

## Chapter 2

# Cultural Identity: Components and Assessment

The concept of cultural identity refers to familial and cultural dimensions of a person's identity, and how others perceive him or her, i.e., factors that are salient to a person's identity both as perceived by the individual and how others perceive the person's identity. Interest in understanding cultural identity began with the publication of Cross (1978) theory of nigrescence. This was a novel notion as previously identity was perceived as a unitary variable, and denoted a sense of belonging to a social setting (Stryker, 1987). Cross' (1978) model expanded our thinking to include (a) identity is influenced by positive or negative experiences in a social setting, especially for marginalized individuals, identity can get facilitated, or compromised; (b) it is possible for identity to evolve to higher levels of functioning in spite of challenging life experiences; and (c) the social construction of race, and the history of slavery, segregation, exclusion, and the negative sociopolitical history of a nation can negatively influence identity development with race-related trauma and stress over several generations (Ibrahim & Ohnishi, 2001; Pascoe & Smart Richman, 2009; Shin, 2015). Ibrahim (1993) anchors cultural identity within a person's primary cultural context, it includes ethnicity, gender and gender identity, spiritual assumptions, age and life stage, ability and disability status, family, community, and nation. Culture influences all these dimensions however; the effect varies across various dimensions, including life experiences and time. Hofstede (2001) states "culture is the collective programming of the mind that distinguishes the members of one group or category of people from others" (p. 10). This conception considers culture as a collective phenomenon; he allows that there can be as many different perspectives within each collective as there are individuals.

Hofstede adds that in general the term culture is used for tribes or ethnic groups (in anthropology), or nations (in political science, sociology and management), and for organizations (in sociology and management). The term culture can also be applied to gender, sexual orientation, generations, social classes, etc., although changing the level of aggregation studied can change the nature of the concept of "culture" (Hofstede, 2001; Ibrahim, 1984). Societal, national, and gender cultures

are acquired from early childhood, are deeply rooted in the psyche, and are usually acquired and held unconsciously. Given the implicit nature of culture, cultural identity assessment cannot be based on ethnicity alone, or cultural characteristics of a specific group (Ibrahim, 1991; Shin, 2015). Rather, the focus shifts to understanding the intersectionality of a client's various identities, and the meaning of the crisis the client faces in terms of what core values or worldview, and identities are affected (Conwill, 2015; Eklund, 2012; Ibrahim, 2007a, 2007b).

Given the ethical mandates and competency guidelines from mental health professional organizations, it is critical that we honor cultural identity in counseling interventions (American Counseling Association (ACA), 1992, 2014; American Psychiatric Association 2000, 2013a, 2013b, 2013c; American Psychological Association [APA], 2002, 2010; Leong, Leach, & Malikiosi-Loizos, 2012; National Association of Social Workers (NASW), 2008; American Association of Marriage and Family Therapy (AAMFT), 2012). The cultural assessment model presented in this text considers cultural identity multidimensional, and identifies several aspects of a person's identity, that may have different salience and relevance to the person depending on the issues they bring to counseling (Conwill, 2015; Ibrahim, 1991; Shin, 2015). Current thinking on identity has moved from single concept of identity to considering the intersections of identity, which is specifically relevant to counseling and psychotherapy (Ibrahim 1991, 2007a, 2007b; McDowell & Jeris, 2004). Conwill (2015) notes that the intersectionality perspective highlights the way in which there is a simultaneous interaction of discrimination that impinges upon multiple identities of an individual. Given such a conceptualization, it is easy to begin to see the interconnection between culture and power (Reyes Cruz & Sonn, 2015).

The Cultural Identity Check List-Revised© (Ibrahim, 2008) includes the following variables: Age, gender, cultural background, and religion/spirituality as identification variables. The exploration of cultural influences begins with racial/ethnic/national identity, migration or indigenous status, migration pattern of the client's cultural group, dominant or nondominant group status, sociopolitical history, gender, sexual orientation, socioeconomic status of family of origin and the client, religion or spirituality, educational level, birth order in the family of origin, the family the client grew up in (two parents, extended, blended, single parent), ability/disability status, region of the country/world client is from, and where the client resides now. These variables contribute to not only client experiences, but also how the therapist relates to the client. Each of these variables will be discussed in this chapter and why they are presented as relevant to cultural identity. In addition, approaching the client from the multidimensional identity perspective also helps in consideration of those aspects of cultural identity that are relevant to the presenting problem.

## Ethnicity

Globally and in US society the concept of ethnicity is gaining attention, as pluralism in societies increases due to economic globalization, and migrations due to wars and conflicts, along with issues of integration of the culturally different in monocultural

societies (Leong, Leach, & Malikiosi-Loizos, 2012; Organista, Marin, & Chun, 2009; Verkuyten, 2005). In the USA the growth of ethnic psychology has emerged as a major force, and continues to identify how ethnicity mediates behavior, even after several generations (McGoldrick, Giordano, & Garcia-Preto, 2005; Phinney & Ong, 2007).

Ethnicity is considered a multifaceted variable. An individual's self-identification can change depending on time and space, and the people in the person's environment at any given time (Huot & Rudman, 2010; Spencer, Dupree, & Hartmann, 1997; Thomas, Townsend, & Belgrave, 2003; Umaña-Taylor, 2011). Ethnic identity can be differently defined in various government agencies and states (Jackson, 2006). Many authors argue that it is the reference to descent and common origin that makes a group an ethnic group; it is this idea and belief that a common origin, descent, and history distinguish ethnic identity from other social identities (Verkuyten, 2005). The emphasis on origin and descent in identifying oneself as a member of a specific ethnic group comes from Weber (1968). Another perspective is that it is primarily the political community that dictates a common ethnicity (Verkuyten, 2005). This may be relevant to how different cultures define themselves, politically, instead of ethnically, as the founding fathers of the USA conceived of a new nation with specific ideals and goals, and conceived of a US identity, based on White Anglo Saxon values, distinct from any of the ethnic or national groups that migrated to the USA (Takaki, 1979).

In this context it is important to consider the concept of race, it is a concept that assumes that there are distinct human populations. Helms, Jernigan, and Mascher (2005) note that this is a concept that has no "consensual, theoretical, or scientific meaning in psychology" (p. 27). Racial classifications are rooted in the idea of biological classification of humans according to morphological features such as skin color or facial characteristics. However, biological sciences do not accept the concept of race either; it is considered a social construct that was created by humans and is maintained to create political and social hierarchies (Cavalli-Sforza, Menozzi, & Piazza, 1996; Long & Kittles, 2003). Ethnicity may be related to physical characteristics of people, however the concept does not refer to physical characteristics specifically; it identifies social-cultural traits that are shared by a group. Some traits used for ethnic classification include but are not limited to: nationality, tribe, religious faith, shared language, shared culture, and shared traditions.

