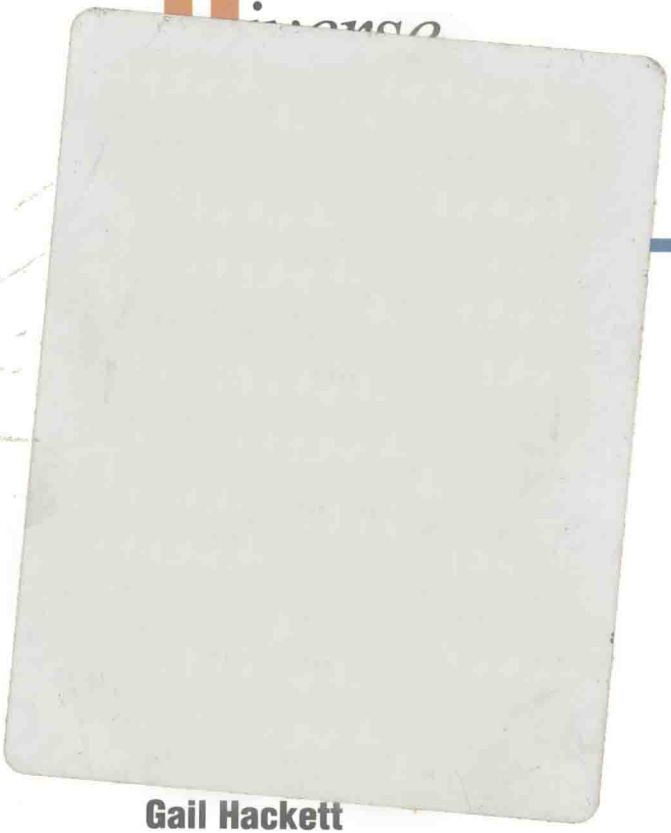
Counseling Diverse



Gail Hackett

SECOND EDITION

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Counseling Diverse Populations

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McGraw-Hill

A Division of The McGraw-Hill Companies

COUNSELING DIVERSE POPULATIONS. SECOND EDITION

This book is printed on recycled, acid-free paper containing 10% postconsumer waste.

4 5 6 7 8 9 0 DOC/DOC 0 9 8 7 6 5 4 3 2 1

ISBN 0-697-25280-9

Editorial director: Jane Vaicunas
Developmental editor: Sharon Geary
Project manager: Jane C. Morgan
Production supervisor: Sandy Ludovissy
Cover design: David Arnold
Part Opener photo credits: 1 © Young-Wolff/Photo Edit. 2 © A. Boccaccio/ The Image Bank. 3 © Stephen J. Wilkes/The Image Bank. 4 © Robert Ginn/ Photo Edit. 5 © Marc Romanelli MCMXCV/The Image Bank. 6 © Barros and Barros/ Image Bank
Compositor: ElectraGraphics, Inc.
Typeface: 10/12 Times Roman
Printer: R. R. Donnelley–Crawfordsville

Library of Congress Cataloging-in-Publication Data

Counseling diverse populations / [edited by] Donald R. Atkinson, Gail Hackett. — 2nd ed.
p. cm.
Includes bibliographical references and index.
ISBN 0-697-25280-9
1. Counseling. 2. Aged—Counseling of. 3. Women—Counseling of. 4. Handicapped—Counseling of. 5. Gays—Counseling of.
I. Atkinson, Donald R. II. Hackett, Gail.
BF637.C6C6372 1997
158´.3´08—dc21 97-8388
CIP

www.mhhe.com

PREFACE

The purpose of this second edition of *Counseling Diverse Populations* is the same as the first edition, to call to the attention of mental health practitioners the unique experiences and needs of four groups within the American society that, along with ethnic and selected other groups, share the common experience of oppression. These four groups are people with disabilities, older people, women, and gay people. Each of these four groups has a common physical and/or behavioral characteristic that identifies individuals as members of the group and that has singled them out for differential and inferior treatment. Each of these groups has in the past experienced (and continues to experience) discrimination as a result of their physical and/or behavioral uniqueness. Discrimination for all four groups has ranged from negative stereotypes to physical violence. It is our thesis that mental health practitioners need to be aware of the unique experiences of these groups in order to effectively intervene on their behalf.

This edition represents a complete revision of the earlier edition. Part 1, which is written by the co-editors of the book, was completely reorganized and expanded from three chapters to five chapters. The first chapter describes how traditional psychotherapeutic approaches have ignored the experiences of, and failed to meet the needs of, people with disabilities, older people, women, and gay people. The first chapter also provides a rationale for identifying the four groups as minorities, as well as a brief profile of each group. In chapters 2 through 5, we review the past and present treatment of each group by society in general and mental health care providers in particular.

