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Teaching Clinicians about Ethnic Cultures

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Clinicians are increasingly aware that a single technique for individual or family counseling is inappropriate in an ethnically complex society. All clients in counseling seek relief for their distress, but, as Mayo (1991: 318) has pointed out, "The paths to that goal are many." Consequently, several works clarify the characteristics of different social and cultural groups, particularly with reference to their acceptance of professional counseling and the most effective techniques. (See McGoldrick, *et al.* 1982; Mindel, *et al.* 1988; Baca Zinn & Eitzen 1993).

At best, such works, and courses based on them, provide summaries of a broad spectrum of ethnic cultures. For example, one work on ethnic families covers 19 cultures, another 17 (McGoldrick, *et al.* 1982; Mindel, *et al.* 1988). While this is a valuable broadening of therapeutic technique, experience in clinical work as well as in teaching clinical method illustrates its insufficiency. Any compendium must be limited to a description of the modal pattern in the best-known communities; for several reasons it has limited value as a guide for a specific client.

Some clients may come from groups which are relatively new on the American scene. Among Asians alone such relatively new and unknown groups as the Hmong, Laotians, or Kampuchians are unlikely to appear in materials readily available to clinicians (Baca Zinn & Eitzen 1993: 162). For such cases, the standard description of common ethnic cultures will miss the mark. Even for the most commonly known minorities, recent arrivals may not resemble their

predecessors: they may be more educated, of urban rather than rural backgrounds, or of different income levels than their predecessors (Baca Zinn & Eitzen 1993: 161). Furthermore, recent arrivals, by definition, have experienced an altered version of the home culture than their predecessors (Sengstock 1982). Hence a clinician cannot consider existing analyses of ethnic communities to be descriptive of newer populations from the same areas.

Finally, even with widely studied ethnic communities, knowledge of the modal type may prove inadequate for dealing with an individual client. Numerous members of any group do not follow the most frequent pattern. Billingsley (1968), for example, identified 12 different family patterns within the Black community, and several families which did not fit any of these. Such deviant types may lack social support and be disproportionately likely to appear in a clinician's office. It follows that a description of a variety of ethnic patterns is necessary but not sufficient preparation. Training must also acquaint clinicians with the dimensions of cultural diversity and techniques for determining the unique pattern of each individual.

Contents of Clinical Training about Ethnic Patterns

Obviously clinicians should have a *broad introduction to a variety of different ethnic patterns*. While the specific examples presented in various clinical programs may vary, it is important that these examples represent a broad spectrum of types. British families, for example, are highly individualistic (McGill & Peare 1982: 458–459); the importance of extended kin and of respect and obligation towards parents is emphasized by other ethnic communities, such as Asians (Shon & Ya 1982: 212–214), Mexicans (Falicov 1982: 140–145), and Blacks (Hines & Boyd-Franklin 1982: 458–459). Mexicans and British also illustrate the maintenance of ethnic patterns for several generations following immigration. Especially important is an introduction to major groups residing in the region the clinician serves. In the southwest U. S., knowledge of Hispanic patterns is important; those who work in major urban areas of the industrial Northeast and Midwest should be introduced to Black culture; Mormon culture should be known by those working in the Utah or Idaho, etc.

Clinicians should also be sensitive to the *diversity of subtypes which may exist even within a specific culture*. Every community exhibits a variety of subpatterns, and one cannot assume that all members conform to the dominant ethnic type. Variant patterns may represent types considered by the group to be

deviant or may represent equally acceptable variations. Such diversity is particularly likely if there have been several waves of immigration from an area, if the group has been in the U. S. for several generations, or if members of the ethnic group intermingle with persons from other backgrounds, particularly by marriage.

In the Polish community, for example, the most numerous members are of peasant origin and immigrated in the early part of the Twentieth Century; those who came later are more educated and wealthier and have had an easier time assimilating to American society and culture (Mondykowski 1982: 394). Similar migration era effects have been found with Cubans (Bernal 1982: 189) and Iraqi Roman Catholics (Sengstock 1982). In Mexican families, the presence of several persons from different migration eras contributes to family dissonance (Falicov 1982: 144–145).

Since it is impossible for clinicians to be knowledgeable about all possible patterns they may encounter, it is important that they become aware of the *major dimensions on which cultural patterns may vary*. Kluckhohn (1951), for example, has developed a model of variation in cultural value orientations, including: time orientation, the nature of humanity, most valued human relationships, proper relationship with nature, and whether active or passive. As Spiegel (1982: 37–42) points out, the dominant American culture is future oriented, individualistic, and activist; assumes humanity to be a mixture of good and bad; and believes that man should dominate nature.

Persons from cultures which differ on one or another dimension have special problems in acculturation. Native Americans, for example, differ dramatically from middle-class Americans in their present time orientation and their belief that humans should live in harmony with nature (Attneave 1982: 63). Family relationships are considered to be more important than the individual by many groups, including Italians and Irish (Spiegel 1982: 39–41), Asians (Shon & Ja 1982), Blacks (Hines & Boyd-Franklin 1982), Mexicans (Falicov 1982), and Native Americans (Attneave 1982). According to Greeley (1971), such family patterns are particularly important and may persist the longest, probably because they are not viewed as ethnic patterns but are simply accepted as the manner in which parents handled the family during a person's formative years.

Other important dimensions of variability include the group's immigration history, the degree of discrimination and prejudice it has encountered, or important historical events for the group (slavery or the Holocaust, for example). The therapist who is unaware of these differing assumptions may make inappropriate demands of a client. Expecting Native Americans or Italians to oppose

family expectations or assume an activist role is likely to exacerbate problems rather than alleviate them.

Lastly, clinicians must learn *techniques of tactful inquiry for eliciting information about an individual client's specific patterns*. Ascertaining such data is likely to be highly sensitive and must be obtained quite early in the clinician-client relationship without unnecessary damage. Knowing some possible variations as well as sensitive techniques of questioning are useful skills in this regard.

Conclusion

Clinical training should provide a broad background through which a clinician can understand the proper management of every client encountered. These can be provided by offering an introduction to a variety of cultures, an appreciation of the subtypes existing within different cultures, the dimensions on which cultures may differ, and a methodology for determining the specific cultural patterns observed by each specific client. These should provide a clinician with the background to work with a variety of cultures, even those with which s/he is not familiar.

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