle class, and working class/poor. Each of these class categories shapes lived experiences, access to quality resources (e.g., education, healthcare, employment), and influences how people are perceived by others. Those in the rich/upper classes are often viewed as being more "capable" than those in the working class/poor.

Religion and Spirituality

Religion is a collection of beliefs and practices of a religious institution. According to Wiggins (2010), "Religion is corporate, cognitive, behavioral, public, ritualistic, external, and institutional. Although 'spirituality' often includes 'religion' the two terms are not identical. In fact, religion may be only one way in which some persons express their spirituality" (p. 76). Many religions use rituals, symbols, and traditions to reflect values, beliefs, and practices. Religious beliefs may influence people's morals, values, and ethics. Life decisions are often guided by religious beliefs and values, which provide purpose and meaning in life.

Parental Status

Parents are caretakers of a child or adult. Everyone has two biological parents, a male and female who reproduce either through sexual reproduction or artificial insemination. Typically, biological parents raise their own offspring. However, children can have caretakers who are not their biological parents (e.g., extended family members, parents of the same sex). State and federal regulations also allow people to become adoptive parents. It is common for same-sex couples to adopt children. It is important for counselors to keep parental status in mind because it influences client's lived experiences. Circumstances often dictate whether children are raised by biological parents, same-sex parents, family members, foster parents, or adoptive parents.

Geographic Location

Geographic location, or where people live, is important to consider as our society continues to become increasingly global. Encompassing many regions, countries, and parts of the world, geographic locations influence the ways people think, feel, and act. For example, people who live in the southeastern part of the United States, also known as the "Bible Belt," are likely to be influenced by conservative political ideologies rooted in Christian values and beliefs. Conversely, those who live in the Pacific Northwest are likely to hold more liberal political ideologies and beliefs that are influenced by regional politics and value systems. People who come from other countries have different perspectives on development issues.

Educational Status

Society often uses education as a formative experience to transmit knowledge and skills from one generation to the next. Education serves the purpose of helping people develop critical thinking and social skills. It is used as a means to determine qualifications and regulate who can enter certain sectors of the work force. Education is often associated with financial benefits, income potential, and increased opportunities.

Relationship Status

Relationship status has to do with whether a person is in an intimate relationship. People can identify as single, divorced, separated, partnered (e.g., married, polyamorous, monogamous), or widowed. The relationships people enter into can be short-term or long-term,

committed or noncommitted, and arranged or unarranged. Culture plays a significant part in the formation of relationships. For instance, arranged marriages are common in South Asia, Africa, and the Middle East. Arranged marriages occur when family members decide that individuals are to wed. People pursue relationships for a variety of reasons, including companionship and financial gain.

Employment Status

Employment is a paid experience that involves a contractual agreement between an employer and an employee. The employer dictates the types of duties required of a particular job, and the employee performs those duties within an agreed upon period of time. The type of work experience people engage in varies from manual labor to highly skilled positions that require the attainment of certifications or education.

Sociopolitical Dimensions of Identity

The social and political landscape must be considered when defining the factors that shape identity. Helping professionals are better able to understand clients when they consider how environmental factors (e.g., local, state, and federal government; businesses; wars; social policies; institutionalized oppression) shape and influence a client's identity and lived experiences. Clients do not exist in a vacuum; we cannot truly understand a client's racial and ethnic identity without also exploring how this aspect of identity is influenced by racial dynamics in society. Similarly, the "coming out" process for lesbian, gay, bisexual, transgender, or queer clients can better be understood by examining how heterosexism influences the coming out experience.

Oppressor, Border, and Oppressed Group Status

An understanding of internal and external dimensions of identity is enhanced by further classifying these dimensions into oppressor, border, and oppressed groups. Oppressor or privileged groups are those who, by virtue of their membership in a social group, have power and unearned privilege in the United States (Adams et al., 2010). According to Adams et al., oppressors appear in any of the following groups:

- *race:* Whites;
- *sex:* cisgender men (*Note*: Cisgender refers to a self-perception that matches the body and the biological sex an individual was born with.);
- *gender:* gender-conforming cisgender men and women;
- *sexual orientation:* heterosexuals;
- *class:* rich, upper class;
- *age:* adults;
- *ability:* temporarily able-bodied; and
- *religion:* Christian.

Border groups are those who experience both privilege and oppression as a result of their social group identity. Adams et al. (2010) identified the following as border groups:

- *race:* biracial and multiracial individuals;
- *sex:* transsexual, intersex;
- *gender:* gender-ambiguous men and women;
- *sexual orientation:* bisexual and asexual;
- *class:* middle class;

- *age:* young adults;
- *ability:* individuals with temporary disabilities; and
- *religion:* Roman Catholics.

Oppressed groups are those in society who are marginalized because of their membership in a social group. They are often placed at a disadvantage because their values, beliefs, and customs are frequently at odds with the oppressor. The different values and beliefs held by individuals from oppressed groups are often viewed as a deviation rather than as a variation in society. Adams et al. (2010) included the following as oppressed groups:

- *race:* people of color (Asian, Latino/a, Black, and Native American);
- *sex:* cisgender women;
- *gender:* transgender, genderqueer (an umbrella term for gender identity that goes beyond traditional notions of man and woman), intersex individuals;
- *sexual orientation:* gay males and lesbians;
- *class:* poor and working class individuals;
- *age:* youth;
- *ability:* people with mental and physical disabilities; and
- *religion:* Jews, Muslims, Buddhists, Mormons, and others.

One's status as a member of an oppressor, border, or oppressed group can influence the counseling relationship. Consider the following examples:

- Victor, a transgender male school counselor, was hired to work in a middle school. Prior to applying for school counseling positions, he changed his name so that search committee members would not be able to Google his name on the Internet and discover his previous transgender advocacy work. After 4 years as a school counselor and earning the School Counselor of the State award, he decided to leave the profession. For 4 years he struggled every day with not being able to be "out" to students, families, and colleagues. After submitting his resignation letter he felt free to be himself again.
- Vu, a Vietnamese American male college counselor working with predominantly White client populations, struggled with issues of confidence. He had a disproportionately high number of "no shows" compared to his White counselor colleagues. He wondered whether his racial identity played a factor in the number of missed appointments. He brought this concern to his White clinical supervisor; she argued that race could not be a factor because of the racial diversity on campus and that the no shows were more likely to be an indication of his inexperience. After 3 years working at the college he decided to leave and work at an Asian counseling agency. The pay was lower, but he was happier than he had been because his racial identity was not a factor in his work with clients.
- Amy, a White female counselor who grew up in an affluent White suburb, was interning at a local mental health agency that served clients who were poor and predominantly people of color. She struggled to connect with clients and wondered whether her racial identity was a factor. Amy never considered herself as part of a White racial group until the internship experience. She noticed that counseling sessions tended to be surface level at best. Clients often did not show up for their second appointment; some requested to see another counselor at the agency. She did not broach the topic of race and poverty with clients because she was afraid to make them uncomfortable.

Dynamics of Power and Privilege Between Client and Counselor

Members of oppressor, border, and oppressed groups interact in counseling in various ways. Understanding these combinations gives insight into how power and privilege influence the client–counselor relationship. These combinations are conceptualized in quadrants with the origin being the center of the quadrant (see Figure 3.2).

Oppressor Client–Oppressed Counselor (Quadrant I). Counselors from oppressed groups who work with clients from oppressor groups are at a disadvantage. On one hand, counselors have power by virtue of their professional title, but this power may be negated because they lack social power and privilege by virtue of their social group status. Oppressed group counselors who work with oppressor group clients must deal with the challenge of how to be taken seriously. For instance, White clients who harbor racist beliefs may undermine an African American counselor's expertise. A gay male school counselor may experience challenges with gaining trust from parents who hold the belief that gay males have pedophile tendencies.

Oppressor Client–Oppressor Counselor (Quadrant II). Both counselors and clients might belong to oppressor groups when they both hold power and privilege in society. As oppressors the assumption may be that cultural diversity and identity politics do not factor into the counseling equation. The dynamics of power and privilege may also not be considered because oppressors are often unaware of their status and dominance. As a result, both counselors and clients may not always realize how privilege can be a burden that can contribute to a client's presenting problem.

Oppressed Client–Oppressor Counselor (Quadrant III). Counselors from oppressor groups hold power and privilege over clients from oppressed groups. Because oppressors are often unaware of their own privileged status, they may use theories and approaches that do not align with the cultural background and worldview of oppressed clients (Sue & Sue, 2013).

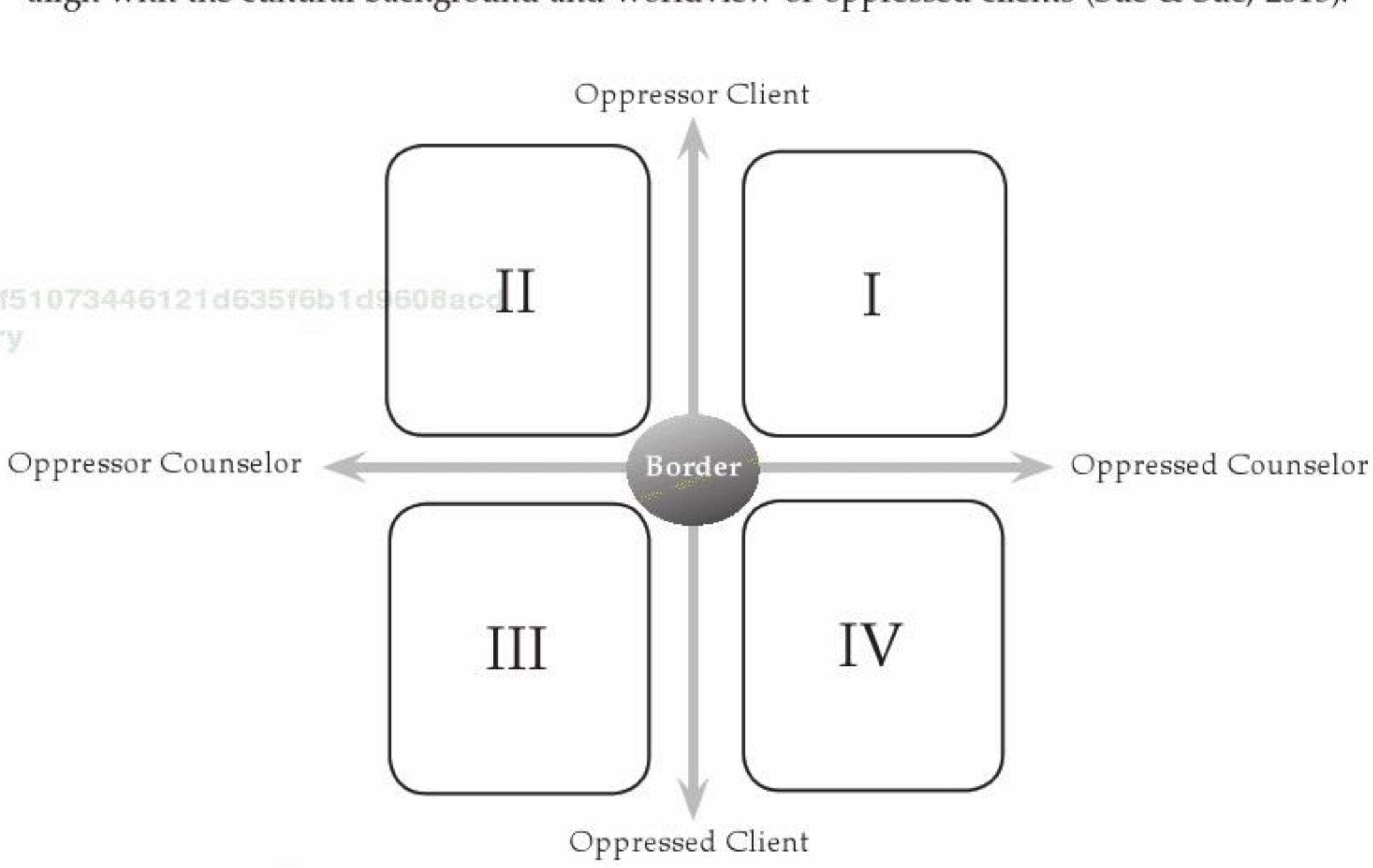

Figure 3.2 • **Oppressor–Border–Oppressed Relationships**

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Gaining trust may also be a challenge for counselors from oppressor groups who work with oppressed clients. Oppressed group clients may be hesitant to share because in their view, counselors who belong to oppressor groups represent power and unearned privilege. This perspective holds true regardless of whether counselors are multiculturally competent or identify as change agents. Oppressor group counselors who initiate dialogue about differences in power dynamics can alleviate concerns and ward off potential barriers with oppressed group clients. Such discussions require oppressor group counselors to be comfortable in their own skin and knowledgeable of the ways in which they benefit from privilege.