Part 2, which consists of three chapters on people with disabilities, is completely new to this edition. Part 3, "The Elderly Client," is also completely new to this edition. In part 4, we have retained two of three readings on the female client from the first edition, but chapter 14 is new to this second edition. Similarly, for part 5, "The Gay Client," we have retained two of the readings from the first edition but added a new reading for chapter 15. The last chapter (chapter 16), which examines the implications of diversity issues for counseling practice, counselor training, and counseling research, has been updated for the current edition.

This book is intended as a text for undergraduate and graduate courses in counseling psychology, clinical psychology, social work, and other mental health professions where human rights issues are discussed. The book might be used as a primary text in courses where diversity or human rights issues are the

primary focus or as a supplemental text in counseling theory and technique courses. When used in conjunction with another McGraw-Hill publication, *Counseling American Minorities: A Cross-Cultural Perspective,* the book provides an excellent introduction to a broad range of diversity issues.

We hope the book will help mental health professionals look beyond the current *Diagnostic and Statistical Manual of Mental Disorders* and conventional psychotherapeutic strategies when diagnosing and treating clients. It is our belief that experiences, behaviors, attitudes, values, and needs based on membership in the groups discussed in this book must be taken into account as part of diagnosis and treatment. Furthermore, it is our hope that counselors and other mental health providers will reconceptualize their roles as facilitators of behavioral *and social* change when working with the diverse populations discussed in this book.

This book is dedicated to those individuals who, because of their physical ability, age, gender, or sexual orientation, have been singled out for differential and inferior treatment.

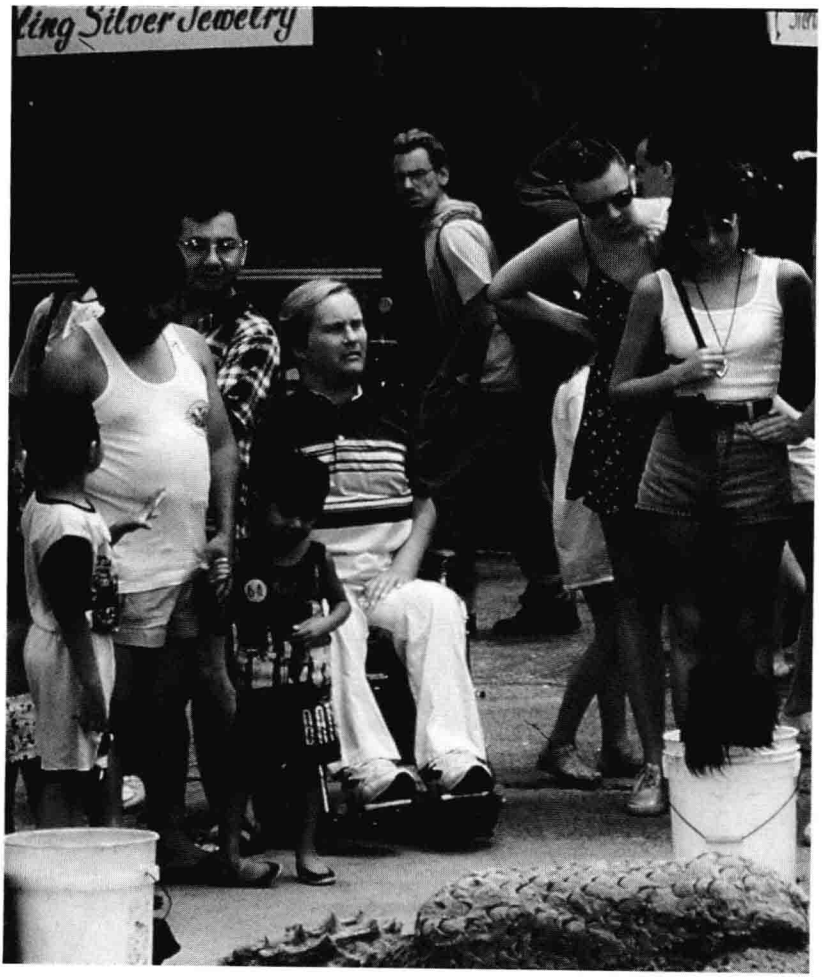
We would also like to dedicate this book to Gail's son, Ryan, and to the memory of Don's son, Jimmie.