According to Hutchinson and Smith (1996) ethnicity is characterized by a common or collective name, a myth of common ancestry or descent, memories of a common past or shared history, elements of common culture, linked with a specific homeland, and a sense of solidarity. Hylland Erickson (2002) considers ethnicity from an anthropological perspective and states "ethnicity is an aspect of social relationships between agents who consider themselves culturally distinctive from members of other groups with whom they have a minimum of regular interaction. It can thus also be defined as a social identity (based on contrast with others) characterized by metaphoric or fictive kinship," (p. 12). Verkuyten (2005) views ethnicity from a social psychological perspective, and states that ethnic identity is not simply the result of social assignments. He believes that ethnic identity is the result of interactions between the individual and society, and has three levels of analysis,

based on House's conception (1981), i.e., individual, interactive, and societal. The first level pertains to personal characteristics and refers to the self, sense of identity and cognitive structures. The interactive level is based on understanding emergence and maintenance of identity in situated interactions. The societal level refers to macrosocial variables of history, politics, ideology, culture, and economics. He maintains that it is in the interaction of all these levels that ethnic identity can be understood, and evaluated.

Ultimately, there are many ways to look at the concept of ethnicity. A common thread between all definitions is that it can be seen as a specific and distinct group, which has many common rituals, beliefs, ways of being, etc., and that it is part of a person's social identity. Beyond these three similarities between conceptions of what ethnicity is the opinion on what it means to be a part of an ethnic group or to define one's ethnicity varies widely in the literature. However, sociopolitical history, culture, economics, etc., all influence the development and maintenance of ethnic identity, and the interactions of all three levels result in an individual perception of ethnic identity.

Having a strong ethnic identity indicates that clients are deeply embedded in the rituals, beliefs, and ways of being of their cultural groups. Usually, very strong ethnic identities are found in recent immigrants or sojourners, because they may not have been exposed to other ethnic groups in their culture of origin. Ethnic identity of immigrants is reshaped over several generations, as each generation successively adapts to the host culture. When an ethnic group is excluded from integrating into mainstream society, due to perceived racial or religious differences, ethnic identity can become stronger, in spite of several generations in the USA, e.g., African Americans, Asian Americans, indigenous people of the USA, Mormons, Presbyterians, Muslims, and Jews (Organista et al., 2009).

In cross-cultural counseling encounters it is imperative that the clients are given the opportunity to describe their ethnicity and what they believe about how they are perceived. The US context also has multiracial identities, a term used to describe individuals who have parents from two different racial/ethnic groups (Root, 2000). Given the 400 years of mixing of cultural groups, the idea that only one ethnicity defines a person has been rejected. It is important to accept the client's self-definition and work on a supportive and caring therapeutic relationship. In addition, in counseling and psychotherapy it is necessary to analyze cultural beliefs and values held by clients as a defining variable to understand how their ethnic identity was formed interacting with their primary familial and cultural groups, and the social-cultural context in which they grew up and how their ethnic identity developed (Root, 2000). In addition, given the complexity of the US context, it is necessary to recognize that the worldview held by the client may not be defined by the last name. Taking the stance that the client is the expert on his or her ethnicity conveys respect and acceptance. It also precludes any assumptions the counselor may make about the client, which can lower trust and reduce the possibility of developing a positive and engaged therapeutic relationship.

## Age and Developmental Stage

It is important to consider the cognitive, affective, and physical development of the client in the context of developmental theories, and from the perspective of developmental counseling (Ivey, Ivey, Myers, & Sweeney, 2004). Being aware of developmental counseling approaches can be very useful for therapists. Developmental Counseling theory can guide the work we do with clients, as it pertains to their cultural identity. It can help complement cultural information that has been collected, and provide greater specificity in counseling and psychotherapy. Too long the counseling profession has been accused of working with generic counseling models that assume that theoretical frameworks that are available to us would work with every age and developmental stage. Age and development is also mediated by the primary cultural context, not by theoretical formulations offered by theorists who may not be from the client's cultural group. In the last 15 years with the advent of Developmental Counseling theory, and specific efforts by theorists and practitioners to consider age and development stage as critical variables, we have many more resources available to us for working with each generation (Ivey, Ivey, Myers, & Sweeney, 2004; Erikson, 1963, 1968, 1980).

Focusing on culture, age, and developmental stage become significant, because culturally, the expectations for age and developmental stage vary, although, this variable is neglected in training programs, and generic information does exist by ethnicity on expectations and norms for developmental stages, it is not given enough attention by professionals and its use in counseling interventions (Deal, 2000). Understanding normative expectations for each developmental stage by culture can help make interventions meaningful to clients, and reduce the chances of judgment and negative evaluation of clients by mainstream educated counselors and therapists (Baruth & Manning, 2011).

It is important for mental health professionals recognize that the social structure of the USA segregates people according to age, and this segregation leads to indifferent attitudes toward other generations from one's own (Jun, 2010). The social segregation creates distance between the generations leading to lack of empathy and connection. In recent years, attention has focused on age discrimination both for the older and the younger worker (Hartzler, 2003; Nelson, 2005; Rosigno, Mong, & Tester, 2007). Research shows that mental health, and medical professionals, along with educators hold negative stereotypes about older adults (Ivey, Wieling, & Harris, 2000; Pasupathi & Lockenhoff, 2002; Reyes-Ortiz, 1997; Williams, 2012). Some theorists posit that negative attitudes toward older adults may be due to threatening aspects of confronting one's own old age and possible fear of death (Edwards & Wetzler, 1998; Snyder & Meine, 1994).

Each stage of life presents opportunities and challenges, it is important for mental health professionals to be equipped with appropriate knowledge and skills to provide meaningful services to clients. It is important to understand age and stage of clients and have information about the opportunities and challenges that these

phases represent to provide services. The most vulnerable populations tend to be older adults and adolescents. The Centers for Disease Control assesses suicide rates per 100,000 people, and the last reported data were for 2011. The highest suicide rates in the nation tend to be for the 45–64 age range and the 85+ age range (18.6 for every 100,000), adolescents and young adults (ages 15–24) had a suicide rate of 11 for every 100,000 (Hoyert & Xu, 2012). In 2011, the highest suicide rate was among White Americans (11 for every 100,000), followed by Native Americans and Alaskan Natives (10.6), lower rates were reported, but roughly similar were reported for Asian American and Pacific Islanders (5.9), Black (5.3), and Hispanics (5.2). Since the CDC collects data separately on Hispanics as they may also be members of other cultural groups in the USA. Suicide rates for men tend to be four times higher than for women. In 2011, suicide rates were 78 % were men (20.2 per 100,000) and 21.5 % were women (5.4).

## Gender

Gender “refers to the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex. Behavior that is compatible with cultural expectations is referred to as gender-normative; behaviors that are viewed as incompatible with societal expectations constitute “gender non-conformity” (APA, 2011).” Gender identity is the internal experience of being either male, female, or transgendered. Usually, it is considered congruent with biological gender; however, as we learn more about transgendered identities, it is clear that in some cases it is not congruent with biological gender (APA, 2011; Gainor, 2000). Stewart and McDermott (2004) note “gender is increasingly recognized as defining a system of power relations embedded in other power relations. Psychological research on gender—which has most often focused on analysis of sex differences, within sex variability, and gender roles—has begun to incorporate this new understanding” (p. 519). They recommend drawing on three resources, to understand the significance of gender for psychological processes: social science theories that link the individual and social levels of analysis; constructs (such as identity) that bridge the social and individual levels; and conceptual tools generated in feminist theory, especially the intersections of aspects of identity.