Oppressed Client–Oppressed Counselor (Quadrant IV). Both clients and counselors may belong to oppressed groups, which means that both lack social power and privilege. Oppressed group counselors who have internalized oppression may perceive clients from oppressed groups as inferior. Conversely, if oppressed group counselors are aware of oppression and its impact, they can be an important resource to oppressed group clients. Such counselors can have a deeper sense of empathy for oppressed group clients because of their shared experiences. They may also be able to connect oppressed clients with important resources in the community. It is also not uncommon for oppressed group clients to seek counselors from the same oppressed group, because they do not want the burden of having to enlighten counselors about oppression. There is also solace in knowing that their counselor is likely to understand their experiences.

Border Groups (the Origin)

Individuals with border group status experience both privilege and oppression, but their identities are not always evident to others. Therefore, the dynamics of privilege and oppression may not be as apparent unless that dimension of identity is shared. For instance, counselors who identify as bisexual and are "out" may experience oppression when working with clients who are homophobic. However, such counselors may experience privilege if they are not "out" to clients. Similarly, clients who identify as bisexual may experience oppression if they are in a gay or lesbian relationship. However, they may experience privilege if they are in a heterosexual relationship. Given the invisible nature of border group identities counselors should refrain from making assumptions about privilege and oppressed group statuses. Counselors who wrongly assume clients' privileged and oppressed group status may offend clients. To the extreme, this inaccurate assumption may lead clients to terminate therapy.

Cycle of Socialization

We learn about ourselves, about others, and about the world through a process referred to as *socialization*. This socialization process occurs throughout the life span. Harro (2010) developed a socialization model, referred to as the *cycle of socialization*, that identifies five key characteristics of the socialization process:

- *Pervasive*: The process is relentless and permeates the individual, social–cultural, and institutional levels.
- *Consistent*: The process is predictable and requires individuals and institutions to play certain roles.
- *Circular*: The process is circular, thereby providing a feedback loop.
- *Self-perpetuating*: The process requires individuals and institutions to work in synchronicity so that it is self-sustaining.
- *Invisible*: The process pervades all aspects of society so thoroughly that we do not notice it.

Harro's (2010) cycle of socialization model is described as a process that works in a symbiotic and systematic fashion. The socialization process is based on the dominant group's perspective, which reinforces the dominant group's explanation of how the world operates. Harro's cycle of socialization model describes the following process:

1. *The beginning:* We are all born as blank slates into a world where certain rules, power structures, laws, and policies are already in place that benefit one group over another. Bias, stereotypes, and prejudices about social groups are already well established before we are born. Through no choice of our own we inherit a world where discrimination and oppression are rampant.
2. *First socialization:* We are socialized from an early age about race, ethnicity, gender, sexual orientation, economic class, religion, and disabilities from those we love and trust the most. This process begins at birth and continues through the life span. The implicit and explicit messages we are taught about the self and about others begin at such an early age that people do not question them. This socialization occurs both "intrapersonally (how we think about ourselves) and interpersonally (how we relate to others)" (Harro, 2010, p. 47). We learn from those we trust about how we should behave and the roles we should play in society. Those closest to us influence our values, our self-concept, and our perception of others. The messages we learn about ourselves and about issues of diversity and social justice can be positive or negative, and they can either be reinforced or contradicted by others.
3. *Institutional and cultural socialization:* The socialization process is multiplied when we begin to interact with institutions and systems outside the immediate family. The messages people learn about themselves, other people, and the way the world works from loved ones are either reinforced or contradicted by schools, places of worship, businesses, media, and Internet sources. People quickly learn the rules of engagement through interaction with social systems: Girls like pink and boys like blue; a healthy family includes a mother and a father; gay men are pedophiles; transgender individuals are mentally ill; poor people are lazy; Asian Americans are sneaky; being White means more opportunities; and success is the result of hard work.
4. *Enforcements:* There is pressure to maintain the social order of things. People are rewarded for maintaining the dominant status quo, and they are punished if they question the way things are done. Those who buck the status quo run the risk of being unpopular. Such individuals are often stigmatized and viewed as troublemakers. Those who help to maintain the status quo are perceived as team players and are often left alone. This type of reward system keeps the status quo in place.
5. *Results:* The impact of socialization results in different experiences for dominant and target group members. Target group members may have a wide range of negative feelings such as anger, dissonance, frustration, dissonance stress, hopelessness, and disempowerment. These feelings often lead to internalized oppression such as low self-esteem, crime, and destructive behavior. Dominant group members experience internalized privilege, guilt, fear of retribution and violence, and stress, and they often become defensive.
6. *Actions and directions for change:* People can choose to do nothing and allow the status quo of oppression to exist, or they can choose to interrupt the cycle of oppression. It is easier to remain quiet than to speak out. Those who choose to remain quiet may do so because they fear retribution from others if they speak out or because they are oblivious to the realities of oppression. Those who speak out do so because they realize that being silent means that they are condoning oppression.

7. *The core of the cycle:* Harro (2010) argued that the combination of fear, ignorance, insecurity, confusion, obliviousness, and powerlessness work to maintain the cycle of socialization.

    - *Fear:* Members of targeted groups fear being labeled as troublemakers, deported, and killed, and so they choose to keep silent. Members of dominant groups fear losing their privilege and being ostracized, so they do not question the status quo.
    - *Ignorance:* Both targeted and dominant group members are unaware that oppression exists and how it works; they may not be aware that they are being socialized.
    - *Confusion:* The complexity of oppression makes it overwhelming to address. People often do not know where to begin and so they choose to do nothing. The fear of doing or saying the wrong thing helps to maintain the cycle of socialization and oppression.
    - *Insecurity:* Many people lack confidence in their ability to address issues of oppression. They lack appropriate training and the knowledge and skills needed to be effective in challenging the status quo.
    - *Power or powerlessness:* Dominant group members hold power and fear losing it. Targeted group members may be overwhelmed by the existing power structure and so choose to do nothing.

Harro's (2010) cycle of socialization model describes how power and privilege are maintained. Moreover, it explains why the dominant status quo is difficult to change. Even when people are aware of the need for change, pressure from individuals and institutions to maintain the system of power and privilege makes change difficult to achieve.

Dynamics of Oppression

The messages we learn about social group identity are often based on stereotypes and prejudice. When left unexamined, stereotypes and prejudice can lead to discrimination and oppression. The link between stereotypes, prejudice, discrimination, and oppression is illustrated and explained in the dynamics of oppression conceptual model (see Figure 3.3).

Research (Katz & Kofkin, 1997; Lewis, 2003; Van Ausdale & Feagin, 2001) indicates that children as young as 6 months begin to recognize difference such as skin color. Children learn about diversity through discussions, observation, modeling, vicarious reinforcement, and imitation of others. Their natural curiosity leads them to ask questions about themselves and the world around them. These experiences lead children to form cognitive schemas, also known as *stereotypes*, about others. *Stereotypes* are mental pictures in our head about people based on their membership in a particular racial, ethnic, gender, sexual orientation, age, economic, disability, or religious group. Stereotypes are often based on half-truths, misconceptions, and misinformation. Stereotypes are harmful because they ascribe negative attributes to a group. Even positive stereotypes are harmful. For example, the stereotype that Asian Americans are the model minority is harmful because it puts undue pressure on Asian Americans to succeed and it pits Asian Americans against other people of color such as Latin@ Americans, American Indians, and African Americans.

When left unchallenged, stereotypes can lead to prejudice. *Prejudices* are preconceived judgments, attitudes, or beliefs about others based on stereotypes. Prejudices are often irrational and are not always based on personal experience. People can be steadfast in their prejudice even when confronted with evidence that contradicts their prejudice. Prejudices are damaging because they lead people to form favorable or unfavorable opinions or attitudes about others. In turn, these preconceived notions lead to discrimination against others.

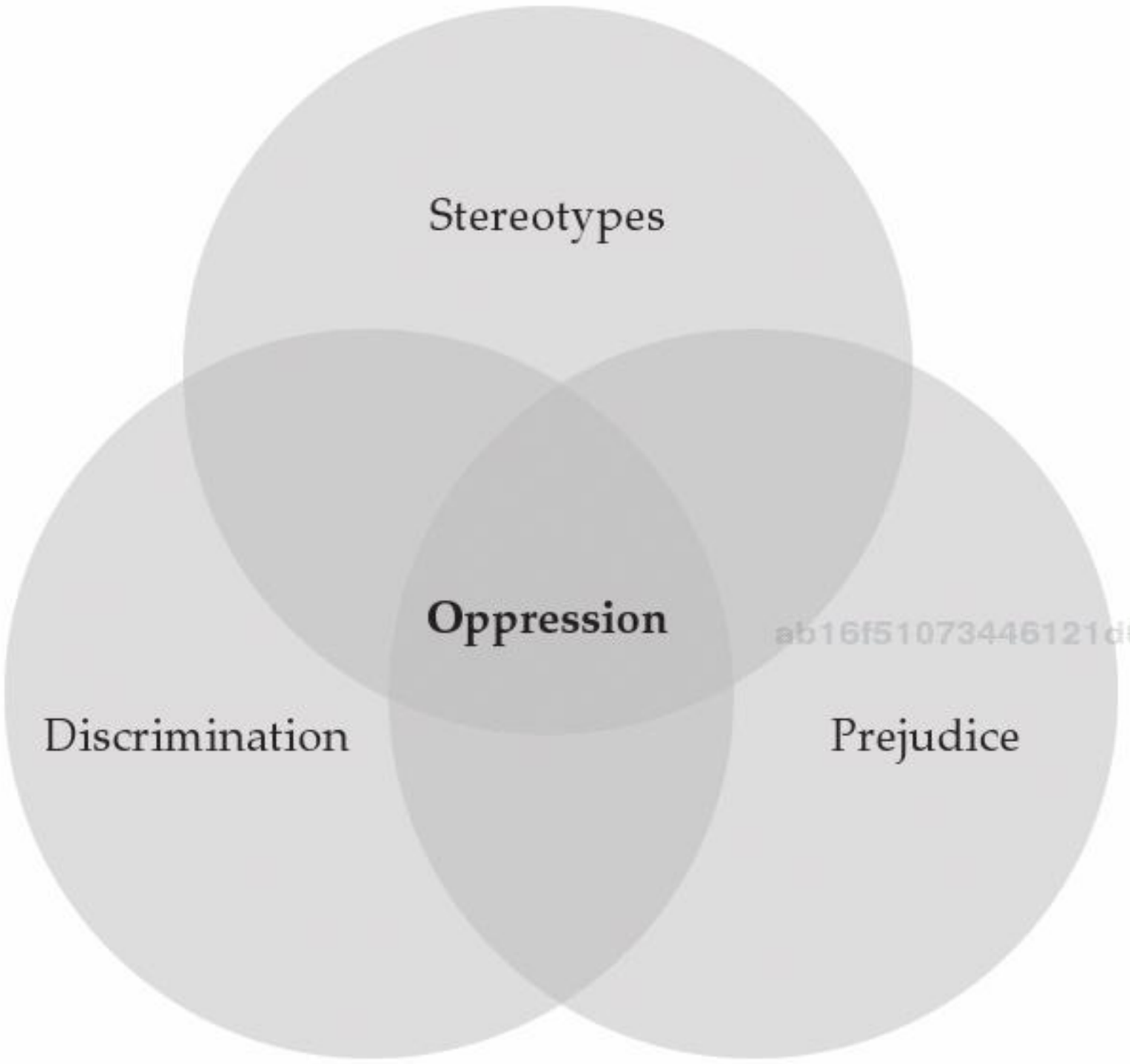

Figure 3.3 • **Dynamics of Oppression**

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Discrimination is an unconscious or conscious act against a person based on prejudice. Discrimination occurs when a person treats another person favorably or unfavorably based on such categories as race, ethnicity, gender, sexual orientation, economic status, age, and religion. For example, unconscious discrimination occurs when a White female clutches her purse when an African American male steps into an elevator. A heterosexual counselor who refuses to see lesbian, gay, bisexual, or transgender (LGBT) clients because of his or her religious beliefs is acting on a conscious form of discrimination. Discrimination is harmful because it leads to decisions that are often based on bias rather than on merit or facts.

When those in power participate in discrimination, what results is *oppression*, a complex interlocking system of advantages one group has over another based on the ability, whether intentional or unintentional, to use power to enact one's prejudices. Oppression is "first and foremost a systematic phenomenon that involves ideological domination, institutional control, and the promulgation of the dominant group's ideology of domination and culture on the oppressed" (Hardiman & Jackson, 1982, p. 2). It is a system that operates on the individual, social–cultural, and institutional levels. Individual forms of oppression include individual acts and attitudes directed toward others. Social and cultural forms of oppression occur when dominant cultural norms and practices of a society are used to dehumanize others. Institutional forms of oppression include the structures, laws, regulations, and policies that result in differential access to goods, services, and opportunities in society based on a person's identification with a racial, ethnic, gender, sexual orientation, age, ability, economic, or religious group.

Oppression is based on both prejudice and power. Lukes (2005) conceived of power as control or influence over others. For instance, those in the privileged group have "power

to" institutionalize policies and "power over" those in the target group. Based on this description, everyone has the ability to discriminate against others. However, only those in the privileged group have the power to use their prejudice to oppress. Many people do not understand the distinction between discrimination and oppression; they think that people of color can be racist or that women can be sexist. However, people cannot oppress when they are also victims of that oppression. A female who selects a woman for a job over a male because of gender or people of color who act on their prejudicial attitudes toward other White people are demonstrating discriminatory behavior and not oppressive behavior. On a systemwide scale, males and Whites still hold power and unearned privilege, and they continue to profit from a system that benefits them.

Research continues to demonstrate that oppression is a chronic stressor that can lead to psychological and physical health problems. The prevalence of heterosexism contributes to increased negative psychosocial development for youth who are identified as or perceived to be LGBT or queer (Toomey, Ryan, Diaz, Card, & Russell, 2010). Krieger and Sidney's (1996) research suggested that the combination of racism and the belief that unfair treatment was inevitable correlated with higher levels of blood pressure in African Americans. Women's experiences with sexism have been associated with depression, anxiety, somatization, and low self-esteem (Klonoff, Landrine, & Campbell, 2000). Individuals who experience more than one form of oppression are affected in even more complex ways. For example, research by the Gay, Lesbian & Straight Education Network (2011) found that LGBT and queer youth of color in K–12 schools were at a greater risk for harassment and physical safety than their heterosexual peers.

Conclusion

The mosaic that makes up the United States is diverse, rich, and complex. America's diversity exists in large part because we are a country primarily made up of immigrants and refugees. As a nation, the United States is rich in diversity. Living in a multicultural society affords opportunities to interact with people from all walks of life and to learn about varying perspectives. The nation's diversity also allows America to compete in an increasingly global economy. Our diversity is not the problem. It is our inability to know what to do with America's diversity that creates problems. Using the diversity of our nation, we have set up an invisible and self-perpetuating system that promotes inequities and allows oppression to thrive.

Given the realities of the world our clients live in, counselors must make a commitment to multiculturalism and social justice. Such a commitment begins with an understanding of the various dimensions that make up human identity. This commitment must also include a belief that we live in a world where people are socialized to maintain an invisible system of oppression. Until counseling as a profession is able to recognize the way we are socialized and do something on a systemwide scale to dismantle oppression, the status quo will continue. Those in privileged groups will continue to reap the benefits of their privileged status. Target group members will remain disenfranchised. Border groups will both benefit and be harmed by the system.

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Chapter 4

Counselor–Advocate–Scholar Model: Merging Multiculturalism and Social Justice

It is difficult to discuss multiculturalism without also considering the relevance of social justice. Multiculturalism and social justice go hand in hand. They are inextricably linked forces that work in synchronicity. Ratts (2011) referred to multiculturalism and social justice as "two sides of the same coin" (p. 26). He argued that the multicultural counseling force paved the way for the social justice force in counseling. Multiculturalism allows counselors to see the harmful consequences of oppression on human growth and development. Social justice focuses on addressing issues of oppression that affect clients.

Both multicultural and social justice counselors recognize that inequities such as racial profiling, anti-marriage equality laws, anti-Semitic attitudes, and poverty create an environment that dehumanizes and disempowers people. Individuals from marginalized communities are often made to feel responsible for their plight. Moreover, the oppressed are led to believe that it is they who must change and adapt to their oppression. Counselors with a belief in a just world realize that if they do not advocate for change in the environment, no one will. Such counselors recognize that they have the power to create positive changes in systems that affect oppressed clients and communities.

It is inevitable that counselors seek to integrate multiculturalism and social justice, two complementary paradigms (Ratts, 2011). Taking the very best from the multicultural and social justice traditions increases the potential impact that counselors can have on individuals and society. Moreover, it expands the boundaries of what is possible in counseling and psychology. As counselors hear firsthand about the debilitating effects of oppression from clients, they begin to realize that they can have a greater impact if they resort to social justice measures that address changing the systems that oppress clients and communities (Lewis & Arnold, 1998). The seamless connection between individual counseling and systems advocacy creates a natural relationship between these two approaches (Lewis, Toporek, & Ratts, 2010). Thus, determining whether change needs to occur with clients or within the environment becomes the challenge for many multicultural and social justice counselors.

This chapter introduces readers to the counselor–advocate–scholar model, a model that helps counselors determine whether individual counseling or systems-level work is needed. Assumptions about human nature and the tenets inherent in a multicultural-social justice counseling perspective are presented; these assumptions (listed in previous chapters)

are included here to provide context to the model. We also describe one way to operationalize the counselor–advocate–scholar model.

We make the following assumptions about human nature:

- We live in a world in which oppression exists.
- Oppression leads to psychological stress and disorders.
- We are socialized from an early age to uphold the status quo of oppression.
- People are members of privileged, border, and target groups.
- People experience both privilege and oppression.
- Culture influences human development.
- There is complexity in diversity.

We subscribe to the following tenets of multicultural–social justice counseling:

- Counseling is a multicultural and sociopolitical process.
- Client problems can be internally or externally based.
- Power and privilege influence the therapeutic relationship.
- Counseling can be liberating or it can be oppressive.
- Counselors are change agents and advocates for social justice.
- The goal of counseling is to liberate clients from oppression.
- Counseling involves balancing individual and systems work.

Counselor–Advocate–Scholar Model

We synthesize the multicultural and social justice force by introducing readers to the counselor–advocate–scholar model (see Figure 4.1). This model provides a conceptual framework of the different roles professional helpers should play in general and the symbiotic relationship between counseling, advocacy, and scholarship. Moreover, this model expands the traditional counselor role of being strong clinicians by incorporating advocacy and scholarship into this role. We believe the combination of counseling, advocacy, and scholarship is essential to multicultural and social justice praxis; all three are linked to and inform one another.

The counselor–advocate–scholar model is molded after the University of Tennessee Counseling Psychology Program's scientist–practitioner–advocate training model (University of Tennessee Counseling Psychology Program, 2013). Their model is an outgrowth of the scientist–practitioner model that was developed to integrate science with practice (Mallinckrodt, Miles, & Levy, 2014). We, too, believe that research and practice should inform one another. The University of Tennessee Counseling Psychology Program expanded on the scientist–practitioner model by including advocacy as an integral part of counselor training. We find this approach to counselor training to be promising.

We revised the scientist–practitioner–advocate training model to better reflect the philosophical underpinnings of counseling. The term *counselor* is used in place of *practitioner* to stress the importance of clinical skills and the need to take an empowerment-based approach. We avoided the term *practitioner* for another reason: It tends to evoke the medical sciences and seems to imply that counselors are experts. McWhirter (1994) defined an empowerment-based counseling approach:

> Counseling for empowerment is a complex and multifaceted process that requires for some, a radical departure from the traditional conceptualization of the helper's role. Empowerment goes far beyond helping people "adjust to" or "feel better about" their lives. The process of empowerment demands that professional helpers and their clients

Figure 4.1 • **Counselor–Advocate–Scholar Model**

Note. The Counselor–Advocate–Scholar Model by M. J. Ratts was adapted from *The Scientist–Practitioner–Advocate Model: Addressing Contemporary Training Needs for Social Justice Advocacy* (p. 26) by B. Mallinckrodt, J. R. Miles, & J. J. Levy, 2014, Manuscript submitted for publication. Copyright 2014 by B. Mallinckrodt, J. R. Miles, & J. J. Levy. Adapted with permission of the authors.

> take an active, collaborative approach to identifying problems and goals. Counseling for empowerment also requires that the counseling relationship become a vehicle for fostering critical awareness of the power dynamics influencing the client's life context. It involves working with clients to develop a repertoire of skills that enable more effective self-direction; to develop a sense of collective history, common identity, or community with others; and to help clients to support the empowerment of others. (xiii)

Incorporating advocacy to the counselor role is important because it acknowledges that client problems can sometimes be externally driven and thus there is a need for counselors to intervene in the community realm. Because "counselors are in positions of institutional power and privilege in relation to clients" (Toporek, 2000, p. 6), they can use their positions in society to advocate for systems change. Moreover, counselors are advocates who work in the social milieu to alter oppressive barriers impacting clients. We believe that developing advocacy skills is as important as developing clinical skills. Advocacy is not an "add on" but rather a natural extension of a counselor's daily routine that evolves out of the counseling setting (Lewis, Ratts, Paladino, & Toporek, 2011). The Advocacy Competencies developed by Lewis, Arnold, House, and Toporek (2002) offer a framework from which to advocate with and on behalf of clients.

We use the term scholar instead of scientist. Scholars are seekers of truth. They look at the world through a critical lens. The term *scientist* conjures up the image of a person experimenting in a lab. Clients are not subjects that are to be experimented on like lab animals. In addition, the term scientist has historically implied a preference for quantitative research over qualitative research. We do not share this preference; we see value in

both quantitative and qualitative epistemologies. There is value in statistical data and a place for using community voices to understand and address social issues. To this end, evidence based practices (EBP), action research, and community based research (CBR) are all valuable methodologies in addressing social justice issues. EBP stresses the importance of making decisions based on the best available research evidence available. In contrast, action research is an emergent process whereby social problems are addressed through research. Similarly, CBR involves community members throughout the research process and occurs within the community setting. Whether using quantitative or qualitative methodologies, scholars are committed to the following endeavors:

- advancing a question or social issue through research;
- developing new ways of practicing informed by research;
- discovering new theories and/or models of helping; and
- seamlessly linking theory, practice, and research (Mallinckrodt et al., 2014).

At the center of the counselor–advocate–scholar model is multicultural and social justice praxis. We also add *multicultural* to the center of this model because effective social justice practice cannot be done effectively or ethically without considering cultural factors. Multiculturalism and social justice should inform how the roles of counselor, advocate, and scholar come to fruition. Helping professionals need to have an eye on how cultural factors influence clients and the degree to which social injustices affect clients.

In the following sections we discuss the counselor–advocate–scholar model both conceptually and operationally.

The roles of counselor, advocate, and scholar intersect in the following ways:

- *Counselor–scholar:* Counselors are skilled clinicians and scholars. Counselor–scholars use applied clinical work to create new scholarship ideas that foster multiculturalism and social justice. Counselors, in collaboration with clients, are cognizant of what scholarship is needed and know what questions to ask based on their clinical experiences. They are guided by a well-articulated question that culminates in research, which is then shared with the public. Counselors are also informed by scholarship. They use scholarship to learn about best practices, current trends, conditions, and discoveries. Scholarship allows counselors to determine what problems exist and how to address them most effectively. Counselor–scholars are critical consumers of research and scholarship. They do not take research at face value; they read and question research with a critical eye. They understand that research is flawed, imperfect, and prone to bias.
- *Counselor–advocate:* Counselor–advocates recognize that office-based clinical work can lead to community-based systems work and vice versa. Such counselors are able to seamlessly transition from the clinical realm to the community arena. As counselors work with clients, they become exposed firsthand to the realities of the world. They see how oppression influences clients in the clinical setting. When counselors step into the community arena, they come into contact with structural barriers that hinder clients. These experiences shape counselors' understanding of oppression and provide insight into the type of change required (i.e., individual or systems).
- *Advocate–scholar:* Advocate–scholars recognize that social change is enhanced when it is combined with research and scholarship. Scholarship equips helping professionals with awareness and knowledge to be effective advocates. Through scholarship, counselors develop more accurate and effective advocacy interventions. Scholar-

ship is also informed by advocacy practices. Advocate–scholars are in the frontlines working with individuals and communities. They see what issues clients struggle with and are informed of the problems existing in communities. These advocacy experiences lead helping professionals to scholarly inquiry and research that improves communities.

- *Counselor–advocate–scholar:* At the heart of this model is the multicultural and social justice praxis. Helping professionals have a professional and ethical responsibility to provide culturally and advocacy competent services (Ratts, Toporek, & Lewis, 2010) and to ground their practice with scholarship. Multiculturalism allows counselors to be effective social justice change agents. To this end, counselors should honor diverse voices and should use counseling as a mechanism to create a more humane world that promotes justice for all. This approach requires being open to alternative ways of helping that honor clients' cultural background and being willing to work within the traditional office setting or in the community realm.

Counselor–Advocate–Scholar Model in Action

In this section we describe how the counselor–advocate–scholar model comes to life (see Figure 4.2). It provides a step-by-step process for determining whether to intervene at the individual level or at the systems level. This model combines the best from the multicultural and social justice perspectives into one unifying approach. It demonstrates the seamless transition from office-based clinical work to systems-level work and vice versa.

The symbiotic relationship between counseling, advocacy, and scholarship is powerful. When counselors possess advocacy, scholarship, and counseling skills, they can be more effective clinicians and change agents. Counselor–advocate–scholars are informed by research, and they use clinical and advocacy practices to inform their scholarship. Counselor–advocate–scholars understand that developing clinical and system skills increases their ability to affect clients. They are able to effortlessly intervene at the individual and systems level.

Step 1. Determine the Root of the Client's Problems

Multicultural and social justice praxis requires that counselors take a comprehensive approach, which necessitates that counselors are attuned to the client's culture and that they see the client's issues through a wider lens (Lewis, Lewis, Daniels, & D'Andrea, 2011). One approach is to use a biopsychosocial lens to establish the root of client problems. The biopsychosocial approach informs counselors of whether client problems are biological (e.g., physiological symptoms), psychological (e.g., cognition, affect, and behavior), or sociological (e.g., cultural and structural barriers). Seeing client issues through a wide-angle lens is in contrast to the narrower lens prevalent in counseling and psychology. The biopsychosocial lens helps counselors understand that different approaches are possible depending on the origin of client problems. Moreover, knowing whether client problems are biological, psychological, or sociological (or a combination of these) informs counselors whether individual counseling or systems work is needed.

The biopsychosocial approach in counseling merges the fields of biology, psychology, and sociology. This approach allows for a more holistic understanding of client problems. When counselors explore the degree to which biological, psychological, or sociological factors influence clients, they are able to determine with precision the origin of client problems. The following questions can be important in ascertaining client issues from a biopsychosocial context.

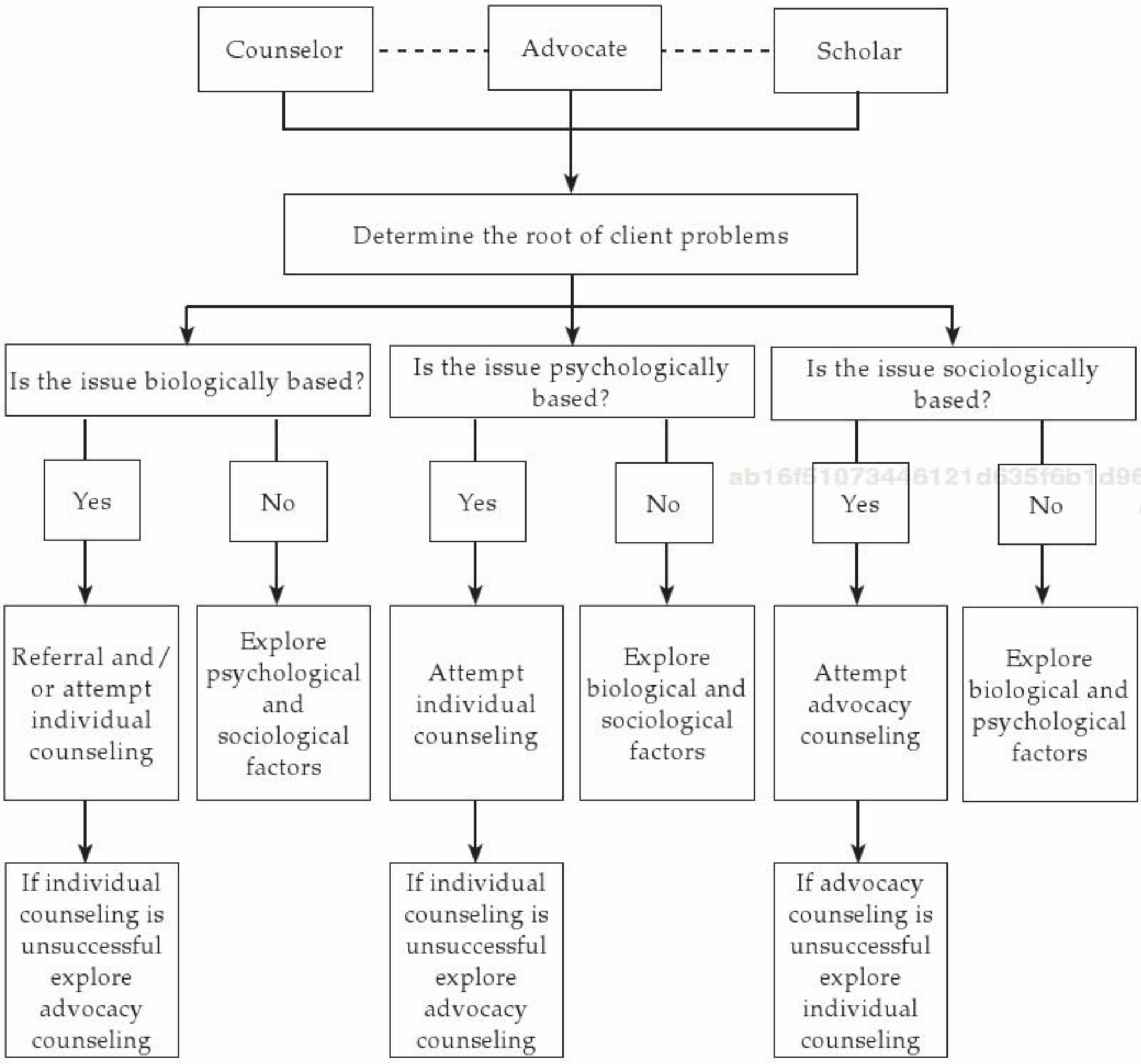

Figure 4.2 • **Operationalizing the Counselor–Advocate–Scholar Model**

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Biological

- What physiological symptoms does the client present?
- Are client problems biologically based?
- Will addressing physiological symptoms alleviate client problems?
- Is consultation with medical professionals needed given a client's physiological symptoms?
- How might biological symptoms influence psychological and sociological factors?

Psychological

- What cognitive, affective, and behavioral issues does the client present?
- Are client problems psychologically based?
- Will addressing psychological factors alleviate client problems?
- How might psychological symptoms influence biological and sociological factors?

Sociological

- What cultural or sociological symptoms does the client present?
- Are client problems culturally or sociologically based?
- How does oppression influence client problems?
- Will addressing sociological conditions alleviate client problems?
- How might sociological symptoms influence biological and psychological factors?

Step 2. Determine Whether Individual Change or Systems Change is Required

Determining the root of client problems helps counselors decide whether referrals, individual counseling, systems work, or a combination of the three is needed. We explore this process in further detail.

Biologically Based Problems

If client problems are biologically based, individual counseling or referral to a medical provider may be necessary. Referral to a physician is dependent on the extent of the client's physiological symptoms. If client problems are not biologically based, counselors should explore the extent to which problems are psychologically or sociologically based. As counselors work with clients, they may realize that individual counseling is unsuccessful. If this occurs, counselors should explore whether systems-level change is needed.

Psychologically Based Problems

Counselors should explore the degree to which client problems are rooted in psychology. If client problems are not psychologically based, counselors should explore the influence of biological and sociological factors. If, however, client problems are psychologically based, counselors should attempt individual counseling. Through individual counseling, counselors may realize that client problems are more systemically based. If this occurs, the focus of counseling should be on environmental change.

Sociologically Based Problems

Counselors should explore whether client problems are rooted in the environment. If client problems are not environmentally based, counselors would do well to examine how biological and psychological variables contribute to client problems. A focus on altering the social context should occur if client problems are systemic. This counseling approach requires counselors to address environmental barriers with, and on behalf of, clients. Altering systemic variables occurs at the individual, social, cultural, and institutional levels. Individual-level advocacy involves working to change individual attitudes and behaviors. For example, school counselors may address a teacher's attitude of low expectations for students of color that permeates throughout the class. Advocacy at the social and cultural level may involve addressing dominant norms and values that are deeply entrenched in society that hinder client development. For instance, counselors may address heterosexual norms that obstruct the development of a healthy sexual identity for lesbian and gay clients. Institutional-level advocacy focuses on altering oppressive social structures, policies, and laws. This approach may involve working with agencies, businesses, schools, and the government to address unjust policies, rules, laws, and statutes. If systems-level work is not effective, counselors should explore whether individual counseling may benefit clients instead.

Conclusion

Should counselors focus their efforts on individual change or environmental change? This question is fundamental to multicultural and social justice work. Establishing the need for individual change or systems change (or both) is in stark contrast to predominant ways of helping. Most counselors rely on individual counseling regardless of clients' presenting concerns. This approach is due in part to tradition (Ratts & Wood, 2011). There is danger in relying solely on one approach to helping. Relying on individual counseling alone limits the type of impact counselors can have on clients and communities. Clients may walk away from counseling feeling better. However, their happiness is likely to be short-lived because the root of their problems has not been completely addressed. Counseling interventions serve only as a Band-Aid when counseling fails to get at the origin of client problems.

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Chapter 5

Worldview and Identity Development

Manivong J. Ratts, Paul B. Pedersen, and Alexa Wayman

Scholars and practitioners use identity development theories to explain human growth and to describe developmental challenges that clients experience throughout the life span (Wijeyesinghe & Jackson, 2012). These challenges are often shaped by sociopolitical events of the times. For example, the struggle for marriage equality is a human development issue that affects individuals from all walks of life. Poverty is a challenge that affects millions of people around the world. These human development issues are complex and ever changing.

Early theories of identity development frequently did not take into account the significance of social influences and social identities in the definition of the self (Briggs & Pepperell, 2009; Gilligan, 1993). Erikson's (1968) seminal work on stages of psychosocial development continues to be popular today even though it applies less accurately to people of color and women. Although Erikson emphasized the importance of autonomy and initiative development during the childhood years in his classic model of identity, it is also true that his psychosocial concepts defined the individual self in the context of the dominant group's values, norms, and social roles. Whereas Erikson's model favors the individualistic worldview and the more masculine roles, the notion of a separated self is now replaced with a notion of self-in-relationship, in which the sense of self reflects the relationships among people (Gilligan, 1993).

This chapter provides an overview of social identity development theories that examine racial, ethnic, gender, and sexual orientation identity development. Social identity development theories evolved out of the civil rights movement of the 1960s. Liberation movements for women, people of color, people with disabilities, the elderly, and other oppressed client populations in the 1960s and 1970s gradually adopted the idea that judging all populations by a narrow standard did more harm than good. Oppressed client populations began to develop their own separate criteria for group identity. The goal of these social identity development theories is to explain the experience of oppressed groups living within a dominant group culture.

Worldview

The process of identity development is essentially linked to the concept of *worldview*, which refers to the way each person sees the world (Koltko-Rivera, 2004). The concept of worldview has been studied for centuries and has been defined in various ways. Koltko-Rivera (2004) defined *worldview* in the following terms:

> [It is a] way of describing the universe and life within it, both in terms of what is and what ought to be. A given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle), what objects or experiences are good or bad, and what objectives, behaviors, and relationships are desirable or undesirable. A worldview defines what can be known or done in the world, and how it can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals should be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system. (p. 4)

Ibrahim (1991) described *worldview* as how people view human nature (e.g., inherently good, inherently bad, or a combination of good and bad), social relationships (e.g., lineal–hierarchical, collateral–mutual, and individualistic), nature (e.g., control nature, live in harmony with nature, or nature over people), time orientation (past, present, or future oriented), and activity orientation (e.g., being, being-in-becoming, and doing).

Sue (1977) developed a two-dimensional model of worldview, matching locus of control with locus of responsibility (see Figure 5.1). This model is divided into four quadrants. Quadrant I matches internal control and internal responsibility (IC–IR), describes dominant culture values, and is achievement oriented. Quadrant II matches external control and internal responsibility (EC–IR), where self-hatred and marginality are problems for individuals in oppressed groups. Quadrant III connects external control and external responsibility (EC–ER); the system is blamed for any and all failures and people must learn appropriate coping skills. Quadrant IV connects internal control with external responsibility (IC–ER); people have the power to change if given the chance, but their typical response is to attack the system and challenge the value of counseling.

The concept of worldview is important to comprehending the various stages of social identity development that will be introduced in this chapter. By understanding worldview it allows for a deeper appreciation of the various stages of development inherent in many identity development theories.

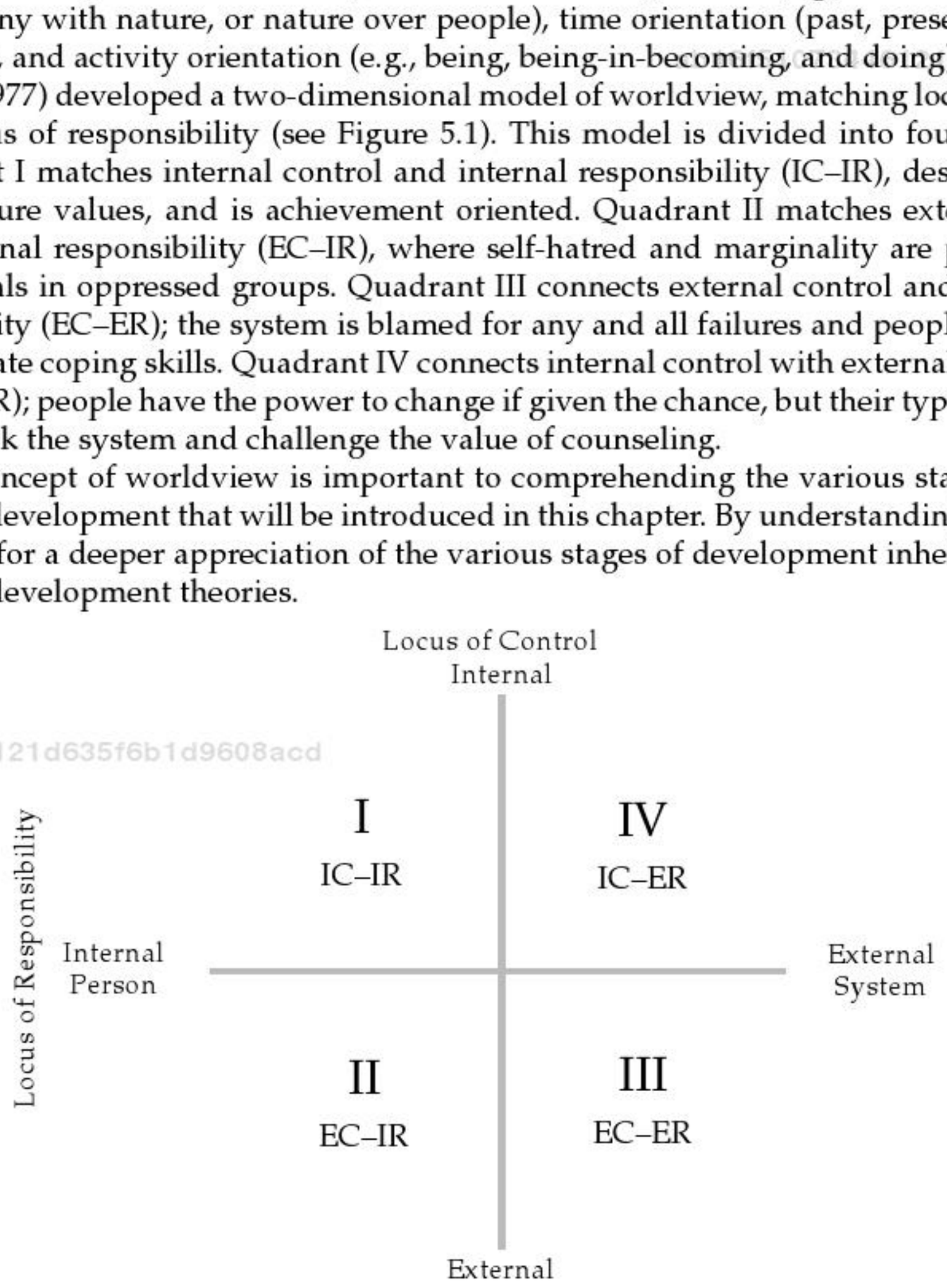

Figure 5.1 • **Control and Responsibility**

Note. Roman numerals are added to facilitate discussion of the quadrants. IC = internal control, IR = internal responsibility, EC = external control, ER = external responsibility. From "Barriers to Effective Cross-Cultural Counseling," by D. W. Sue, 1977, *Journal of Counseling Psychology, 24*, pp. 420–429. Copyright 1977 by the American Psychological Association. Reprinted with permission.

Social Identity Development

Social identity development theories describe how people come to understand their own social group identities and how these identities influence lived experiences (Wijeyesinghe & Jackson, 2012). These theories differ from earlier models of human development because they take into consideration a person's surroundings, including oppression. Our understanding of race, ethnicity, gender, sexual orientation, age, disability status, religious status, and economic class are influenced by the self, others, the environment, and our understanding and experience of oppression. This explains why Asian Americans in predominantly White schools can have different experiences from Asian Americans who attend schools where students of color are the majority. It also explains why people act one way when they are among their own group members and another way when they are surrounded by individuals from other social groups.

Social identity development is dynamic and is often described as a process that occurs in a sequential stagelike manner. Nevertheless, it is possible for individuals to be in more than one stage of identity development at the same time and to skip earlier stages of development. Within each stage of development, characteristics and qualities are shared among individuals within a particular social group. Each stage of identity development reflects how people see themselves in relation to their world and how they understand and experience the world. Although theories of identity development identify the highest or final stage of identity development in different ways, there is general uniformity in the way they identify the lowest stage (as one in which people are oppressed). Individuals from oppressed groups experience internalized oppression, and individuals from dominant groups experience internalized privilege. At the lowest stage of development the criteria for normal behavior, personal beauty, and competence are based on characteristics associated with the dominant group. For example, with respect to racial identity development Whites are the standard by which all racial groups are compared. Similarly, heterosexuals are the normative group for sexual identity development.

Key Assumptions

Social identity development theories all share several key assumptions (Adams, Bell, & Griffin, 2007):

1. Individuals of all social groups are influenced by pervasive and interacting multiple oppressions and may respond to situations differently, depending on their consciousness levels and worldview.
2. Manifestations of social identity respond in different ways to interpersonal, organizational, and/or social contexts and also reflect psychosocial and cognitive development.
3. Social identity development theory provides a way of tracking one's progress away from internalized subordination or internalized domination toward a liberated social identity.
4. Interpersonal interactions within groups as well as between groups are influenced by developmental differences and different levels of conscious awareness of oppression.
5. Developmental terms such as stage, phase, or worldview provide convenient metaphors for differentiating levels of consciousness or experiences of identity. (p. 17)

Jackson and Hardiman's Social Identity Development Model

Jackson and Hardiman (2012) developed a generic model of social identity development to illustrate how various forms of oppression (e.g., racism, sexism, heterosexism, classism, ageism, anti-Semitism, ableism) affect members of dominant and target groups across the life span. Their social identity development model evolved out of Jackson's (1976) work

on Black identity development and Hardiman's (1982) White identity development theory. Jackson and Hardiman's (2012) social identity development model includes five stages; people can be in more than one stage simultaneously.

Stage 1: Naïve or No Social Consciousness

During the formative years (from birth to early childhood), children from dominant and target groups are unaware of themselves as members of social groups and the behaviors assigned to social groups. They are naïve about societal rules of social group membership and the boundaries of what is appropriate and inappropriate. Whereas children recognize differences among people, they do not necessarily place a positive or negative value judgment on social group differences. Young children are naturally curious about and interested in others and their surroundings. Because they have not learned societal rules of engagement, they may ask questions that are considered taboo by adults (e.g., "Why is her skin dark?"; "Why does Raul have two dads?"). As children grow older, they quickly learn (through socialization from parents or guardians, teachers, friends, family, and religious institutions) the rules, laws, and types of behaviors permitted in society.

Stage 2: Acceptance

In the acceptance stage, individuals internalize the dominant group's ideology and worldview. This stage includes active acceptance and passive acceptance. Individuals in the active acceptance stage are more overt and intentional in their support of the dominant group's perspective. In contrast, those in the passive acceptance stage are more covert and unaware of how their attitudes, beliefs, and behaviors support the dominant group's worldview.

Individuals in the dominant group have internalized their privilege. At the active acceptance stage they may hold beliefs that stereotype nondominant group members (e.g., Blacks are lazy, gay people are sinners), or they may join organizations that support the dominant group's supremacy. If these attitudes are learned early and are not questioned, they may lead a person to believe that the dominant status quo is normal and healthy. In the passive acceptance stage, dominant group members tend to be well-intentioned yet unaware of how their attitudes and behaviors support oppression. A woman may believe that she is not racist because she has friends of color. Yet she may clutch her purse tightly when an African American male enters the elevator. Similarly, individuals may support gay and lesbian relationships only to the extent that their own children are not involved in such relationships.

Target group members have internalized their oppression. They believe in the superiority of the dominant group and in the inferiority of their own group. Such individuals may not question their support of the status quo. They may look down on target group members and often adopt the dominant group's worldview as their own. At the active acceptance stage, people of color may not support affirmative action policies. Gay and lesbian individuals may be unwavering in their lack of support for marriage equality. At the passive acceptance stage, individuals are unaware of how their attitudes and behaviors support dominant ideology. For example, persons of color may not seek counselors of color because of their belief that counselors of color are inferior to White counselors.

Stage 3: Resistance

The resistance stage is characterized by an increased awareness and understanding of oppression. Both dominant and target group members begin to question and resist dominant ideology and worldviews. A new worldview is constructed that names the dominant group as responsible for oppression. Persons in the active resistance stage may openly question

oppressive attitudes, behaviors, and policies. In contrast, people in the passive resistance stage may challenge and question oppressive attitudes and behaviors only when there is little to no risk to their personal and professional well-being. Target group members may experience mixed feelings of emotions and may surround themselves only with people from their own social group for support. Dominant group members may experience shame and guilt for being responsible for oppression and for having unearned privileges. They seek ways to avoid and actively reject the privileges gained from an oppressive system.

Stage 4: Redefinition

In the redefinition stage, individuals seek to formulate their own identity free from the dominant group's definition. For dominant group members this process involves forming an identity that is free from oppression and that does not blame or stereotype target groups. Target group members focus on reclaiming their identity and cultural heritage. Both dominant and target group members develop a sense of pride in their own groups. They begin to see the good in all social groups and to internalize the belief that no group is better than another. The anger directed at dominant group members in previous stages has subsided.

Stage 5: Internalization

Both dominant and target groups begin to integrate their new identities into other aspects of their identity. They seek to work in collaboration to address issues of oppression. Addressing oppression also becomes more spontaneous and natural at this stage. Target group members seek to become allies to other target groups. For example, heterosexual women may advocate for marriage equality to support lesbian, gay, and bisexual (LGB) couples.

In the following sections we explore racial and sexual orientation identity development models. These models of social identity development are important because they help provide a framework for understanding how racism, sexism, and heterosexism affect the individual's sense of self in relation to the world.

Racial Identity Development Models

Despite the advances made in the civil rights movement, Dr. Martin Luther King, Jr.'s dream of racial equality has yet to become a reality. Racism creates profoundly different experiences that influence self-concept and mental health for Whites and people of color in the United States. People continue to live in racially segregated communities that fall along class lines. Within the same city, middle and upper class White Americans continue to have access to higher quality education, health care, and food simply because they can afford to live in neighborhoods that have better resources. White women who work are paid 77 cents for every dollar paid to men, but this disparity is much worse for women of color. According to the National Partnership for Women and Families (2011), "African American women are paid only 64 cents and Latina women are paid just 55 cents for every dollar paid to non-Hispanic White men" (para. 2).

Racial identity is an important element of both individual and group identity (Wijeyesinghe & Jackson, 2012). Models of racial identity development have existed for some time in the counseling and psychology literature. Racial identity development models were developed to explain the integration of race into an individual's sense of self (Sue & Sue, 2013). Helms (1993) described racial identity as "a sense of group or collective identity based on one's perceptions that he or she shares a common racial heritage with a particular racial group" (p. 3). Racial identity development models grew out of the limitations inherent in Erikson's (1968) work on psychosocial development.

Most racial development models suggest that individuals experience three to four phases or stages of racial identification. First, there is identification with the dominant culture in a pre-encounter, conformity, or traditional stage. Second, there is an awakening to the impact of racism in a transitional encounter or dissonance stage. Third, there is identification with one's own racial group. Fourth, there is an internalization and integration of one's own racial group with the dominant racial group.

Many models of racial identity development exist that explain the process of racial identity for people of color. These models of racial identity refer to people of color in the United States. Individuals of color from other countries may find that these models do not reflect their experiences in the United States. In this chapter we present five models of racial identity, each of which illustrates the racial identity for specific racial minority groups:

- Atkinson, Morten, and Sue's (1998) racial-cultural identity development model;
- Cross and Fhagen-Smith's (2001) Black identity development model;
- Kim's (1981, 2001, 2012) Asian American identity development model;
- Ferdman and Gallegos's (2001, 2012) Latino/a American identity development model; and
- Horse's (2012) Native American identity development model.

We also highlight White racial identity development, which explains how living in a predominantly White society affects White Americans. Two White racial identity development models are summarized:

- Hardiman's (1982) White identity development model, and
- Helms's (1984, 1993, 1995) White identity development model.

A new development in the literature includes explanations of multiracial and biracial identity development for people who come from more than one race. We highlight Wijeyesinghe and Jackson's (2012) model that describes racial identity for multiracial individuals.

Racial–Cultural Identity Development Model for People of Color

Atkinson, Morten, and Sue's (1998) five-stage minority identity development model, which was later revised and labeled the *racial/cultural identity development model*, was one of the first to focus on the collective racial identity of people of color (i.e., African Americans, Asian Americans, Latino/a Americans, and Native Americans). It is considered the foundational racial identity model that examines the experiences of people of color. The following summary provides an overview of each of the five stages:

1. *Conformity.* Individuals in this stage have internalized racism. They idealize White culture at the expense of their own racial identity. Negative stereotypes about their racial group and other minority racial groups have been internalized. Persons in this stage lack a desire to learn about or maintain their own cultural heritage.
2. *Dissonance.* Personal experiences lead individuals to question their once unwavering commitment to the White dominant culture's worldview. Individuals begin to take an interest in their own racial or ethnic group.
3. *Resistance and immersion.* Individuals begin to reject White cultural worldviews and immerse themselves in their own racial or ethnic identity. There is increased interest in learning about one's own racial or ethnic identity, which leads to the formation of a new identity.

4. *Introspection.* Individuals begin to seek ways to integrate their new identity into the dominant culture without sacrificing their own racial or ethnic identity.
5. *Synergistic articulation and awareness.* Individuals are able to balance their new identity with other aspects of their identity. There is an appreciation for all groups and a full acceptance of oneself.

Cross and Fhagen-Smith's Black Identity Development Model

Many models of Black identity development exist (Helms, 1993; Jackson, 2012; Thomas, 1971). Cross's (1991) *nigrescence model* is arguably one of the most well known. The term *nigrescence* is a French term meaning the "process of becoming Black" (Cross, 1991, p. 147). Cross's early descriptions of Black identity development were "convergent," moving from a broad to a narrow focus in Black identity development and included five stages. Cross revised his 1991 model (Cross & Fhagen-Smith, 2001) to move from a broad focus to a narrow convergent focus midway in the Black identity development process and then toward a broader divergent focus at the highest stages. This revised model included four stages and introduced three key concepts that define Black racial identity: (a) *personal identity*, the traits and characteristics that make up an individual's personality; (b) *reference group orientation*, how a person sees the world and the values a person holds; and (c) *race salience*, the degree to which race is important in a person's life.

Cross and Fhagen-Smith (2001) elaborated on the nigrescence model by integrating a life span perspective that considers Black racial identity development from infancy to adulthood. They referred to Black racial identity as sectors rather than stages. This particular model of Black identity identified three key patterns: (a) *Nigrescence Pattern A*, which describes how individuals form a Black racial identity as a result of interaction with family, friends, and significant others throughout the life span; (b) *Nigrescence Pattern B*, the development of a healthy Black racial identity in later adulthood even when individuals lacked the opportunity to develop a Black racial identity in the formative years; and (c) *Nigrescence Pattern C*, the development of a more complex Black racial identity that evolves during later adulthood.

The Cross and Fhagen-Smith's (2001) model of Black racial identity includes six sectors that incorporate all three nigrescence patterns.

- *Sector 1: Infancy and childhood in early Black identity development.* Black racial identity is formed early in life through interaction with family, friends, school, church, and community events. Just as influential in the development of a Black racial identity are cultural traditions and class status of the family (Cross & Fhagen-Smith, 2001).
- *Sector 2: Preadolescence.* Low race salience, high race salience, and internalized racism emerge depending on how youth are socialized at home and in their community. Youth with low race salience have little to no interactions with parents or guardians about race and therefore do not attach significance to being Black. Youth with high race salience perceive being Black as important to their identity because pride in their race was instilled in them by their parents or guardians. High-race-salience youth are likely to develop a positive self-concept in later adulthood. Internalized racism occurs when Black youth develop hatred of themselves and their racial group as a result of seeing and experiencing negative messages about being Black within their own family unit. Fully developed Black racial identity does not develop until the adolescence stage.

- *Sector 3: Adolescence.* During a period of exploration and reflection, Black adolescents begin to form their own personal beliefs about their racial identity. This process involves reflecting on whether their understanding of their racial identity was formed based on their own beliefs or on other people's beliefs. Those with low race salience or internalized racism patterns maintain beliefs related to these patterns if their beliefs and assumptions are not challenged. Black adolescence with low race salience seek to understand the nonrace aspects of their identity. Those who have internalized racism continue to hold negative beliefs and stereotypes of their own racial group.
- *Sector 4: Early adulthood.* Individuals with high race salience have an established reference group orientation that values Black culture. Those who developed a low race salience do not see race as significant to their life as adults; they see other aspects of their identity as more important. Young African American adults with low internalized racism continue to maintain negative beliefs of their racial group held earlier in their lives.
- *Sector 5: Adult nigrescence.* This sector incorporates Cross's (1991) original model of nigrescence and consists of four stages:

  1. *Preencounter:* Individuals with low race salience assimilate into mainstream culture whereas those with internalized racism hold anti-Black sentiments.
  2. *Encounter:* Individuals experience an event that causes them to question previously held beliefs about their racial identity.
  3. *Immersion-emersion:* Individuals begin this stage by completely immersing themselves in the Black community without a clear understanding of the Black identity they want to assume; they come out of this stage with a more balanced perspective of their racial identity.
  4. *Internalization:* Individuals develop a more defined and secure sense of Black racial identity. They either develop a Black nationalist identity (being Black is the most important identity and they promote causes that support the Black community); a bicultural identity (individuals integrate their Black identity with their dominant group identity into one identity); or a multicultural identity (being Black is just one of many aspects of their identity).

- *Sector 6: Nigrescence recycling.* Throughout adulthood African Americans encounter personal and professional events or situations that cause them to reflect and question their Black racial identity. These situations can lead individuals to reach a complex understanding of their racial identity.

Kim's Asian American Identity Development Model

Racial identity models pertaining to Asian Americans are not as well known as those relating to Black identity (Sue & Sue, 2013). In a review of the literature, we noticed that Asian American identity development models tended to describe both the ethnic and racial identity experiences of specific Asian American groups such as Japanese Americans. This seems to suggest how intertwined race and ethnicity are to the Asian American experience. Whereas each of these Asian ethnic groups may have similar racial experiences, their ethnic cultures are vastly different from one another. Caution should be taken when examining particular Asian American identity development models so that generalizations are not made to other Asian American ethnic groups such as Vietnamese Americans, Laotian Americans, and Filipino Americans.

Kim's (1981, 2001, 2012) qualitative research on Japanese American women led to a five-stage model of Asian American racial identity development. Kim described an Asian

American identity development model in which conflict is resolved in a five-stage progression from a negative self-concept and identity confusion to a positive self-concept and positive identification with being Asian American. In her most recent model Kim (2012) found the following factors to be influential to Asian American racial identity development:

- *social environment:* family, school, social political movements, campus politics, Asian American community;
- *critical factors:* participation in ethnic activities, contact with Whites, awareness of racism and political consciousness, immersion in Asian American experience, clear and firm Asian American identity;
- *self-concept:* positive, neutral, or negative self-concept;
- *ego identity:* participation leads to a clear or unclear sense of their Asian heritage;
- *primary reference group:* family, Whites and dominant society, people with similar political views, and Asian Americans at similar stages of racial identity development; and
- *hallmark of the stage:* major themes within each stage of identity.

The salience of racial and ethnic identity is based on social context and can be explained in five stages (Kim, 2012):

1. *Ethnic awareness.* This stage begins at around 3 to 4 years of age where interaction with family first forms the individual's sense of ethnic identity.
2. *White identification.* This stage is often linked to the time when children begin attending school. A sense of being different tends to alienate Asian children from their own ethnic background. Peer influence leads individuals to develop negative views of their own racial group.
3. *Awakening to social political consciousness.* Increased political awareness leads to the realization that discrimination exists and that it is a result of societal infrastructures. Individuals shed previously held identification with White culture as they begin to understand oppression and its impact on oppressed groups. During this stage, individuals begin to form their racial identity.
4. *Redirection.* A sense of racial pride develops as individuals reconnect and recommit to their Asian heritage and culture. Individuals find support from their family, friends, and the Asian community. The belief that Whites and White supremacy are responsible for racism leads to negative attitudes toward White people.
5. *Incorporation.* Individuals have developed a positive Asian American identity and self-concept. There is also increased respect for other racial groups, including Whites. Being Asian is just one of many aspects of identity.

Ferdman and Gallegos's Latino/a American Identity Development Model

Ferdman and Gallegos (2001, 2012) developed a racial identity development model that described the process of Latino and Latina racial identity development. Their first model of Latino/a identity development (2001) focused on race in the United States. This model also focused on how Latino/a individuals perceived themselves in relation to others. The most current model incorporates the concept *ethnoracial* to emphasize the importance of both racial and ethnic identity development for Latino and Latina Americans. Their new model also examines how social context plays a role in the development of a Latino and Latina racial identity.

Instead of referring to stages of racial identity, Ferdman and Gallegos (2001, 2012) identified six orientations that serve as a lens to describe the process of achieving a healthy

Latino/a racial identity. Each orientation is influenced by the context and the particular situation. Each orientation is influenced by the following factors:

- *lens:* how one views identity,
- *identity (self):* how individuals identify themselves,
- *view of Latino/as :* how Latino/as are seen as a group,
- *view of Whites:* how Whites are seen as a group,
- *framing of race:* how race is understood,
- *key challenges:* main challenge(s) to be addressed,
- *most adaptive for:* what environments or situations are best situated for each orientation,
- *behavioral manifestations:* how a person lives his or her daily life, and
- *limitations:* the limitations inherent within each orientation.

The six orientations are summarized in the following list:

- *Latino integrated:* Being Latino/a is just as important as other dimensions of identity. Individuals have a good understanding of how race, gender, sexual orientation, class status, disabilities, and religion are socially constructed. They also stand up against social injustices.
- *Latino identified:* Individuals hold a pan-Latino/a identity. As a group Latino/as are seen as a unified racial group regardless of ethnic background. There is an emphasis on developing unity and connection among various Latino/a groups.
- *Subgroup identified:* Persons identify solely within their Latino/a subgroup (Puerto Rican, Mexican, Cuban, etc.) and may view other Latino/a subgroups as inferior. There is a strong connection with one's country of origin. Ethnic group identity is more important than racial group identity.
- *Latino as other:* Individuals see themselves as Latino/as but do not really understand what it means to be a person of color in a predominantly White society. They lack a deep understanding of their cultural heritage.
- *Undifferentiated/denial:* Individuals are indifferent to issues of race and tend not to see cultural or ethnic differences. Latino/as at this orientation have a color-blind view of the world in which race is not a factor in interactions with others. There is a lack of connection with other Latino/as .
- *White identified:* Latino/as are assimilated into dominant White culture and ideology. Individuals see themselves as White and view the world through the White cultural lens. They view their racial group and other people of color as inferior to the White racial group.

Horse's Native American Identity Development Model

Horse (2012) identified three labels commonly used to refer to aboriginal peoples of America: Native American, Indian, and Indian American. Each of these descriptors is used interchangeably in the literature. Horse (2001) identified five psychosocial influences that affect American Indian consciousness:

- knowledge of one's native language and culture,
- the validity of one's genealogical heritage as Indian,
- adoption of an Indian worldview that respects Native traditions and philosophies,
- the degree to which a person identifies as Indian, and
- one's status as a member of an officially recognized Indian tribe.

Horse (2012) believed that the need to maintain an Indian identity is becoming increasingly important because Native elders are dying and the multicultural and technological world is rapidly changing. Both the past and the present inform and influence American Indian identity. Horse highlighted five areas of consciousness that are expected to influence American Indian identity in the 21st century:

- *Eras of change in Indian consciousness.* American Indian consciousness is shaped by tribal histories and cultures, and it is indelibly connected to their past (Horse, 2012). American Indian cultures can be understood through different eras: (a) the first era or epoch, when Indians were free and before non-Indians came to North America, (b) the second era, beginning with the U.S. Declaration of Independence and westward expansion, (c) the third era covered the latter part of the nineteenth century, when the U.S. government declared Indians as "domestic dependent nations" (Horse, 2012, p. 110), and (d) the new era which encompasses the twenty-first century, where American Indians strive for more independence from the U.S. government.
- *Orientation to race consciousness.* Race did not enter the minds of American Indians until White explorers came to America. Individual, social–cultural, and institutional forms of racism hindered American Indian development. Many American Indians view themselves as "the people" (Horse, 2012, p. 111) rather than as a race.
- *Orientation toward political consciousness.* The U.S. federal government recognizes American Indian tribes as sovereign nations with the right of self-governance. Being aware of the political struggles Indian tribes experience is important to understanding current political events. Understanding the political history of American Indians and relations with the U.S. government helps explain why American Indians mistrust the U.S. government.
- *Orientation toward linguistic consciousness.* The ability to speak their native language allows American Indians to connect to their past and to maintain their cultural heritage. The struggle for new generations of American Indians is to maintain their native language. Most native speakers are middle-aged or older and many do not hold academic degrees. As elders pass, so too will their native language; it may in fact become extinct.
- *Orientation toward cultural consciousness.* Language and culture are intertwined; both shape American Indian identity. Maintaining cultural traditions in an ever-changing world will be the challenge for new generations of American Indians.

Hardiman's White Identity Development Model

Hardiman (1982) examined race and gender issues in the context of social identity theory in a five-stage White identity model. She was one of the first to examine White identity development and White privilege in the United States. Social identity includes conscious or unconscious membership that contributes to a person's conception of herself or himself. Hardiman looked at gender, occupation, religion, and White racial identity as contributing to that self-perception. She drew on the autobiographies of four White females and two White males to develop her White racial identity development model:

Stage 1: No Social Consciousness

In the first stage (birth to about age 4 or 5 years), individuals operate naively from their own needs and do not recognize or accept the restrictions of any particular social role; they can be presumed to act spontaneously or independently.

Stage 2: Acceptance

This transition period (which lasts until adulthood) is one of acceptance and role learning; the person is suddenly aware of her or his social role based on the White dominant culture's worldview and conforms to that role.

Stage 3: Resistance

This stage results in critical analysis of restrictions imposed by the social role resulting in rebellion and some rejection of social pressure to conform from others who share the same social role. Individuals resist the "myths" they had learned and experience an emotionally painful reaction to their own "Whiteness."

Stage 4: Redefinition

The rules of the person's social role are adapted to fit the circumstances and rediscover the importance of that social role in this new personalized context. This stage involves redefining one's White identity in a more positive direction, acknowledging both strengths and limitations.

Stage 5: Internalization

The individual integrates insights from the previous four stages into a newly defined social role or identity. White individuals in this stage have internalized and established this new identity as their own.

Helms's White Identity Development Model

Helms's (1984, 1993, 1995) model of White identity development is more widely known in the counseling and psychology literature than Hardiman's (1982). Helms's White identity model is also one of the most robust models because it has gone through empirical testing (Helms & Carter, 1990). Like Hardiman's model, Helms's White identity development model was constructed to understand how White Americans maintain racism.

Helms's (1984, 1993, 1995) White identity model includes six statuses and two phases. (Rather than use the term *stage*, Helms decided to use *statuses* to imply that racial identity did not occur in a stagelike linear fashion.) Her original model referred to the process of White racial identity development as stages. Helms believed White individuals develop a healthy racial identity when they move through two phases: (a) the abandonment of racism phase, the process of moving from being unaware of their role in racism to becoming cognizant of how Whites as a group are responsible for racism; and (b) the evolution of a nonracist White identity phase, during which White individuals spend time reflecting on whether it is possible to be White without being racist. White individuals attempt to construct a racial identity that is more positive and that is free of racism.

The following are the six statuses of Helms's White identity development model:

1. *Contact status.* White people are oblivious to race and issues of racism. As a result of limited exposure to people of color, White individuals believe that all people are treated equally, that society is color-blind, and that all people can succeed if they work hard enough. There is a conscious and unconscious belief that racial differences do not exist and a naïve acceptance of White dominant group ideologies that view people of color as inferior.
2. *Disintegration status.* Inner turmoil is common because of unresolved racial dilemmas and conflicting beliefs about race and White privilege. For example, individuals may believe they are not racist while at the same time assume that a group of Black males

are athletes. Individuals begin to recognize themselves as part of a White racial group and the benefits they receive as a result of White privilege. This realization often leads to feelings of guilt and helplessness. To deal with these feelings, White individuals avoid interacting with people of color, attempt to avoid discussions about race, and seek reassurance from others that White people are not responsible for racism.

3. *Reintegration status.* Individuals believe in White superiority when the guilt and self-blame they experienced turns into anger and aggressiveness. Persons idealize White culture to the point where they view White individuals as superior to people of color. This attitude leads to intolerance toward people of color; it might be expressed as "I am successful because of hard work and people of color can become successful too if they just stop complaining and work hard."
4. *Pseudoindependence status.* Individuals make an effort to define a nonracist White identity. Responsibility for racism is acknowledged and an alternative nonracist identity is sought out. People enter this status because of encounters that propel them from the reintegration status. White individuals recognize that people of color are often unfairly treated, and they feel discomfort because they are White and have unearned privilege. This attitude leads White individuals to have more interactions with people of color and less interaction with other White individuals.
5. *Immersion–emersion status.* Individuals engage in the hard work of developing a new identity and gathering accurate information on what it means to be White. Individuals explore what it means to live in a predominately White society and the various ways one benefits from White privilege. Confronting one's own biases as well as other people's prejudices is common during this time.
6. *Autonomy status.* Individuals experience less White guilt and have a firm awareness and understanding of what being White means. There is knowledge of racism and a natural tendency to combat racism in all of its forms. The end goal is openness and flexibility through self-actualization.

Multiracial Identity Development Models

The scholarly literature on biracial and multiracial identity development is leaner than the literature on other racial identity development models. Poston (1990) and Root (1990) developed the first publications on healthy biracial identity development (Renn, 2008). Both models were significant because they addressed prevailing attitudes that biracial and multiracial people were not able to develop a healthy self-concept. Biracial and multiracial individuals were viewed as "confused, distraught, and unable to fit in anywhere in the American racial landscape" (Wijeyesinghe, 2001, p. 131).

Wijeyesinghe (2012) identified the following core characteristics important to understanding multiracial theory:

- *Emergence: When and why.* Research on multiracial people emerged in the late 1980s and early 1990s (Wijeyesinghe, 2012). In terms of intersectionality of identity, scholars did not consider how race, class, and gender merged at the time even though multiracial people existed.
- *Identity: Holistic and multiply influenced.* Early beliefs about multiracial people discussed how they had an "either–or" (Wijeyesinghe, 2012, p. 85) experience in which they had to choose among their identities. Multiracial theory gave way to a new more holistic identity that allowed for the integration of all dimensions of their iden-

tity. Individuals encompass identities of both power and marginalization; they can be members of both dominant and target groups. For example, a Black–White biracial person can experience both oppression and White privilege.

- *Identity: Fluid and changing over time.* Identity is a dynamic process that continually evolves over time. Sociopolitical factors often influence the salience of identities at different periods in a person's life.
- *Whose voices and how to hear them.* Qualitative research allows for the voices and lived experiences of multiracial individuals to be heard.
- *Linking theory to social change.* The literature on multiracial and intersectionality changes society's understanding of multiracial people, which in turn, can lead to important education, advocacy, and social policies that support multiracial people.

The factor model of multiracial identity (FMMI; Wijeyesinghe, 2001; Wijeyesinghe & Jackson, 2012) is centered on the assumption that people make a choice when they determine their identity. The choice made by multiracial people regarding their identity is also influenced by the social and political landscape. A light-skinned person with blonde hair may identify as Native American whereas society perceives the person as White. The FMMI model identifies seven factors that affect choice of racial identity. Each of these factors is defined individually, but they are all interrelated.

- *Racial ancestry.* Individuals of multiracial descent may determine their racial identity according to their family racial ancestry.
- *Early experiences and socialization.* Early life experiences and interactions with family and friends provide multiracial people with overt and covert messages regarding their racial identity. These messages can be a combination of positive and negative messages about their racial identity.
- *Cultural attachment.* Being exposed to cultural traditions and practices can influence multiracial people's choice of racial identity.
- *Physical appearance.* Physical appearance influences how multiracial peoples choose their racial identity. Wijeyesinghe and Jackson (2012) argued that

> skin color and tone, hair color and texture, eye color and shape, size and shape of facial features, and body structure are used by the general public and society to make assumptions about people's racial ancestry, racial group membership, and racial identity. (p. 89)

Physical appearance can be used to help determine a person's racial identity, or it can serve as a barrier to a person's choice of racial identity. For example, people who fit into society's image of what an Asian person looks like may have less difficulty identifying with being Asian than a person who identifies as Asian but has blonde hair.

- *Political awareness and orientation.* Awareness and experiences with issues of race and racism can also influence a person's choice of racial identity. Sometimes multiracial people choose a particular racial identity for political purposes.
- *Other social identities.* Other dimensions of identity such as gender, class, sexual orientation, religion, age, and disability status also influence a person's racial identity. For some, racial identity may not be as salient as gender based on personal experiences and circumstances.
- *Spirituality.* People who are spiritual may use their spirituality to help them understand issues of race, racism, and racial identity.

Sexual Identity Development Models

Sexual identity development models evolved out of the research on racial identity development. Theories of sexual identity development examine how living in a predominantly homophobic and heterosexual world affects the development of one's sexual identity. Most sexual identity development models describe the process of lesbian and gay identity development. The first two sexual identity development models presented in this section focus on the experiences of gay men and lesbian women rather than bisexual individuals; we discuss the latter group separately because the group faces unique challenges. It is important to note that these models on sexual identity development refer to adults and not youth.

Lesbian and Gay Identity Development Models

The Cass Model

Australian psychologist Vivienne Cass (1979, 1984) was one of the first to publish studies about lesbian and gay identity using her clinical work with lesbian women and gay men. Cass's work was significant because it viewed lesbian and gay identity as a normal aspect of human growth and development. The common belief at the time, reflected in the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952), was that lesbian women and gay men were mentally ill.

Cass (1979, 1984) believed lesbian and gay identity to be a developmental process that was acquired based on the interaction of individuals and their environment. She proposed a six-stage model for the coming out process where individuals fully integrate a positive lesbian or gay identity into their self-concept:

1. *Identity confusion.* In this stage, individuals experience a sense of dissonance and confusion as they begin to question whether they are gay or lesbian. For the first time, they are aware that they have gay or lesbian thoughts, feelings, and attractions. This awareness often causes inner turmoil and confusion. Questions such as "Who am I?" and "Am I gay or lesbian?" surface during this stage of development as individuals attempt to understand their experiences.
2. *Identity comparison.* Individuals begin to realize that they might be gay or lesbian; they compare their experiences with those in the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) and heterosexual communities. Social alienation is common in this stage of development.
3. *Identity tolerance.* Individuals begin to tolerate but not fully accept their LGBTQ identity. Activities in this stage promote decreasing social isolation by immersing oneself in lesbian and gay communities. They may still view lesbian or gay individuals negatively because they have internalized homophobic attitudes; individuals may be "out" in their private life but not in their public life.
4. *Identity acceptance.* Individuals fully identify as LGBTQ; their private and public identities are increasingly congruent. Contact with and immersion within the lesbian and gay community continues to increase.
5. *Identity pride.* Dichotomous thinking is prevalent. Heterosexuals are viewed as the root cause of homophobia, biphobia, and heterosexism. This belief leads to an "us versus them" mentality that may seem to be militaristic by others. Anger is directed toward the heterosexual community and to those who do not support LGBTQ causes. Individuals have a strong desire to be "out" in both their private and personal lives.

6. *Identity synthesis.* Individuals integrate their sexual identity with other aspects of their identity. Being LGBTQ is viewed as only one aspect of the self.

Ritter and Terndrup's Phase Model

In order to simplify the various sexual identity models, Ritter and Terndrup (2002) identified key concepts from the Cass (1979), Coleman (1982), Grace (1992), and Troiden (1989) models and combined them into a single model having five phases:

1. *Phase 1: sensitization* (Troiden); pre-coming out (Coleman); emergence (Grace). This first phase involves dealing with client feelings of "estrangement, isolation, loneliness, and fear" (Ritter & Terndrup, 2002, p. 169). This includes treating depression, illness, suicidal ideation, isolation, and acting-out behaviors through interventions and other alleviation methods.
2. *Phase 2: identity confusion* (Cass, Troiden); identity comparison (Cass); coming out (Coleman); acknowledgement (Grace). Psychotherapeutic techniques more specifically begin to foster LGBTQ identity through challenging heterosexist assumptions that others hold in a client's life as well as those that have been internalized by the client. This stage lays the groundwork for approaching and unpacking Warner's (2002) concept of heteronormativity as it influences the client's life and well-being. At this stage, clients begin to accept the idea that they might identify as LGBTQ rather than as heterosexual.
3. *Phase 3: identity tolerance* (Cass); identity assumption (Troiden); exploration (Coleman); finding community (Grace). Through psychotherapeutic care and individual growth and exploration, clients are able to tolerate their new identity and accept themselves as probably LGBTQ. Clients are able to work with the counselor to explore past sexual encounters and attach LGBTQ meaning to these encounters.
4. *Phase 4: identity acceptance* (Cass); commitment (Troiden); first relationships (Coleman, Grace). Clients are supported in their engagement with and participation in LGBTQ subcultures and are referred to as *lesbian*, *gay*, *bisexual*, *transgender*, or *questioning*, which supports the development and consolidation of a healthy new identity.
5. *Phase 5: identity pride/synthesis* (Cass); integration (Coleman); self-definition and reintegration (Grace). Counselors and psychologists patiently guide any clients who are driven to act out in aggression against heterosexism in society, severing ties with the sexual majority, to a less hostile position. Counselors can work with clients to allow them to see that not all heterosexual individuals are against them and guide them to healthy participation in society.

Bisexual Identity Development Model

Bisexual individuals experience discrimination on all fronts. Heterosexuals and those in the lesbian and gay community often misunderstand the bisexual experience. Weinberg, Williams, and Pryor (1994) were the first to develop a model on bisexual identity based on interviews with bisexual individuals in the San Francisco area. Those interviewed indicated that they initially identified as heterosexuals and that over time they developed a bisexual identity. For men, having sex was more of a priority than falling in love; women reported the opposite priority.

Weinberg et al. (1994) conducted interviews that led to the creation of a four-stage bisexual identity development model. This model described bisexual individuals as being in a perpetual state of confusion over their bisexuality. Brown (2002) built on Weinberg et al.'s (1994) model by elaborating on the experiences of bisexual females and males. Brown's model of

bisexuality includes four stages. The first three stages are directly from Weinberg et al.'s model, and the fourth stage, "identity uncertainty," was renamed "identity maintenance":

1. *Initial confusion.* This stage can last for years if not a lifetime. Bisexual males experience conflict between gender roles and sexual feelings. Same-sex attractions may lead to anxiety because of the belief that their masculinity is being questioned. Bisexual women may feel intense emotional feelings for other women, but they may not act on these feelings in a sexual way. Both men and women fear that attraction to one sex will lead to un-attraction for the other sex. Self-identifying as heterosexual or as gay or lesbian rather than bisexual can lead to confusion. Difficulty acknowledging one's same-sex attraction can also lead to anxiety and further confusion.
2. *Finding and applying the label.* Individuals eventually explore their bisexuality either through intimate relationships with others or through connections with the bisexual community. Such experiences can lead individuals to accept or reject their bisexuality. Those who experience support are more inclined to identify as bisexual. Bisexual women might self-label as bisexual for political reasons and may be involved in romantic relationships with only one sex. Some bisexual women might identify as either lesbian or heterosexual to avoid labels of bisexuality because they fear stigmatization and rejection. Bisexual men might reject their bisexual identity because of threats to their masculinity and manhood.
3. *Settling into the identity.* People at this stage are more comfortable with their bisexual identity because of a strong support network. Individuals at this stage question whether bisexuality is a phase or a transition period. They also actively seek out relationships. Bisexual women seek emotional relationships with others whereas bisexual men will seek physical relationships with others.
4. *Identity maintenance.* Initially referred to as the "continued uncertainty" stage by Weinberg et al. (1994), individuals begin to engage in behaviors throughout the life span that help maintain a bisexual identity. Bisexual women may have "concomitant or serial relationships with members of both sexes" to maintain their bisexual identity (Brown, 2002, p. 84). Bisexual men may act upon their bisexual tendencies with members of both sexes before identifying themselves as bisexual. The lack of accurate knowledge regarding the bisexual experience and the complexity that comes with being in a relationship (e.g., jealousy and misunderstandings) can often lead to continued uncertainty for bisexual individuals at this stage.

Heterosexual Identity Development Model

When people think about sexual orientation, they tend to automatically think about LGB people first instead of heterosexuals, in part because heterosexuality is considered the norm in society. Heterosexual values, behaviors, and ideologies are so ingrained into the fabric of everyday life that they are rarely examined. As a result, heterosexuality and heterosexual privilege are rendered invisible. Research on heterosexual identity development is limited; thus, helping professionals have little to no understanding of heterosexual identity formation and its implication for counseling.

Models of heterosexual identity development evolved out of racial identity and LGB identity literature. Heterosexual identity development models explain how living in a predominantly homophobic and biphobic society influences the formation of a heterosexual identity. Such models are also useful because they shed light on heterosexual privilege and the development of heterosexual sexual identity (Worthington & Mohr, 2002).

Worthington, Savoy, Dillon, and Vernaglia (2002) developed a multidimensional model of heterosexual identity development built on earlier identity development models. Worthington et al.'s model considers biopsychosocial influences on sexual development and distinguishes between *sexual orientation* as "one's sexual predisposition" (p. 497) and *sexual identity* as "one's recognition and identification with such predispositions" (p. 497). Sexual orientation is something other than a choice, and sexual identity is something people "adopt" (Worthington et al., 2002, p. 497).

Worthington et al. (2002) identified the following biopsychosocial influences on heterosexual identity development:

- *Biology.* Sexual health, development, desire, behavior, reproduction, and orientation are all influenced to varying degrees by biological processes.
- *Microsocial context.* The values held by family, peers, coworkers, and neighbors provide the context in which identity is developed.
- *Gender norms and socialization.* Men and women are socialized to fulfill gender roles in society.
- *Culture.* Cultural context gives meaning to sexuality.
- *Religious orientation.* For many people, religious beliefs can influence sexual identity development.
- *Systematic homonegativity, sexual prejudice, and privilege.* Stereotypes, discrimination, and oppression combine to dehumanize LGB individuals and serve to benefit heterosexuals.

In Worthington et al.'s (2002) multidimensional model of heterosexual identity, individuals go through two processes: (a) an internal process that involves awareness and acceptance of one's "sexual needs, values, sexual orientation and preferences for activities, partner characteristics, and modes of sexual expression" (p. 510); and (b) an external process of developing a social identity where one begins to see oneself as a member of a heterosexual group that also shares similar attitudes about LGB individuals.

Worthington et al.'s (2002) multidimensional model of heterosexual identity model includes five identity developmental statuses that affect both internal and external processes. These statuses are also experienced in a circular fashion in that a status can be revisited at different points in a person's life.

1. *Unexplored commitment status.* People develop a heterosexual identity with very little if any conscious thought as a result of socialization from family and society. Heterosexuality is accepted as the norm. There is no conscious recognition of one's dominant status as heterosexual. At the group level, individuals conform to the heterosexual norms established in society. This means having negative attitudes and beliefs about LGB people.
2. *Active exploration status.* This involves intentional cognitive and behavioral "exploration, evaluation, or experimentation of one's sexual needs, values, orientation, and/or preferences for activities, partner characteristics, or modes of sexual expression" (Worthington et al., 2002, p. 516) at the individual identity level. Heterosexual norms are often questioned during this time. At the group level, individuals become aware of their unearned heterosexual privilege and either (a) question the fairness of this privileged status or (b) exercise their "rights" to this privilege. As individuals exit the active exploration status, they enter either the deepening commitment status or the diffusion status.

3. *Diffusion status.* Individuals do not involve themselves in exploration or commitment. Diffusion occurs because of a crisis and is connected to intense psychological distress. There may be active rejection of a heterosexual identity without much intentionality or thought into the consequences of one's actions. The pathway out of diffusion is active exploration.
4. *Deepening commitment status.* Individuals have a deeper understanding of their individual and group sexual identities. A more meaningful understanding of oneself as heterosexual develops. There is also an awareness of homophobia, biphobia, and heterosexism. Attitudes toward LGB individuals vary from supportive to unsupportive. Upon exiting this status, individuals enter either the synthesis, active exploration, or diffusion status.
5. *Synthesis status.* There is congruence between individual, group, and attitudes toward sexual minorities. This synergy of identities and attitudes converges as individuals form a holistic self-concept. There is a heightened level of maturity within this status.

Transgender Identity Development Model

Western medicine and psychology continue to pathologize transgender individuals as people with "mental illnesses and biological maladies" (Bilodeau, 2005, p. 30). The American Psychiatric Association (2013) recently addressed concerns that gender variant individuals were labeled as sick by changing some of the diagnostic criteria and renaming "gender identity disorder" to "gender dysphoria" in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.); nevertheless, this diagnostic classification still considers the individual and not the environment as the problem.

Models of transgender identity development, which describe the process individuals go through to identify as transgender, are in their infancy when compared with sexual identity development models. Renn and Bilodeau (2005) proposed that the process to fully developing a transgender identity is similar to the coming out process for LGB individuals. For gender-conforming people, developing a gender identity is a normal and often unconscious process because they conform to what is considered the norm in society. The process of gender identity development for gender variant people is one that has many challenges because of the lack of family and social support.

Bilodeau's (2005) transgender identity development model was built on D'Augelli's (1994) model of identity development and sexual orientation. Bilodeau's model describes transgender identity as a process that can be described in six categories (Process 1, Process 2, and so on). Having a supportive environment, being politically conscious, and being able to access community resources are important to developing a fully integrated transgender identity.

1. *Process 1: Exiting a traditionally gendered identity.* This involves being cognizant of one's gender and experiences with gender. Individuals identify as transgender and recognize that exiting a traditional gender identity is a lifelong process.
2. *Process 2: Developing a personal transgender identity.* Having positive role models and supportive people helps to foster a transgender identity. Interacting with other transgender individuals can help clarify questions about gender identity and nurture a deeper understanding of one's gender.
3. *Process 3: Developing a transgender social identity.* Surrounding oneself with a supportive group of people who know and accept the person's transgender identity is important during this time. Transgender resources and organizations in the community can be helpful in developing a support network.

4. *Process 4: Becoming a transgender offspring.* Transgender persons recognize that their gender identity may lead to isolation and to a mix of reactions from family. Some families support a person's transgender identity and some are unsupportive, which results in distant family relationships.
5. *Process 5: Developing a transgender intimacy status.* Being intimate with others is an important process to further understanding one's gender identity and sexual orientation. Individuals may experience either synergy or conflict with their gender identity and sexual orientation depending on their partner's support or lack thereof.
6. *Process 6: Entering a transgender community.* This process involves being committed to addressing societal barriers on the transgender community. Involvement in social advocacy can occur on an individual level or with organizations.

Intersection of Identities

A limitation of the models of identity development described in the preceding sections is that they examine only one dimension of identity. Race and sexual orientation are viewed through a single lens separate from other dimensions of identity. Compartmentalizing one dimension of identity while disregarding other equally important identity dimensions gives only a partial picture of a person. Another limitation is that identity development models are too linear and restrictive. People do not experience the world in a stagelike fashion. Human development issues are too complex to categorize into tightly packaged stages. Some may not identify with a particular stage within a particular model.

In this section we discuss the intersection of identities. We examine theories that explore how race, ethnicity, gender, sexual orientation, ability status, religion, and economic class converge at different points in a person's life. Being able to see when different dimensions of identity intersect allows one to see the relationship between each facet of identity.

Jones and McEwen's (2000) research on college women evolved out of the limitations they believed to be inherent in predominant identity development models. They argued that major identity development models were too linear and overly simplistic and that they did not fully capture all dimensions of human identity. Most models explored only one dimension of human diversity, such as race, which does not provide a comprehensive understanding of individuals. The dimensions that form human identity are not separate and disconnected parts (Jones & McEwen, 2000); rather, they are all interconnected and combine in equally meaningful ways to make up the whole person.

Jones and McEwen's (2000) research on the intersection and salience of identities led to the development of a nonlinear model of multiple dimensions of identity. Their research supported earlier identity development theories regarding the fluidity of identity and the influential role social context plays in identity development. In their research Jones and McEwen concluded that the salience of identity is dependent on whether an individual is a member of an oppressed group or whether he or she experiences being different among a group. For example, women and people of color tend to be more conscious of their gender and racial identity than White men. Being in settings where a particular dimension of identity is different from the crowd can also make that dimension of identity salient at that moment in time. For instance, a White individual may become conscious of being White if he or she is the only White person in a room of people of color.

Jones and McEwen (2000) created an atomlike conceptual illustration of the intersection and salience of the dimensions of identity.

- The nucleus of the atomlike structure, referred to as the *core*, represents a person's values, beliefs, and characteristics. This core is a participant's "inside self" or "inner identity" (p. 408), the dimensions of identity that others are not readily able to see or notice.
- Surrounding a person's core are "outside identities" (p. 408) such as race, class, gender, culture, and sexual orientation. Outside identities are essentially social constructs people use to categorize and label others. Participants found less meaning in their outside identities because they rarely addressed the true essence of their sense of self.
- The various dimensions of identity surrounding the core suggest that no one aspect of identity can be understood without the other. For example, race cannot be fully understood without also considering a person's ethnicity, gender, sexual orientation, religion, and class status.
- The placement of the various dimensions of identity around the core represents the salience of identity in a given situation. Dimensions of identity closest to the core represent aspects of identity a person is conscious of at that moment in time. Those furthest from the core reflect a dimension of identity a person is least conscious of at a given moment in time.
- The various dimensions of identity orbiting the core move around the nucleus to represent the dynamic nature of identity and how the salience of identities varies from one social setting and situation to the next.
- Surrounding the dimensions of identity is the social context. Identity is both internally defined by the individual and externally defined by society.

Conclusion

Theories of identity development have long established the importance of sociocultural contexts in identify formation. Early measures of identity were defined by the dominant culture, with oppressed populations having to either adapt to dominant group characteristics or suffer the consequences. The research on racial, ethnic, gender, and sexual orientation identity development has made a significant contribution to research on identity development generally. Although there are many differences across the various research models studying racial, ethnic, gender, and sexual orientation identity development, the general patterns apply across the various models.

First, there is a clear differentiation between lower and higher levels of development regarding the person's identity. This development is usually related to intentional or unintentional, conscious or unconscious, or articulate or inarticulate aspects of identity. In some cases, the lower levels of development correlate with measures of illness or personal inadequacy whereas higher levels of development correlate with healthy competent functioning.

Second, it is clear that culture relates to the process of personal identity development in profoundly meaningful ways. Culture, broadly defined, describes the significant experiences that lead the person to defined roles. It should be clear to the reader that measures of identity development that disregard cultural aspects are likely to be inaccurate and inadequate.

Oppressed client populations from at least the last 200 years in the United States began the process of reflecting on culture and identity issues in social, political, and economic situations. In most cases, these persons were not counselors or psychologists, although the implications of their ideas were certainly psychological. As we examine racial, ethnic, gender, and sexual orientation identity development as a process, it is

important to recognize that these ideas have a history that goes far beyond the last several decades.

The next section of the book explores practical ways counselors can develop into multicultural and social justice competent helping professionals. We discuss the importance of using appropriate terminology in counseling. We also introduce two inventories that can help counselors develop both multicultural and advocacy competence and discuss ways in which counselors can address any potential pitfalls with doing multicultural and social justice work.

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