D. R. A. and G. H.

CONTENTS

PART 1

Counseling and Diverse Populations



1
Introduction

Traditional Approaches to Counseling and Psychotherapy

Most, if not all, mental health professions that practice counseling and psychotherapy can trace their roots to Freud and psychoanalysis; Shilling (1984) refers to Freud as "grandfather to all of us . . . who are psychologists and/or counselors" (p. 17). Many of the concepts and constructs developed by Freud are still perceived as necessary and sufficient conditions for psychotherapy. Indeed, Corey (1991) suggests that Freud's theory "is a benchmark against which many other theories are measured" (p. 96). While many of Freud's contributions to the mental health professions have been widely applauded, some of his ideas have been criticized as erroneous or even deleterious.

Two of the unfortunate legacies that Freud left to mental health professionals are the overemphasis on intrapsychic etiologies for mental health problems and the exclusive reliance on one-to-one psychotherapy for the treatment of psychological disturbances. Freud believed an individual's behavior was the result of instinctual, biological drives originating within the individual. While neo-Freudians and subsequent theorists have moved away from the heavy stress Freud placed on sexual instinct and aggression as determinants of behavior, they continue to emphasize an internal model of psychopathology, one which views the etiology of the client's problem (and the resources to resolve it) as residing within the client. Thus, for example, advocates of person-centered therapy believe that psychological maladjustment occurs when "the *organism denies* to awareness, or *distorts* in awareness, significant experiences" (italics added, Meador & Rogers, 1984, p. 159). Gestalt therapists believe that individuals are responsible for their own behavior and that "*People are responsible* for what they choose to do" (italics added, Simkin & Yontef, 1984, p. 291). Even behavior therapists, who eschew needs, drives, motives, traits, and conflicts as underlying causes of behavior, believe that "A crucial factor in therapy is the *client's motivation,* and *willingness to cooperate* in the arduous and challenging task of making significant changes in real-life behavior" (italics added, Wilson, 1984, p. 253).

If the primary mechanisms that shape and maintain affect, behavior, and cognition reside within the individual, then it follows that psychotherapy should

focus attention on the individual. Freud's use of the psychoanalytic situation, a one-to-one therapeutic environment in which the analyst facilitates critical self-examination, had a significant and enduring impact on counseling and psychotherapy. This emphasis on intrapsychic pathology and psychotherapy is evident in the goals therapists have for counseling. Although the client may be encouraged to state therapeutic goals as part of the counseling process, therapists conventionally pursue metagoals of changing the client's affect, behavior, and/or cognitions. The therapist works on these metagoals by encouraging catharsis, interpreting feelings, challenging negative self-perceptions, assigning homework, and a myriad of other counseling strategies. Regardless of the counselor's material and the strategies employed to reach it, an underlying assumption of nearly all conventional counseling approaches is that some aspect of the client must change in order to resolve the problem. With the exception of embryonic group and family counseling efforts, counseling and psychotherapy prior to the 1950s involved a one-therapist, one-client model.

Family therapists were among the first to recognize the limitations of focusing therapy on the individual outside the context of the family. According to Nichols (1984), Freud actively discouraged psychotherapists from involving other family members when they were treating a patient. Involving other family members in therapy was discouraged because it would undermine the transference process, considered essential for treatment success. As a result, early attempts at interviewing with families were little more than individual psychotherapy for each family member. It was not until the early 1950s that researchers examining communication patterns in the families of schizophrenics developed a system theory approach to therapy and with it the concept that it is more effective to treat a family system conjointly than a single family member individually (Nichols, 1984).

The social conditions of the 1960s set the stage for a second, more disparate, group of mental health professionals to criticize the shortcomings of conventional psychopathology and psychotherapy theory. Civil rights, antiwar, feminist, and other human rights movements directly and indirectly motivated many disfranchised groups to seek (and in some cases demand) mental health services. Counselors and other mental health professionals soon discovered that their training did not prepare them to work with such issues as discrimination, alienation, and basic survival (Aubrey & Lewis, 1983). The result of pressure by disfranchised groups for counseling services has been referred to as a "fundamental if not revolutionary change" (Larson, 1982, p. 843) in counseling.