The sociological perspective on gender refers to social expectations about behavior considered appropriate for members of a gender. It does not refer to the physical attributes on which men and women differ, but to socially formed traits of masculinity and femininity (Giddens, 1997). Gender is considered distinct from biological sex; it refers to the socially constructed categories of masculine and feminine that are differently defined in various cultures. Many contemporary theorists use a broader definition to refer to the set of beliefs and practices about male and female (or other genders), that not only feed into individual identities, and are fundamental to social institutions and symbolic systems (Bilton, Bonnett, Jones, Lawson et al., 2002). Smith and Chambers (2015) present a model for social justice alterity as it

pertains to nondominant ethnicity, age/life stage, or gender; this includes (a) identifying colonizing dominant discourses, (b) awareness of tacit collusion in dominant discourses, and (c) advocacy efforts to promote counter-discourses.

Within anthropology, gender is a specialized area of study that emerged in significance during the 1970s and is linked to the advent of the feminist movement. Early research focused on how and why women were subordinated in patriarchal social systems. This was followed by the recognition that men, too, have gender, and it led to a much deeper analysis of the ways in which definitions of gender were constructed (Collier & Rosaldo, 1981; Coltrane, 1994; Connell, 1995). Research focused on different societies produced a variety of religious, kinship, gender, and economic systems (Petchesky, 2000; Sargent & Brettell, 1996). It is generally assumed that sex is the natural given; and gender based on a cultural definition is built upon that base. Additional research raised questions about the relation between sex and sexual orientation, and whether there might be more than two genders, and whether sex itself may to a large extent be a social and cultural construct. Studies of primates, long thought to hold the key to human behavior, have shown results that depend to a significant extent on the theoretical lens through which scientists view their behavior, as well as on which primates are the object of study; these discoveries have destabilized the base on which many assumptions about gender exist. When the critical gender lens has been focused on the archaeological record, old biases and assumptions, such as “man the hunter, woman the gatherer,” have been overturned or significantly modified; new approaches to the study of the past and material culture have emerged (Paul, 2014).

Another area relevant to understanding gender in a cultural context comes from linguistic anthropology. This area of research focuses on gendered aspects of linguistic structure, for example, pronouns. It includes a study of the different ways in which women and men use language, to identify the extent to which gender is culturally constituted through linguistic practice over the life cycle. Other researchers have an interest in the way in which language applies connotations of gender to conceptual areas of study such as “soft” versus “hard” sciences, and how these labels may affect the gendered beings working within these fields. Gendered language and its impact on broader systems including worldviews, theology, and cosmology has also emerged, including the consequences for men and women when the deity is symbolically male and the earth is symbolically female (Eckert & McConnell, 2003).

Gender is not adequately addressed in the multicultural counseling literature. Historically in the counseling literature analysis of various cultural groups have focused on generic variables in terms of values, beliefs, assumptions, rituals, life cycle tasks, developmental markers, etc., of different cultures. The focus has been on considering similarity and differences among cultures (Baruth & Manning, 2011; McGoldrick et al., 2005; Sue & Sue, 2013). Gender, however, within each culture has specific meaning that may not emerge as a result of a global analysis of a culture. Although, most cultures of the world appear to be patriarchal, the world of men and women and their socialization tends to be different within social-cultural contexts. Gender roles, and power within a cultural system are influenced by the



cultural context including the domains of influence that are allowed for each gender (Carli, 2001; Falbo, 1977). Understanding gender as a social construct helps in not pathologizing the client, or considering the client as resistant to change, it can also prevent misinterpretation of cultural conceptualizations and cultural malpractice (Dana, 1998). Smith and Chambers (2015) present a model for social justice alterity as it pertains to nondominant ethnicity, age/life stage, or gender; this includes (a) identifying colonizing dominant discourses, (b) awareness of tacit collusion in dominant discourses, and (c) advocacy efforts to promote counter-discourses.

## ***Gender Identity***

Money (1973) was the first person to define gender identity as composed of three distinct aspects: gender role—the external presentation of gender, gender identity—the internal experience of gender, and core gender identity (the developmental process of the identity that begins around 18 months of age). LaTorre (1976) notes that gender identity can be understood as composed of several parts, and these parts are described differently by theorists; however, there is considerable overlap among the categories subsumed within gender identity. Gender identity is differentiated from biological gender. Gender identity is a sense of awareness, usually beginning in infancy, continuing throughout childhood, and reaching maturity in adolescence, of being male or female. Barker and Kuiper (2003) note that gender identity is “the degree to which an individual takes on the behaviors, personality patterns, and attitudes that are usually associated with male or female *sex roles*” (p. 394). It can be consistent with biological sex, but it does not necessarily have to be, as is the case with people who identify with the other sex. Eagly (2009) emphasizes that gender role beliefs are both descriptive and prescriptive; they identify what men and women usually do, and what they should do. According to her, the descriptive aspects of gender role identify what is expected and are stereotypes about what is typical behavior for a specific gender. The prescriptive aspect of gender roles defines what is worthy of admiration within a culture. This is behavior that is executed to gain social approval and increase self-esteem. In addition, according to Eagly, gender role beliefs are derived from the cultural context and provide a template for culturally normative behavior, and are internalized as gender identities that enact personal dispositions. Studies of gender stereotypes show two main themes ascribed to male and female gender roles and these are communion and agency, with communion being ascribed to women and agency to men, and this appears to be a worldwide phenomenon (Kite, Deaux, & Haines, 2008; Williams & Best, 1990).

In the past psychiatry has considered gender identity when inconsistent from biological gender as pathology. However, it is accepted in psychological circles that gender identity can vary from the defined biological gender, without pathology. Social justice psychological theorists do not accept the pathology assumption, and note that if there is any, it is not the result of a neurological or biological deficit, but the result of societal emotional abuse, and victimization due to not subscribing to



descriptive or prescriptive gendered behaviors (Higgins, Barker, & Begley, 2008; Ibrahim & Ohnishi, 2001; Ohnishi, Ibrahim, & Gzregorek, 2006). Stress, trauma, and emotional abuse over the lifespan can lead to severe anxiety, depression, and other psychological problems (Pascoe & Smart Richman, 2009). This analysis points to the need for understanding the issues clients may face in their primary cultural and familial contexts, it clearly shows how oppression and victimization of people can occur in their familial, social, and occupational worlds, creating a need for social justice training on issues of privilege, oppression, and advocacy.

## ***Transgender Identity***

A case of gender identity that has not been adequately addressed in the psychological literature pertains to transgendered individuals (Garrett, 2004; Mizock & Lewis, 2008). Transgendered people do not accept their biological gender as their gender identity or outward gender expression (Mizock & Fleming, 2011). Usually, transgendered individuals are misclassified as delusional primarily due to the DSM-IV-TR label of Gender Identity Disorder (American Psychiatric Association, 2000). Although, the DSM-IV-TR clearly differentiates between gender identity and delusional disorders, the label of disorder creates a confusion for the professional. Further, the psychological literature identifies that cultural competence for working with transgendered clients is not the focus in psychology training programs (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Russell & Horne, 2009). Bockting, Benner, and Coleman (2009) appropriately notes in response to the DSM-IV-TR categorization in the editorial to a special issue of *Sexual Relationship Therapy* (2009):

The disease-based model assumes that normative gender identity development has been compromised and that establishing congruence between biological sex can alleviate the associated distress, gender identity and gender role, if necessary through hormonal and surgical sex reassignment. The identity-based model assumes that gender variance is merely an example of human diversity and that the distress transgender individuals might experience results from social stigma attached to gender variance (p. 103).