By the late 1960s, radical psychiatrists, social change psychologists, feminist counselors, and others were suggesting that psychological problems experienced by many clients were the result of oppressive environments, not intrapsychic pathology. Concurrently, a number of authors began criticizing the mental health professions for their neutral stance with respect to social issues. Seymour Halleck (1971) indicted psychotherapists for helping to maintain the status quo in social institutions that are oppressive. According to

Halleck, psychotherapists, whether they intend to or not, commit a political act every time they reinforce the positions of persons who hold power. Intrapsychic views of client problems were criticized for being shortsighted and for promoting institutional oppression through passive acceptance. This position is articulated in its extreme by Claude Steiner (1975) in his manifesto for psychiatrists:

> Extended individual psychotherapy is an elitist, outmoded, as well as nonproductive, form of psychiatric help. It concentrates the talents of a few on a few. It silently colludes with the notion that people's difficulties have their source within them while implying that everything is well with the world. It promotes oppression by shrouding its consequences with shame and secrecy . . . People's troubles have their source not within them but in their alienated relationships, in their exploitation in polluted environments, in war, and in the profit motive. (Steiner, 1975, pp. 3–4).

Sarason (1981) also chastised American psychology as "quintessentially a psychology of the individual organism, a characteristic that, however, it may have been and is productive has severely and adversely affected psychology's contribution to human welfare" (p. 827). In examining the social issues and counseling needs of the 1980s and 1990s, Aubrey and Lewis (1983) expressed concern that "counselors still tend to overlook the impact of environmental factors on individual functioning, to distrust the efficacy of preventative interventions, and to narrow the score of their attention to the individual psyche" (p. 10).

We share these concerns that counselors and psychologists ignore environmental sources of mental health problems and rely almost exclusively on an intrapsychic model of psychopathology. We believe that for some of the issues clients bring to counseling, particularly for clients from groups that are victims of oppression, counselors need to consider alternatives to the intrapsychic pathology and individual psychotherapy models. This book examines the experiences of four oppressed groups with the goal of sensitizing counselors to the external sources of the psychological problems and to the nontraditional interventions designed to assist them with these problems.

Defining Oppressed Groups as Minorities

The term *minority* has been widely used in the United States since the 1950s with reference to racial and ethnic groups, and more recently with respect to nonethnic groups. Based on Wirth's (1945) definition that minorities are groups who "because of physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment" (p. 347), the term has been generalized to any group oppressed by those in power. The concept of minorities being groups that are singled out for differential and unequal treatment allows us to expand the list of minorities

beyond ethnic groups who are a numerical minority in the society. When applied to Blacks in South Africa and women in the United States, the term describes groups that are actually a numerical majority of the population. Gay men and lesbian women, young children and elders, to the extent they are oppressed by the social system in which they live, also can be identified as minorities.

Dworkin and Dworkin (1976) proposed that "a minority group is a group characterized by four qualities: identifiability, differential power, differential and pejorative treatment, and group awareness." (p. 17). Biological (skin color, eye shape and color, facial structure) and cultural (religion, dress, behavior) variables identify a minority group as does the position of inferior power relative to a power group (a group that uses power to influence and control others). When such differential power exists between two groups, it is probably inevitable that the dominant group exercise their power, resulting in differential and discriminatory treatment of the minority group. One effect of experiencing differential and discriminatory treatment is to make the minority group more aware of its common bond.

A definition offered by Kinloch (1979) also addresses the issue of power. Kinloch (1979) defines a minority as "any group that is defined by a power elite as different and/or inferior on the basis of certain perceived characteristics and is consequently treated in a negative fashion" (p. 7). Further, he identifies four types of minorities: those who are identified as different or inferior based on physiological criteria (e.g., non-White racial minorities, women, elders), cultural criteria (non–Anglo-Saxon ethnic groups), economic criteria (the poor and/or lower class), and behavioral criteria (e.g., gay men and lesbian women, persons with mental disabilities, persons with physical disabilities).

Similarly Larson (1982) identifies minorities as groups of people who are stigmatized by the majority group in some way. He refers to Goffman's (1963) classification system for identifying conditions subject to stigma. The system consists of three categories:

> (a) physical—for example, visible manifestations of disability; (b) blemishes of character, for example, conditions that are viewed as voluntary deviant choices such as political dissidents, alternate sexual orientations, criminals, some categories of mental illness, such as addictions; and (c) tribal—for example, racial, ethnic, linguistic, or religious groups. (Larson, 1982, p. 845)

These definitions by Dworkin and Dworkin (1976), Kinloch (1979), and Larson (1982) stipulate that oppressed individuals be recognized or perceived as a group sharing common characteristics in order to qualify as a minority. However, Pope (1995) makes the interesting point that even those individuals who attempt to "pass" as members of the dominant society (e. g., gay men or lesbian women who hid their sexual orientation, people of color who are not visibly identifiable and deny their ethnic heritage) experience oppression in the form of lower self-esteem, feelings of inferiority, and internalization of negative

self-concepts (p. 303). Thus, the recognition or perception of membership in a minority group need not be public for a member of that group to experience the effects of oppression.