In the recent revision of the DSM (5th ed., APA, 2013), this category has been redefined as Gender Dysphoria. The insistence on bringing biological gender into congruence with normative beliefs is an index of societal oppression and emotional abuse that overtime, given the accumulated stress may lead to psychological problems that may have nothing to do with being transgendered; given the heterosexist emphasis in most societies, and especially in the West and the USA. The APA Task Force on Gender Identity and Gender Variance (2008) notes:

The concerns of transgender and gender variant persons are inextricably tied to issues of social justice, which have historically been important to APA. The stigmatization and discrimination experienced by transgender people affect virtually all aspects of their lives, including physical safety, psychological wellbeing, access to services, and basic human rights. The Task Force report highlights opportunities for APA to advance social justice, as well as to support competent and ethical practice, by promoting research, education, and

professional development concerning transgender issues among psychologists; by creating a welcoming environment for transgender psychologists and students of psychology; and by supporting the human rights of all transgender citizens (p. 10)

This population is highly vulnerable to social exclusion and isolation, we recommend that initial client assessment needs to take into account relationship history, social support, privilege and oppression of clients and the impact on psychological adjustment prior to establishing therapeutic goals. Ethically, it is important that therapists get supervision and training in working with gender variant individuals, and reflect on their learned biases and feelings toward this vulnerable population (APA, 2009). Recently there has been progress in identifying the exclusion and stressors faced by transgendered individuals as exemplified by the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force *Survey on Transgender Discrimination* (2011), along with an earlier report on trans health priorities to eliminate health disparities (Xavier et al., 2004). Another positive outcome as a result of the Affordable Health Care Act (US Department of Health & Human Services (HHS.give/HealthCare), 2010) is the ban on sex discrimination in many health care facilities and programs, and has led to the publication of *Health care rights and transgender people* by NCTE in March 2012.

## Sexual Orientation

Sexual orientation is important in understanding the impact of the intersection of multiple identities held by individuals, as it creates another category, where privilege and oppression function without recognition by most professionals. We live in a very heterosexist world (APA, 2009) and majority of the world religions with the largest following hold a negative perspective on any sexual behavior that is not in the service of procreation of the species. The norms established for gender roles also overlap with sexual orientation. Behaving in a culturally or socially inconsistent manner with regard to culturally accepted sexual norms leads to victimization and oppressive behavior, exclusion, and emotional abuse. The Institute of Medicine (2011) in their report on Lesbian Gay Bisexual and Transgendered (LGBT) health note that it is important to consider the contextual factors that impact the lives of GLBT groups, including sociopolitical history, societal and religious stigmas, laws and policies, demographic factors, and barriers to care. Gay, Lesbian, and Bisexual individuals are defined by their sexual orientation. Meanwhile transsexual individuals are defined by their gender identity and presentation. The LGBT umbrella is a loose coalition of four distinct and diverse groups. However, they also have commonalities in terms of stigmatization, exclusion, and oppression.

Since the 1970s several models of homosexual identity development have been proposed. These include stage models (Cass, 1979, 1984; Fassinger, 1991; Savin-Williams, 1988, 1990; Troiden, 1979, 1988); theories specific to Bisexual (Fox, 1995; Klein, 1990, 1993), Lesbian (Brown, 1995; Sears, 1989), and nondominant LGBT populations (Boykin, 1996; Crow, Brown, & Wright, 1997; Diaz, 1997;

Espin, 1993; Manalansan, 1993; Wilson, 1996); and lifespan approach to LGBT identity development (D'Augelli, 1994). The stage models did not address the intersectionality of identities, or the multiple influences that impinge upon identity development within a cultural context. However, lifespan development and theories addressing lesbian, bisexual, and nondominant groups identity development theories offer approaches that take into account the multiple factors that impinge upon identity, along with contextual factors (Bilodeau & Renn, 2005; Eklund, 2012). Shin (2015) notes that critical consciousness and intersectionality can be useful tools in decolonizing identity development models. Further, Smith (2015) recommends that it is time to “queer” the multicultural counseling paradigm by “examining taken-for-granted assumptions within the paradigm, challenging the status quo of multicultural competence, deconstructing hegemonic practices, and promoting critical consciousness” (p. 25).

## Cultural Background

It is important to understand how the client perceives his or her cultural identity, recognizing the vital aspects of identity and how the client wishes to be perceived (Castillo, 1996). Accepting the client's evaluation of his or her own cultural identity is critical to the process of developing a therapeutic relationship. Hipolito-Delgado (2007) reported on a study of Latino/a college students that several students preferred Hispanic, Latino/a, or Chicano/a as their cultural identity, instead of the politically accepted term Hispanic. Therapists need to respect clients' preferred self-definition and cultural identity, if they hope to develop a working alliance with the client (Dana, 1998).

Castillo (1996) recommends always conducting a cultural identity assessment to understand the meaning of the presenting problem, and the implications of the presenting problem for the client. He also recommends seeking input from the client on what would be the resolution to the dilemma. During the process of counseling or psychotherapy, it may be necessary to correct some of the assumptions by identifying what the clients believe about their cultural background and the influence or lack of it on their cultural identity, especially when negative stereotypes are internalized and accepted (Knapp, Lemoncelli, & VandeCreek, 2010).

## Migration Status

The USA, along with a few other countries, such as Australia, Canada, New Zealand, and South Africa, have a sociopolitical history, where indigenous people were outnumbered by immigrants, who were culturally very different from the native people. Although similar attempts were made by other colonial powers, none were as successful as the Western European immigrants in the four nations mentioned above.

The sociopolitical changes that occurred in these cultures made the culture of the colonial rulers the norm, due to the large numbers, and the power they held as invaders of these lands (Diamond, 1999). Understanding migration status, and its impact on identity is much more complex for people who have colonial ancestors, and now constitute the dominant cultural group, due to several hundred years of residence. The Europeans who settled in these lands believe they are indigenous to these societies. If the indigenous populations had not survived, or not retained their culture, languages, rituals, etc., it would have been easier to understand the stance taken by several generations of immigrants, over the last 250–400 years in these societies. There is considerable shame and anxiety when issues of culture, and sociopolitical history are brought up for the dominant groups, due to abuse, extermination, exclusion, forced poverty and lack of opportunities, and several other violations that indigenous populations have undergone. Reyes Cruz and Sonn (2015) note that Western thought has been characterized by dichotomous thinking, and this worldview would have been one of many in general, except for the globalization of the European colonialization that began with the Americas. This movement also led to a “the imposition of a hierarchical articulation of difference (e.g., “civilized/uncivilized,” “modern/primitive,” “expert knowledge/general knowledge,” “development/underdevelopment,” “saved/condemn,” “European/Other,” “White/Other”) to the benefit of the ruling classes” (p. 128). Further Reyes Cruz and Sonn identify that coloniality shaped culture and as a result identity, and positioned the West as the only standard of civilization, paving the way for oppression and marginalization. For mental health professionals who are from the dominant cultural in the USA, it is important to approach their sociopolitical history from a reflective dialectical perspective to overcome the anxiety or stress in working with a diverse population (Israel, 2012; Todd & Abrams, 2011).

Recent immigrants face issues of acculturative stress, confusion about adapting to a new culture, and not understanding the rules and norms in the host culture (Sam & Berry, 2010). In addition, when migration is from cultural systems that are collectivistic to Western individualistic cultures, adaptation and adjustment is much more difficult. Historically, people from cultures very different from the host culture retain their culture of origin and either develop a bicultural identity, or choose to stay separate from the dominant culture (Berry, 1980; Rogers-Sirin, Ryce, & Sirin, 2014). Several orthodox religions, such as orthodox Jews and Muslims have had a difficult time developing a bicultural identity postmigration (Sam & Berry, 2010; Rogers-Sirin, Ryce, & Sirin, 2014). Integration into US society has been difficult for immigrants from Africa, Asia, and Latin America because of the anti-miscegenation laws adopted in the USA (and repealed in 1926), people from these cultural groups were forced to form tight social connections in order to survive due to exclusion, and racism (Landrine & Klonoff, 2002, 2004; Portes & Rumbaut, 2006; Rudmin, 2003).

All immigrants whether they are coming from collectivistic or individualistic cultures have significant stress and go through an adjustment process integrating to a new system (Phinney, 1990; Portes & Rumbaut, 2006; Verkuyten, 1998). Immigrants come to their new country with several assumptions and hopes. However, many of these assumptions are based on superficial knowledge or understanding of

a culture, and there is always culture shock, despondency, homesickness, or a desire to get back to a familiar world. The immigrant generation generally ends up living in two worlds, culture of origin, and culture of the adopted land, or psychologically staying in the culture of origin and choosing to do a daily “border crossing” when they go to work, or interact with the host culture, e.g., educational, and/or local, state, and national institutions (Portes & Rumbaut). If the cultural system is flexible, and willing to adapt, first generation immigrants tend to adjust better as they are born and educated in a system that they have the ability to comprehend, learn the unwritten norms and rules of society, and have less adjustment issues than their parents. However, in groups that are excluded from mainstream society due to cultural, ethnic, racial, or religious differences, future generations of immigrants have two social-cultural-psychological worlds that they negotiate daily as they interact with mainstream society (Portes & Zhou, 1993; Rudmin, 2003).

## Languages

Being bilingual or being able to use several languages with facility is a gift that most cultures value, especially as research in the last 15 years has shown evidence of all the benefits (Grosjean, 2010). In many countries of the world, and within one country there may be more than three or four languages (Allardi, Bak, Duggirala, Surampudi, Shailaja, Shukla et al., 2013; European Commission, 2012). A survey by Eurobarometer estimated that 54 % of Europe was bilingual. Neuroscience, neurolinguistics, and researchers studying the brain have shown that white matter increases in the brain of bilinguals, and that they are able to have better focus during learning, and better recall. Further, bilingual individuals have better decision-making skills; recent research shows that being bilingual delays dementia in older adults by approximately four and a half years, when compared to monolingual individuals (Allardi, Bak, Duggirala, Surampudi, Shailaja, Shukla et al., 2013; Mortimer et al., 2014; Krizman, Marian, Shook, Skoe, & Kraus, 2012; Mechelli et al., 2004; Luk, Bialystok, Craik, & Grady, 2011).

With the monolingual focus adopted by the founding fathers, primarily to create a unified nation in the USA, having more than one language was not seen as an asset (Takaki, 2000). With globalization of economic systems of the world, being bilingual is an asset. Individuals with accents and who had acquired multiple languages were historically not respected for the language skills they possessed. If we approach a client with an accent with a position that obviously they are recent immigrants and English is not their primary language, therefore they are not very “smart.” We may be underestimating the knowledge and skills of the client, given that he or she may have additional resources having lived, worked, or functioned in different cultures. Multiple languages are a strength and can be employed as an asset to help the client resolve the issues that brought him or her to counseling. The client may need coaching and assistance coping with US culture, and we as therapists can be very helpful in providing assistance to negotiate cultural impasses as recent immigrants and sojourners acclimate to the culture.

One issue that has been debated significantly in the literature pertains to using a translator when conducting therapy with a non-English speaking client. Current research cautions against using translators as in many cases the translator may not translate culturally sensitive issues that the client is bringing up to “save face,” this can actually be harmful to the therapeutic process (DeAngelis, 2010). Further, miscommunications can occur due to cultural misunderstandings, social class differences, and research shows that more severe diagnosis are given to individuals who cannot speak the dominant language (Putsch, 1985; Westermeyer, 1989). In addition, when emotional dialogues are translated, affect can get “flattened” due to the limited words available for emotional expression in the English language and the therapist may not understand the depth of emotion connected to the situation, and what it means to the client (McNamee & Gergen, 1992). Sometimes, highly emotional expression can be intimidating and exhausting for both the therapist and the translator (if they both represent non-emotional cultures), especially in working with traumatized refugees (Lipton, Arends, Bastian, Wright, & O’Hara, 2002).

Tribe and Lane (2009) and DeAngelis (2010) provide excellent recommendations for preparing for a psychological consultation and intervention, when an interpreter is needed. DeAngelis notes that several programs exist for training translators for mental health services, if possible a trained individual should be hired. When working with translators, it is important to set appropriate boundaries, provide information on confidentiality, and protection of clients’ rights. Both Tribe and Lane and DeAngelis caution mental health service providers to ensure that the client is comfortable with the arrangement, and understands that the interpreter is part of the treatment team. In taking on clients who are culturally different, therapists must have clarity on their own beliefs, values, and biases, and also consider if a client with minimal English proficiency would be best served by them; in such cases it may be best to refer the client to a therapist who can communicate with a client in his or her native language.

## Religion and Spirituality

Religion and spirituality have deep seated emotional meaning for individuals (Cornish, Wade, Tucker, & Post, 2014; Taylor, Chatters, & Jackson, 2007). Hodge and Derezotes (2008) note that religion is a set of shared communal beliefs and practices, which are organized with the goal of spiritual development. Hodge and Derezotes consider spirituality as a subjective, individualistic set of assumptions. They identify two common themes between the two concepts: (a) the existence of a transcendent reality, transpersonal in nature and (b) this reality is personal, existential, and subjective, and involves a connection with the nontemporal, i.e., not related to worldly affairs or time.

Mohr (2006) notes that spirituality and religion are often neglected in mental health assessment, intervention, and care. Further, it is an understudied aspect of client identity, and not addressed in training (Cornish et al., 2014). This gap in focus

and especially in training is confounding given that 92 % of people in the USA report a belief in God or a universal entity, and 56 % report that religion is an important part of their lives (Pew Forum on Religion & Public Life, 2008).

When working across religious and spiritual differences, once again, therapists need to be clear on their own worldview and perception of religion and spirituality. Dinham and Jones (2010) note that religious literacy and the ability to communicate one's own religious values, along with critical reflection on religion and recognition of the legitimacy of religious views held by others are very important skills. Counseling at its core is about negotiating deep-seated values, beliefs, and assumptions, acquired very early in life. Usually, our core beliefs and values are derived from religious socialization, which takes place from birth onwards as parents identify right and wrong, and socialize children, within a community and a cultural context. Furseth and Repstad (2006) in their introduction on the concept of religious socialization argue that through this process individuals largely adopt ways of thinking and acting that are transmitted and controlled by the expectations of others, and eventually come to comply with these expectations. Lövheim (2012) notes that empirical studies of socialization place a high value on the role of parents in the process of religious socialization. Most individuals are socialized in their parents' faith or spiritual beliefs (Erikson, 1977). However, commitment to a specific faith or spirituality varies among people, considering the influence of the cyber age and the access to global knowledge bases (Høeg, 2011; Lövheim, 2011; Martin, White, & Perlman, 2003; Pettersson, 2006). Further, the rise of atheism in the USA requires sensitivity and care in therapeutic work, specifically given the lack of attention in the psychological literature to people who do not subscribe to a religion or spirituality (Brewster, Robinson, Sandil, Esposito, & Geiger, 2014).

Religious differences can negatively affect the therapeutic relationship if assumptions are not clarified. Clarity for the client on the therapist's assumptions and beliefs about the client's religion, and how it is perceived are very important. Mental health practitioners are encouraged to have an open dialogue about religion or spiritual beliefs. It is also important to conduct a spiritual assessment to understand the strength of commitment (Hodge & Derezotes, 2008; Ibrahim & Dykeman, 2011; Ibrahim & Heuer, 2013). Clarity on these core assumptions and their importance to the client will facilitate the therapeutic process (Mohr, 2006). Another necessary condition for working in a culturally pluralistic society is to accurately understand the assumptions underlying major religions of the world, and using this as a backdrop to gauge how deeply client may be embedded in a religion (Hodge, Bonifas, & Chou, 2010).

We maintain that religion and spirituality is mediated by the cultural context. Religion and spirituality have core concepts and how these are expressed, accepted, and practiced depends on a culture that has adopted it (Ibrahim & Dykeman, 2011; Ibrahim & Heuer, 2013). Most cultures of the world have had religions imposed upon them by invaders and colonizers of their lands, and assumptions from previous religious or spiritual beliefs are still functioning within the acquired religious context. For example, Latino/a cultures in South America retained several values from their original assumptions and translated Catholic beliefs to fit what they



believed, e.g., the concept of Marianismo, is ascribed to Mary, as the ideal Madonna, however, the status of women as mothers is highly revered in Latino culture and that has been translated to fit Catholic assumptions (Garcia-Preto, 2005). Similarly, Jewish religion and culture has been mediated in the US context to create three distinct sets of assumptions that fit the lifestyle of the followers in the USA (Rosen & Weltman, 2005). In addition, Bedouin culture has greatly influenced how Islam is practiced in Saudi Arabia and other nomadic Arab societies. Several assumptions regarding revenge, war, status, and treatment of women are derived from ancient beliefs in Bedouin culture, and do not reflect the values embedded in Islam (Abudabbeh, 2005). We must consider culture of origin, generations in the host culture, depth of commitment to the religion or spirituality, and how the client perceives his/her/zir commitment to the religion or spirituality. It may vary from the traditional assumptions about the religion or the spiritual practice. This process will help facilitate the therapeutic process, because the client knows his or her beliefs best, for us to put our own interpretation on it would be disrespectful, and lead to a break in the therapeutic relationship (Hodge, Bonifas, & Chou, 2010).

## Ability/Disability Status

People with disabilities constitute the largest minority group in the USA (Artman & Daniels, 2010). Approximately 54 million Americans (about 1 in 5) have physical, sensory, psychiatric, or cognitive disabilities that interfere with daily living (Bowe, 2000). Olkin (2002) notes that with the increased focus on multicultural counseling, one population has not received adequate attention, i.e., people with disabilities. Although, recently there has been a focus in psychology on disability, Artman and Daniel note that “the disability-related literature in psychology focuses on psychosocial adjustment to disability, rather than strategies for better serving this population” (p. 442). Ability and disability status has an impact on identity. It defines what people can and cannot do, and also addresses the limitations that a lack of ability can have on a person. This plays a meditational role in cultural identity development. Another aspect to consider is the role of intersectionality of identities, and the role of multiple stigmatized aspects of identity, along with disability (Bryan, 2007; Hernandez, Balcazar, Keys, Hidalgo, & Rosen, 2006; Thompson, Noel, & Campbell, 2004). Societal attitudes toward visible disabilities can also pose oppressions for a person with disabilities. Hatzenbuehler, Phelan, and Link (2013) note that stigma influences several physical and mental health outcomes for millions of people in the USA. Sensitivity to issues of ability/disability is critical in creating an accepting therapeutic context (APA, 2014).

Very little research focuses on invisible disabilities, i.e., people may have physical limitations that are not visible, such as deafness, and the problems of aging, difficulty walking, bending, or sitting on the floor (Elliot, Uswatte, Lewis, & Palmatier, 2000; Thompson et al., 2004). These issues create different sociocultural

contexts for dealing with limitations, and when these are not acknowledged it affects cultural identity of an individual, and this aspect needs to be explored with clients.

Multicultural movement in applied psychology has given a sense of group identity and pride to disability-rights activists (Artman & Daniels, 2010; Gilson & DePoy, 2000). Gross and Hahn (2004) maintain that disability community identifies as an oppressed group because of the projected embarrassment, hostility, and existential anxiety of the nondisabled in society. As a culture, people with disability share a common history and an outrage at the stigmatization, oppression they experience, placing their plight within the context of civil rights (Gilson & DePoy, 2000; Olkin, 1999; Phemister, 2001). Recent developments in psychology have started to address disability issues (APA, 2014; Cornish et al., 2008; Olkin, 1999, 2002; Olkin & Pledger, 2003).

People born with a disability, generally adjust better to their situation, and achieve a high level of functionality in their lives. However, losing abilities over the lifespan due to accidents, war, aging, or late onset of a debilitating condition makes it much harder for people to accept limitations (Bowe, 2000; Elliot et al., 2000). There is a grieving process that needs to be undertaken, to help the client accept the changes, even when people appear to be doing well despite their ability to cope with the changes that they are encountering (Burke, Hainsworth, Eakes, & Lindgren, 1992; Davis, 1987). Group support with similar people who are also dealing with similar changes is highly recommended as the cultural identity of the individual has changed, and being in a group with people also struggling or coping well with a similar disability reinforces a positive cultural identity for a person with disabilities. For both groups, people born with disabilities or people having to confront loss of abilities, group support helps validate the new cultural identity, which is now mediated by the ability/disability context (Chan, Thomas, & Berven, 2002; Rajeski & Focht, 2002).

Two disability affirmative therapy models exist (Balcazar, Suarez-Balcazar, & Taylor-Ritzler, 2009; Olkin, 2008). These models provide guidance on case formulation and do not over- or under-inflate the role of disability, a common hazard when able-bodied therapists work with individuals with disabilities. Artman and Daniels (2010) provide specific information to achieve cultural competence in working with people with disabilities, along with information for therapists on becoming active advocates for their clients. It is important for therapists to confront their own attitudes toward disability and to review the legal mandates (Americans with Disabilities Act [ADA], 2008), and review the *APA Guidelines for Assessment of and Intervention with people with disabilities* (APA, 2014).

## Composition of the Family

The familial context clients come from is an important variable in understanding cultural identity (Fowers & Olson, 1993; Olson & Gorall, 2003). A significant body of research exists on how people negotiate intact, blended, single parent, or two-parent, adoptive, gay or lesbian families; however, it is mostly focused on the

majority group culture (Borrine, Handal, Brown, & Searight, 1991; Bray & Berger, 1993; Lansford, Ceballo, Abbey, & Stewart, 2001). How the client perceives the composition of the family and what their primary culture believes is the “ideal” family has an effect on identity development and adjustment in life (Baruth & Manning, 2011; McGoldrick, 2005). Exploration with the clients of the meaning and impact of the type of family they grew up in, is useful in understanding the influence of family dynamics on the client’s personality, and outlook (Demo & Acock, 1996; Friedman, Terras, & Kreisher, 1995; Vandewater & Lansford, 1998).

Research indicates considering a person’s attachment orientation in infancy predicts the emotional quality of romantic relationships a person will have in early adulthood. A significant association exists between parent–child relationships and adult romantic relationships (Dinero, Conger, Shaver, Widaman, & Larsen-Rife, 2011). All factors that influence developmental processes are useful in understanding strengths and challenges that the client brings to counseling as they work on the presenting problem. It is important for therapists to confront their own experience of growing up in their own family of origin, and how these experiences may influence their work with their clients.

## Birth Order

Birth order research addresses how children in specific cultural contexts develop certain behavioral characteristics based on whether they are the first, the middle, or the last child in a family (Booth & Kee, 2009; Iacovou, 2001; Zajonc & Sulloway, 2007). What has not been adequately explored is how gender affects these characteristics, of being a leader, an accommodator, or the baby of the family (Conley, 2000; Stewart, 2012). Rosenblatt and Skoogberg (1974) reported on a study with a worldwide sample of 39 countries that the birth of the first child of either sex resulted in increased status for the parents and marital stability. First-born daughters in adulthood received more respect and had greater influence on siblings than other daughters, or first-born sons. Contrary to this finding, in two specific cultures of the world, if the first child is female, there is open mourning, e.g., in South Asia, because a daughter is seen as a burden, who is a guest in her parents home, until she marries, and her dowry will be a significant cost for the family (Bumiller, 1991). In the Middle East, a mother is not called a mother if she does not have a son, when she has a son, she is referred to as a mother (Brooks, 1995). Obviously, female children who are the oldest child in such cultures would be hampered by these cultural beliefs, and would possibly develop lower self-esteem, because they may view themselves as liabilities, or children who did not bring honor to their mother. The opposite also can occur, where despite their gender, they strive to show their parents that they are capable, dependable, and out-excel their peers and brothers. Educational level of the parents can be a major mediational factor in how the identity of a female child in these cultures develops. It is important for helping professionals to reflect on their own birth order, their role in the family, and cultural beliefs about their own gender.

## Geographical Environment

Chandler and Munday (2014) define geographical identity in two ways: (1) an individual or group's sense of attachment to the country, region, city, or village in which they live and (2) the key characteristics with which a particular country, region, city, or village is associated. Individuals have deep attachments to geographical locations, where significant development tasks were completed and/or life cycle events take place, and these locations are romanticized (Brown & Swanson, 2003; Logan, 1996). Socialization in a specific geographical region has an influence on cultural identity; each type of geographical location provides strengths and challenges based on the topography of the region. Moving from one geographical setting to another also provides additional strengths in coping with different geographical environments.

Socialization in urban, suburban, and rural environments has somewhat different dynamics, i.e., rural communities, although fast becoming diverse, tend to not be diverse, professional jobs may be lacking, economy may be dependent on agriculture and retail businesses, income and tax base tends to be lower than in metropolitan centers (Crockett, Shanahan, & Jackson-Newsom, 2000; Yang & Fetsch, 2007). Metropolitan centers provide higher incomes, greater diversity, choice and access to many educational models, and greater options for better health care (Harter, 1999; Yang & Fetsch, 2007). This is an important factor in exploring with a client about the location of their primary identity development and comfort level in current setting. The presenting problem may or may not be occurring due to geographical changes, however coping with urban settings, versus living in a rural setting requires different knowledge and skills (Gimpel & Karnes, 2006). The research available on rural children and youth has often referred to the challenges of rural life (Adams, 2003; Conger & Elder, 1994; MacTavish & Salamon, 2003). However, Yang and Fetsch found children in rural areas in their sample did not have any negative impact, their sense of self-esteem and academic achievements were higher than the norm. The negative findings were similar to children in metropolitan areas (both urban and suburban) these included concerns about physical appearance (Pipher, 1995). Bronfenbrenner (1958) notes that socialization practices flow from urban middle-class families to rural working-class families. This phenomenon of anxiety about appearance and the body may be related to this variable. It could also be due to the increased time youth in the USA are spending online and engaged with the media, as the desire to be out of doors is no longer valued in all geographical areas of the USA reducing physical activity (Strife & Downey, 2009).

Research on psychological implications of growing up in metropolitan areas identifies several negative outcomes, primarily, lack of attachments to grandparents and extended kinship systems, neighborhood connections, along with overcrowding and distance from nature (Kunstler, 1993; Putnam, 2000; Suarez, 1999; Strife & Downey, 2009). However, is no specific evidence has been presented that shows a direct connection with patterns of psychological distress or low levels of happiness in urban, and suburban settings (Argyle, 1999). Research in psychology and sociology has linked the effect of physical environments, such as crowding, noise,

pollution, to mood disorders, delinquency and suicide (Freedman 1975; Halpern, 1995) and social isolation (Gable & Nezlek, 1998). Fischer (1984) in a literature review of psychological outcomes of urban and rural areas found no evidence of negative psychological outcomes of living in urban areas. Although, there is evidence of negative psychological consequences due to economic segregation, as noted by Oliver (1999); research shows that affluence reduces community engagement and leads to social isolation and alienation. Understanding client concerns may be limited for a therapist who does not understand what it means to be a person from the suburbs or a densely populated urban area. Once again, we as therapists must explore where we grew up, and our understanding of different geographical environments, and the strengths and challenges of different settings.

## Social Class

The concept of social class is an emotionally loaded issue in the USA; the concept that people may be unequal is not readily accepted (Hollingshead & Redlich, 1958; Hooks, 2000; Rothenberg). Baker (1996) has argued that class is difficult to define, because it is a construct used in stratification of societies and is therefore difficult to recognize. Social class, an external variable influences cultural identity based on how one understands one's place in a system, the environment one grows up in, and how others perceive a person. Anderson and Collins (2012) note that social class, similar to race, ethnicity, and sexual orientation, does not reside within the individual, it is the result of a system of power created by institutional structures that create inequities. This coincides with Bourdieu (1989) conception that social structures transform into mental structures, and the mental structures in turn provide social structures, there is a possibility for change with the bidirectional interaction between social and mental structures. How people define or understand their social class is based on economic, cultural, and social capital; these capitals are used to define one's place on a system (Bourdieu, 1989; Whitman-Raymond, 2009). As a subjective variable it is important to understand how an individual perceives his or her social class and despite the objective circumstances (Adler & Snibbe, 2003). This reinforces the client-centered perspective, essential for therapeutic work, especially as therapists work across culture and class boundaries (Castillo, 1997; Dana, 1998; Ibrahim, 1985). The concept of social class has received limited attention in applied psychology research (Ballinger & Wright, 2007; Levy & O'Hara, 2010; Liu, Soleck, Hopps, Dunston, & Pickett, 2004; Smith, 2000, 2005, 2009; Smith & Chambers, 2015). Falconnier (2009) asserts that the practice of counseling and psychotherapy is rooted in middle-class values and may not be relevant for other social classes, especially low income clients.

Neil Altman (1995) introduced the concept of a three-person psychology, instead of the counseling dyad, he asserts the third "person" refers to social context. Liu et al.'s (2004) *Social Class Worldview Model* (SCWM) is a cultural variable that is highly subjective, it not static, and neither is it linked to a place and time. In counsel-

ing and psychotherapy it is important for therapists to recognize how they perceive social class and what their assumptions are about the different socioeconomic levels. Therapist assumptions and bias can influence diagnosis, interventions, and the possible outcome of the intervention (Liu, 2002; Liu et al., 2004). The counseling relationship can be compromised when social class issues are ignored and the middle-class model is applied to working, lower social class, or homeless clients (Balmforth, 2009; Rose-Innes, 2006; Liu, 2001; Smith, 2005; Snowden & Yamada, 2005; US Department of Health & Human Services, 2001). When low income clients, who are also from racial-cultural nondominant groups seek mental health assistance they are less likely to receive evidence-based interventions (Le, Zmuda, Perry, & Munoz, 2010; Miranda et al., 2005), and more likely to terminate counseling prematurely (Organista, Munoz, & Gonzalez, 1994; Sue & Zane, 1987). Research suggests that people in lower social classes tend to get more severe diagnosis than people in affluent social classes (Belle, 1990; Hollingshead & Redlich, 1958; Shubert & Miller, 1978; Siegel, Kahn, Pollack, & Fink, 1962). These studies show that there is an implicit assumption that people in upper classes, being affluent, and more educated would be healthier (Baker, 1996; Belle, 1990; Liu, Alt, & Pittinger, 2013).

Kim and Cardemil (2012) note that no one is immune to the influence of class divisions that everyone is institutionalized. Further, interpersonal and internalized classism is displayed in stereotypes, prejudice, and discrimination. Therefore, self-awareness and critical reflection about one's own biases is necessary to address classist behaviors and attitudes. They provide several helpful guidelines for assessment and intervention with lower social class clients. Including guidelines for assessment, explicit and ongoing attention to social class issues (including explicit discussion of social class issues and barriers that clients may face), intersectionality of social class with other dimensions of identity, and attending to needed cultural adaptations to the counseling process (individual, group, family interventions, psychoeducation, and number and frequency of sessions), and a need for increased self-disclosure (Cardemil, 2010; Castro, Barrera, & Holleran Steiker, 2010; Grote, Swartz, & Zuckoff, 2008; Miranda et al., 2005).

### **Three Key Domains of Identity That Feature in the Presenting Problem**

The last question on the Cultural Identity Check List-Revised© requires respondents to identify aspects of cultural identity that are implicated in the presenting problem. This helps in narrowing down the core values involved, and where the distress is located (Castillo, 1997; Dana, 1998; Ibrahim, 1999). Culture usually emerges as a very strong factor in human suffering, because many of life's major dilemmas are focused on an individual's need to do something, and the constraints usually come from learned cultural, gendered, religious, assumptions, or internalized privilege and oppressions (Brody et al., 2006; Caughy, Nettles, O'Campo, & Lohrfink, 2006; Chen & Bargh, 1997). However, we cannot assume that culture is

always the issue; exploration of core values, as they affect these domains helps in creating a fuller understanding of the client's cultural identity, and especially on variables that have not been traditionally considered as important (Castillo, 1997; Dana, 1998; Ibrahim, 2003). Frable (1997) notes that the multidimensionality of identity is overlooked in counseling and psychotherapy because the aspects of identity have been studied in a fragmented manner in the psychological literature.

To integrate the social justice perspective in this discussion, it is important to recognize that ethnic, cultural/racial identity, along with the other variables discussed in this chapter, i.e., gender, gender identity, sexual orientation, age and life stage, educational status, religion, ability-disability continuum, and the geographic location one comes from, given the context can be a source of privilege or oppression (Dana, 1998; Frable, 1997; Ibrahim, 2010). Societal values, beliefs, and assumptions can elevate some aspects and down grade other aspects of a person's identity and either provide opportunities or deny access to opportunities for the good life. The constant stress of either high expectations (privilege) or low expectations (oppressions) on a daily basis results in stress-related disorders, which affect the mind and the body (Adams et al., 2013; Ibrahim & Ohnishi, 2001). Epidemiological studies have shown that lifetime exposure to trauma is high, with 50–69 % of people (Hetzel-Riggin & Roby, 2013; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

When conducting a cultural identity assessment, it is important to also incorporate the *DSM-5* Cultural Formulation Interview (CFI; American Psychiatric Association, 2013a, 2013b, 2013c). This interview will provide the answers to the cultural meaning of the distress for the client, what it represents and how to resolve the problem. It will also highlight what resources the client may have that would support the therapeutic intervention, e.g., support system (familial, kin, or friends, coworkers), occupational status, change in level of functioning at home and on the job (if employed), and current religious or spiritual status (Castillo, 1997; Dadlani, Overtree, & Perry-Jenkins, 2012; Ibrahim, 2010; Ivey, D'Andrea, & Ivey, 2011). This will be useful adjunct to cultural identity assessment in preparation for diagnosis, case formulation, and intervention (APA, 2002).

It is important for mental health professionals to meditate and reflect on each of these categories to identify their own assumptions, and to critically examine the meaning of each of these categories; given individual sociopolitical history, unearned and earned privilege, and oppressions, and actively seek experiential training in working with the dimensions that are unfamiliar and were not addressed in their training program (Collins & Pieterse, 2007; Croteau, Lark, Lidderdale, & Chung, 2005; Hardiman, Jackson, & Griffin, 2007). Critical awareness requires reflection and practice through experiential exercises, meditation and journaling to understand our unconscious and implicit learning (Banaji & Hardin, 1996; DeCoster, Banner, Smith, & Semin, 2006; Jun, 2010). As professionals we are always evolving and growing and incorporating a regular practice on understanding our conscious and unconscious assumptions will prove to be very helpful in enhancing the ability to be culturally responsive.



## Conclusion

Each of the cultural identity categories is critical for understanding the client, the presenting problem, and the possible resolutions. It is equally important for therapists to recognize the multidimensionality of their own identity. Both the therapist and the client's identities are interacting within the therapeutic encounter. For therapists, it is very important to be aware of their own identity, their issues, and their privilege and oppressions; if not understood and addressed, these will come up as unguided missiles in the therapeutic encounter (Ibrahim, 2003). Our focus in counseling and psychotherapy has always reduced the client to a single identity, e.g., an American, which usually implies White Anglo Saxon Protestant, as historically, it has been used as a label for European immigrants. However, given that there are 21 distinct White ethnic groups in the USA, from several regions, and geographical settings (McGoldrick et al., 2005), we may be making several erroneous assumptions about the client. This checklist was developed in 1990 to address all possible variables inherent in a cultural identity, and to supplement information gained from the Scale to Assess World View© on core values and assumptions. Without the information from the CICL-R we do not have all the information we need for a personal encounter, which involves helping an individual address serious issues in counseling and psychotherapy.

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