Not only are minority groups singled out for stigmatization and discrimination, they are placed in double jeopardy by a society that blames them for the social conditions they experience as a result of discrimination. This phenomenon, known as victim-blaming, "is the tendency when examining a social problem to attribute that problem to the characteristics of the people who are its victims" (Levin & Levin, 1980, p. 36). For example, early forms of victim-blaming of ethnic minorities were often racially based and usually cited assumed biological inferiorities as causes of the groups' social problems (e.g., Mexican-American assumed intellectual inferiority cited as a reason for Mexican-American underachievement in school). More recently, cultural deviance has been cited as a cause of social problems experienced by ethnic minorities (e.g., breakdown of the traditional two-parent family among Blacks cited as a reason for a myriad of problems experienced by that group). The argument that seductive behavior is the cause of child sexual abuse (Muller, Caldwell, & Hunter, 1995) and rape (Bell, Kuriloff, & Lottes, 1994) is another current example of blaming the victim. Thus, victim-blaming overlooks the societal and institutional causes of social problems experienced by minorities and blames the problem on assumed biological or cultural inferiority.

Victim-blaming is particularly insidious when the minority group toward which it is directed begins to accept the blame for problems caused by oppression:

> The ultimate personal consequence of victim-blaming occurs when victims come to see themselves as those who blame them do. Lower self-esteem, even self-hatred, are outcomes more likely to emerge for those who are already marginalized and devalued in society. One's adoption of negative images from others can be viewed as a form of auto-oppression which has within it the seeds of self-destruction. Tragically and ironically, self-destruction accomplishes for society what social isolation and genocide do, but without raising the spectre of rights violations. (Dressel, Carter, & Balachandran, 1995, p. 118)

A further negative effect of victim-blaming is to misdirect the resources expended to resolve the social problems faced by a minority. Ryan (1971) has suggested that once we identify a social problem, we study the group affected by it to determine how they are different from the rest of us. We next define those differences as the source of the problem and develop a bureaucratic program to correct the differences, not the social cause of the problem. Further, we often withhold resources from minorities needed to resolve the social sources of their problems because we assume they are incapable of resolving their own difficulties. The National Council on Aging has suggested that "The social and economic opportunities available to any group in this society depends not only on their own resources, capabilities and aspirations but, as

importantly, on the resources, capabilities and aspirations that the public at large attribute to them" (Harris, 1975, p. i).

This book focuses on two groups who are perceived as different and treated in a negative fashion because of physical characteristics (women and elders), one group because of behavioral characteristics (gay men and lesbian women), and one group because of either physical or behavioral characteristics (people with disabilities). As we shall see in chapters 2 and 3, these four groups have experienced discrimination and victim-blaming much like ethnic minorities have.

Our readings relating to these four groups by necessity focus on the distinctiveness of each group and may reinforce the view that they are mutually exclusive populations. Nothing could be further from the truth. For example, the greater survival rate of Americans with lifelong disabilities and the growing number of elders with later-life disabilities (Ansello, 1991) means that there is considerable overlap between these two groups. Further, the fact that there are only 67 elderly men for every 100 elderly women in the United States suggests that there are a large number of elderly women with disabilities. Since some of those elderly women with disabilities are also Lesbians, the overlap of all four groups on which we have chosen to focus becomes obvious. The fact that the four groups are not mutually exclusive is significant because it suggests that many individuals in our society are subject to multiple layers of discrimination.

Brief profiles of these four groups, who were selected for the current discussion because they include substantial numbers of people who seek counseling services, are provided in the following section.

Profiles of Selected Minorities

Persons with Disabilities

Any discussion of persons with disabilities by necessity must begin with a discussion of the terms *handicap, handicapped, disability,* and *disabled.* Those who have followed the literature on people with disabilities have witnessed an evolution in terminology (not unlike the evolution in terminology used to designate members of racial/ethnic minority groups) applied to this population. Professional articles and federal laws in the 1970s followed the convention of referring to people with disabilities as "handicapped people" or "people with handicaps." During the 1970s, the terms *handicapped person* and *disabled person* were often used interchangeably. By the 1980s, however, advocates for people with disabilities began to make distinctions between handicap and disability. The term *disability* began to be used with reference to some physical or mental diagnosis, one which may or may not limit the individual's major life activities. The term *handicap* began to be used to indicate the restricting consequences of the diagnosed disability. Thus, a handicap was seen as more situationally defined than is a disability: