2 LEGAL, ETHICAL, AND CROSS-CULTURAL ISSUES

CHAPTER OBJECTIVES

1. Be aware of the various legal issues associated with the delivery and confidentiality of counseling services.
2. Discuss key ethical and legal considerations when providing counseling services within the institution and within the community.
3. Understand the dynamics associated with the counseling relationship that can lead to ethical violations.
4. Discuss the emergence of teletherapy within the counseling field for both general counseling services and the treatment of serious mental illness.
5. Define cultural competence and its importance when administering counseling services.
6. Discuss people with disabilities as a minority group and explain some of the protections that the Americans with Disabilities Act (ADA) affords them.

Legal issues in counseling can often be important since counselors are charge with protecting the rights of their clients. This is particularly true in regard to the client's confidentiality and other such concerns. However, the correctional environment opens up a number of additional concerns that are not usually found within the realm of the traditional counseling setting. It is important for the correctional counselor to understand basic legal principles common to the correctional setting so that counselors do not find themselves at cross purposes with the environment in which they work.

Correctional counselors have many responsibilities and obligations when providing therapeutic services. First they have a responsibility to their client. As such, they must promote the dignity and the welfare of their client, even though that client is incarcerated. This can actually be much more difficult than many novice counselors may realize. Amid this, counselors must take careful and complete notes of the clinical experiences during each session. These notes are records that are often referred to as case notes. The use of the Subjective, Objective, Assessment, and Plan/Prognosis approach, otherwise known as SOAP is presented as an organized and widely recognized method of constructing case notes.

It is important that the counselor safeguards the relationship between counselor and client. To do this, it is important that the client is given informed consent and that this is obtained in writing. Typically, a disclosure statement or a declarations of practices page. These documents simply inform the client of the counselor's credentials while also explaining the parameters associated with confidentiality. Though many clients will already be aware of much of this information, it is still strongly advised that counselors complete the process of obtaining signed informed consent; this safeguards the client and the counselor. Other ethical considerations associated with the client–counselor relationship, such as transference or countertransference, **dual relationships**, stress, and burnout, all must be attended to by the counselor.

It is important for correctional counselors to be culturally competent due to the diverse nature of the incarcerated population. **Cultural competence** is the idea of understanding how a multitude of different factors influence one's reasoning and decision-making processes. This general description applies to both counselors and clients. In order for counselors to successfully work with their clients, especially those who are members of one or more minority groups, they must intimately understand their own feelings and biases. Without this understanding it is doubtful that a counselor will be able to enact meaningful change on a consistent basis.

It is important to understand some of the distinguishing characteristics of each racial group. As indicated, in the correctional setting, each racial group is comprised of different subgroups and all share considerable diversity. Minority racial groups have suffered extreme oppression throughout their history that must be considered when attempting to diagnose and treat current symptoms. And it is important to note that some of their oppressive experiences have been at the hands of the criminal justice system.

One of the most important aspects of correctional counseling that practitioners and students need to be aware of involves the myriad of legal issues that must be considered. In addition, it is important to identify the sources of these rights so that a comprehensive understanding is possible. Before proceeding, however, a quick note should be made. It is likely that legal and ethical issues, concerning correctional counseling, are not usually the areas of interest to most persons wishing to learn about the correctional counseling process. However, this area of knowledge is fundamental for every counselor working in the criminal justice system for several reasons. First, incarcerated clients can be litigious and it is wise for mental health practitioners to understand the legal parameters within their field to avoid pitfalls or manipulation by their clientele. Second, ethical practice is a key to developing genuine rapport between the counselor and the client. Third, a counselor is essentially incompetent if they are not familiar with their profession's strictures on conduct and practice.

CONFIDENTIALITY

In relation to counseling, confidentiality is a concept that describes the process of keeping private or secret, information disclosed by a client to a counselor during a counseling session. The essence of confidentiality is very important to the success of counseling. This point was highlighted in the United States Supreme Court case of *Jaffee v. Redmond* (1996). In its opinion, the Court clearly articulated that an atmosphere of confidence and trust is necessary for a

client to feel comfortable enough to make disclosures relating to emotions, memories, and fears. The Court further reasoned that because of the nature of the problems for which clients seek the assistance of counselors, embarrassment or disgrace may be endured if information is not properly contained and is likely to impede the confidential relationship necessary for effective treatment.

Beyond these, however, the issue of confidentiality becomes much less clear, especially within the domain of correctional counseling. Remember, correctional counseling describes the process of a trained counselor helping a client identify and implement better methods of handling stressful life circumstances. Usually, confidentiality will be maintained unless the client presents a danger to self or others. *What needs to be made exceptionally clear, however, is the fact that the client is considered an adjudicated offender under the care of the criminal justice system*. In these circumstances confidentiality will always yield to issues of security, safety, and order, as well as the concept of punishment in the event the client discloses participation or knowledge of past, present or future criminal behavior. This is the reality of correctional counseling.

As Masters (2004) states, "In a criminal justice setting, whether during probation, incarceration, or some form of aftercare such as parole, it is impossible to assure a client of complete confidentiality" (p. 170). This is why it is paramount that informed consent be practiced in all circumstances and the stipulations governing the informed consent need to be articulated clearly and accurately. The concept of **informed consent** describes the process of a trained counselor educating the client on all legal and ethical parameters governing the counseling relationship. In other words, clients must be told that it is possible that anything they discuss in counseling may be disclosed under certain circumstances to the courts. Masters (2004) captures the essence of this point well by stating, "It is ethically indefensible to assure the client of confidentiality or have the client assume that privacy exists when it does not" (p. 171). Clients have the right to know what kind of treatment they are receiving, the associated risks, as well as the benefits and alternatives.

HIPAA and 42 CFR, Part 2

When considering confidentiality, it is important for correctional clinicians to know and understand the sources of confidentiality for their clients. Earlier, in the Vignette for Chapter 1, Sonya and Mr. Anderson referred to HIPAA, a commonly known acronym for the **Healthcare Insurance Portability and Accountability Act**. This act was originally developed in 1996 to allow persons in the work force to keep insurance and health-care rights and information between employers, but it's rules on privacy and security of personal medical information is where this act holds the most utility. It is important for students to understand that mental health information, including notes and other records are considered to be protected health information.

Protected health information (PHI) actually includes numerous forms of information that might be personal identifiers that, either alone or in tandem with other information, might reveal the identity of the individual and their medical (mental health) history. As Mr. Anderson had noted in the Vignette from Chapter 1, even disclosing the name of a client receiving services is a violation of HIPAA if it is to an unauthorized individual. It is important to understand

that HIPAA has numerous requirements, particularly regarding the security of electronic PHI. Further, for supervisors and agency administrators, requirements also include the need to conduct routine risk assessments for potential violations, audits for HIPAA compliance, and the need to train employees on secure procedures. This discussion has only presented an introductory explanation of HIPAA because this is sufficient for the purposes of this text. However, for those working in medical or mental health programs, the requirements can be a bit more extensive.

Because substance abuse treatment is so common within correctional treatment programs, it would be remiss to not include information related to that particular type of programming within the correctional environment. The purpose of **42 CFR, part 2** (note that CFR is an acronym for Code of Federal Regulations), is to apply protections to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. This is a federal confidentiality law that is specifically designed for persons who have a substance use disorder (SUD). It protects the privacy of (SUD) patient records by prohibiting unauthorized disclosures of patient records except in limited circumstances. This legislation was enacted in the 1970s to encourage individuals with SUDs to enter and remain in treatment (Legal Action Center, 2020). Without these protections, many people would avoid treatment. Note that there are multiple sections within Part 2 which, when taken together, generally prohibit treatment programs and from disclosing patient identities or records without patient consent, except in the following circumstances:

1. Medical emergencies
2. Child abuse or neglect reports required by state law
3. Reporting a patient's crime on program premises or against program personnel
4. A qualified audit or evaluation of the program
5. Court orders authorizing disclosure and use of the patient records
6. Research requests

Many persons who work in the field of correctional treatment are either not aware of 42 CFR, part 2 or, if they are, they do not really understand how it differs from HIPAA protections. While both Part 2 and HIPAA protect client privacy by regulating the way that client information can be shared and disclosed. HIPAA applies to many types of client information, not just SUD information, and generally is less protective of privacy than 42 CFR, Part 2. One of the most important differences between 42 CFR, Part 2 and HIPAA is the privacy protections for patient records in criminal and civil law suits. In both criminal and civil suit cases, 42 CFR, Part 2 requires a specific court order for the disclosure of protected information in response to a subpoena, search warrant, or law enforcement request. Unlike other types of protected health information, SUD records may expose a patient to criminal liability or other negative legal consequences. This is obviously very important in the correctional setting where all clients have criminal records and where many are involved with different types of civil litigation.

Likewise important, especially when correctional clients are on community supervision and seeking treatment, is that HIPAA does permit disclosures *without patient consent* for "treatment, payment, or healthcare operations." For clients with SUDs, these disclosures may lead to stigma and discrimination at the hands of their health-care providers and the loss of insurance or even employment. Contrary to HIPAA, 42 CFR, Part 2 requires patient consent authorizing disclosure of SUD records for treatment, payment, or health-care operations (Legal Action Center, 2020).

Duty to Warn and the Case of Tarasoff

One of the leading court cases governing the concept of confidentiality as it applies to information concerning the safety of a third party is *Tarasoff v. Regents* (1976). In essence, the court ruled that mental health professionals have the duty and obligation to protect a third party (public) in cases where they reasonably believe a client might endanger the third party; and this duty overrides any obligation to confidentiality. This is often referred to as the **duty to warn** requirement. Prosenjit Poddar was a graduate student at the University of California at Berkeley. He was also a voluntary outpatient at the University's student health center. During a counseling session, Poddar told the psychologist that he intended to kill his former girlfriend, Tatiana Tarasoff, when she returned to campus from visiting her Aunt in Brazil. In a counseling session, he disclosed that he was upset and depressed due to the fact that Tatiana was involved in other relationships with other men. Poddar stated that he was going to get a gun and shoot Tatiana. Based on this information the psychologist notified the campus police and informed them of what Poddar had stated. The campus police detained and questioned Poddar, who denied any intention of killing Tatiana. The campus police found Poddar to be rational and released him after he promised to stay away from Tatiana. Meanwhile, Poddar no longer sought counseling from the psychologist and no further action was taken. Two months later, when Tatiana returned, Poddar first stalked her and then stabbed her to death. Based on these circumstances the court stated, "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances" (*Tarasoff v. Regents*, 1976, p. 430).

When Do You Have Permission to Deviate From Confidentiality?

While confidentiality is a serious protection for clients in therapeutic programs, there are some exceptions and there are means available to get permission to talk to persons about the client, with their written consent. Prior to beginning and throughout the counseling process, correctional treatment providers must inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached (American Counseling Association, 2014). According to the American Counseling Association (2014), the limitations of confidentiality typically exist as follows:

1. **Serious and Foreseeable Harm and Legal Requirements**: The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed.
2. **Confidentiality Regarding End-of-Life Decisions**: Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties.
3. **Contagious, Life-Threatening Diseases**: When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease.
4. **Court-Ordered Disclosure**: When ordered by a court to release confidential or privileged information without a client's permission, counselors seek to obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible because of potential harm to the client or counseling relationship.
5. **Minimal Disclosure**: To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed. (p. 7)

ETHICS IN CORRECTIONAL COUNSELING

Ethics is a concept that describes the process of focusing on principles and standards that are used to guide the relationships between people and specifically for our purposes the relationship between counselor and client (Gladding, 2007). The concept of ethics is often used in conjunction with describing whether certain behaviors are considered legal. For example, someone may state, "Such conduct, within the context of counseling would be considered illegal and unethical." Appreciate, however, that in such a statement two different disciplines have been called on: one being the study of ethics and the other dealing with law. It may be that one way of teasing out the intended meaning of ethics is to think of the term as describing a discipline aimed at studying and identifying the parameters of human behavior and values within particular contexts.

When counselors are faced with situations containing circumstances that are difficult to resolve, they are expected to handle these situations in ways that are professionally appropriate for the well-being of the client and the integrity of the counseling process. Students may remember from Chapter 1 that the American Counseling Association (ACA, 2014) publishes a code of ethics aimed at providing direction and guidelines for counselors

when practicing their profession. Specifically, the *ACA Code of Ethics* serves the following purposes, among others:

1. The *Code* sets forth the ethical obligations of ACA members and provides guidance intended to inform the ethical practice of professional counselors.
2. The *Code* identifies ethical considerations relevant to professional counselors and counselors-in-training.
3. The *Code* enables the association to clarify for current and prospective members, and for those served by members, the nature of the ethical responsibilities held in common by its members.
4. The *Code* serves as an ethical guide designed to assist members in constructing a course of action that best serves those utilizing counseling services and establishes expectations of conduct with a primary emphasis on the role of the professional counselor.

The remainder of this section of the chapter will draw from basic tenets derived from the *ACA Code of Ethics*. To begin, we consider Section A.1.a., titled Primary Responsibility, which states, "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (ACA, 2014, p.4). Although not specific in providing dictates of exact behavior, the above section does provide crucial guidance. In essence, when attempting to figure out what behavior is most appropriate, one question to ask oneself is, "Are my actions in accordance with the best interest of my client?"

Case Notes and Session Recording

One of the most important elements of the correctional counseling process and, directly addressed by ethical codes of conduct, is the accurate recording of notes pertaining to the activities of all counseling sessions. Recording and maintaining accurate records is no longer something counselors should do but instead something counselors must do. This is partly due to the litigious nature of current society and the accurate recording of notes is one way to guard against potential liability concerns. In addition, case notes are vital to the process of keeping counseling sessions focused on pertinent issues of concern to the client(s). To keep counseling sessions on track, case notes should reflect the client's progress, or lack thereof, especially as it relates to the particular goals of a client. Case notes provide one avenue for counselors to stay focused on particular issues as well as to verify compliance with legal issues. In their code of ethics, the ACA (2014) in section A.1.b. states the following regarding clients' records:

> Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services

provided. If errors are made in client records, counselors take steps to properly not the correction of such errors according to agency or institutional policies. (p. 4)

One of the most popular methods of capturing necessary information regarding the events that transpire during counseling sessions is described by the acronym SOAP. **SOAP notes** originally developed by Weed (1964) provide a method of collecting and documenting information that help counselors identify, prioritize, and track needs of clients so that they may be attended to in a timely and systematic fashion (Cameron & Turtle-Song, 2002). Each letter of the acronym represents a particular component of the data collection method:

- **S (Subjective)—**A concept that describes the process of interpreting observations based on one's own mind. This is where a counselor describes their impressions of a particular client. Particularly salient to this section is the description of a client's expression of feelings, concerns, plans, or goals, as well as the attendant levels of intensity attached to each (Cameron & Turtle-Song, 2002).
- **O (Objective)—**A concept that describes the process of a particular phenomenon being observable. The objective portion may consist of an client's appearance, certain behaviors, abilities, among others. In this section, counselor observations should be stated in precise and descriptive terms that are quantifiable. Labels, judgments and opinions should be avoided.
- **A (Assessment)—**An assessment is a concept that describes the process of a trained counselor providing an evaluation of a client that incorporates the subjective and objective observations. It usually contains diagnostic terms such as *depression, anxiety, anti-social disorder, bi-polar, obsessive compulsive disorder* (OCD), among others. The assessment component is the most likely section to be read by outside reviewers or auditors. It should be complete, and based on factual evidence that is supported by information contained in the subjective and objective portions of the format (Cameron & Turtle-Song, 2002).
- **P (Plan/Prognosis)—**A plan is a concept that describes the particular actions that will be carried out as a result of the assessment. Information contained in the plan usually consists of such entries describing the particular interventions used, educational components used to assist comprehension, the client's progress, direction that will be taken in the next session, as well as the date of the next section.

Accountability is a vital component of the counseling process that must be adhered too. The best way to ensure accountability is to accurately and ethically note all happenings of the counseling process and then record these notes in appropriate files. SOAP is one format, among many, that provides guidelines that serve to help counselors ensure they are recording necessary information. The following tables are meant to serve as a guide or reference point (Tables 2.1 and 2.2). They are not meant to be all inclusive but instead a tool provided to assist counselors in making sure they are capturing the essence of what is required in documenting the status of a particular client. The tables contain our selections borrowed from the work of Cameron and Turtle-Song (2002).

TABLE 2.1 ■ Summary of Definitions and Examples

Section	Definitions	Examples
(S) Subjective	What the client tells you What pertinent others tell you about the client Basically, how the client experiences the world	Client's feelings, concerns, plans, goals, and thoughts Intensity of problems and impact on relationships Client's orientation time, place, and person
(O) Objective	Factual What the counselor personally observes/witnesses Quantifiable—what was seen, counted, smelled, heard, or measured	The client's general appearance Client's demonstrated strengths and weaknesses
(A) Assessment	Summarized the counselor's clinical thinking A synthesis of the analysis of the subjective and objective portion of the notes	Include clinical diagnosis and impressions
(P) Plan	Describes the parameters of treatment based on the assessment	Includes interventions used, progress, and direction of future intervention

TABLE 2.2 ■ Guidelines for Note-Taking

Do	Avoid
Be brief and concise. Keep quotes to a minimum. Use an active voice. Use precise and descriptive terminology. Record immediately after each session. Use proper spelling, grammar, and punctuation. Document all contact or attempted contacts. Use only black ink if notes are handwritten. Sign-off using legal signature and include your title.	Do not use names of other clients, family members, or other individuals named by the client. Avoid terms like *seems* or *appears*. Avoid common labels that can be interpreted in various ways. Only use terminology that you are trained to use. Do not leave blank spaces. Do not use margins or try to squeeze additional commentary between lines.

Informed Consent

As discussed earlier, informed consent is a critical component of any respectable counseling process. It is important to note that there are ethical guidelines that inform the proper process and circumstances in which consent should be obtained from clients. In addition, informed consent is often obtained in separate circumstances that may fall under the umbrella of counseling. For example, within correctional counseling, clients will often be asked to provide consent to the initial assessment. In addition, it is common to have an evaluation component attached to many of the correctional counseling programs, which also requires informed consent. Evaluation

studies are primarily aimed at measuring selected variables at different points in time to determine if progress is being made by the client. It is important that clients' know the nature of the data that will be collected and the uses of such data. In its ethical standards the American Counseling Association (2021) directly addresses the issue of informed consent as it relates to assessment for the purposes of research as well as the counseling relationship.

Prior to assessing a client counselors should "explain the nature and purposes of assessment and the specific use of results in language the client (or other legally authorized person on behalf of the client) can understand, unless an explicit exception to this right has been agreed upon in advance. Regardless of whether scoring and interpretation are completed by counselors, by assistants, or by computer or other outside services, counselors take reasonable steps to ensure that appropriate explanations are given to the client" (ACA, p. 12).

In addition, clients need to be informed, in a manner in which they understand, the likely processes that will take place during counseling sessions. The ACA (2021) makes this clear in section A.2.a. where it states,

> Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship. (p. 4).

Further, clients need to be given clear and distinct information in regard to the counselor who delivers therapeutic services. Beyond matters of confidentiality, clients have a right to know other parameters related to their counselor and their perspective, before any counseling begins. Clients should be informed of the counselor's qualifications and credentials, the parameters related to those credentials, the nature of the counseling relationship, the counselor's areas of expertise, fess and services offered, the boundaries of privileged communication, the limits of confidentiality, client responsibilities, and any potential risks that may occur as a result of the counseling process. Each of these points of information are important because they educate the client on the process and they ensure that no feelings of betrayal emerge from the client as the counselor administers services or ensures compliance with the agreed-upon treatment plan. The information just noted is typically included on what is referred to as a Disclosure Statement in many states. In other states, the official term may be a *Declarations and Procedures* form (see Figure 2.1 for an example). Regardless of the specific name given to the hardcopy form that is used, this process ensures that clients know, upfront, all of the specific details about the counseling process that they are about to become involved in. This is important because this goes well beyond being informed of limitations of confidentiality; it tells the client exactly what they should expect in therapy. While the boundaries of confidentiality are indeed important, clients need to understand the mechanics behind the therapeutic process since this optimizes their ability to participate. In many cases, clients may see the process of completing the disclosure statement as a mere formality and some may even find it to be a trifling issue, but the counselor should ensure that this information is understood

FIGURE 2.1 ■ Declarations and Procedures Form

DECLARATION OF PRACTICES AND PROCEDURES

John Smith

101 Main Street, Mayberry, USA 11001

(000) 000-000

Qualifications: I earned an MA degree from the University of _____ in 2010. I am a **Licensed Professional Counselor** (L.P.C. #0000) with the LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS, 8631 SUMMA AVENUE, BATON ROUGE, LOUISIANA 70809, TELEPHONE (225) 765-2515. I am also a **Licensed Addiction Counselor** (LAC # 0000) with the Addictive Disorder Regulatory Authority of Louisiana, Baton Rouge, Louisiana 70809. Telephone: (225) 922-7700.

Counseling Relationship: I see counseling as a process in which you, the client, and I, the counselor have come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals.

Areas of Expertise: I have a specialty in addictions counseling and I am licensed to provide services that are related to the addicted population as well as general counseling services to a wide variety of populations.

Fee Scale: The fee for my services typically range from $50.00 to $75.00 per session. However, I do operate on a sliding scale for remuneration, depending on the individual client's particular financial circumstances and their state of need. Payment is due at the time of service and clients are seen by appointment only. Clients will be charged for appointments that are broken or canceled without 24-hour notice. Payment is not accepted from insurance companies.

Services Offered and Clients Served: I approach counseling from a cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the client's problems and to develop solutions. I work in a variety of formats, including individual counseling, couples counseling (related to addiction issues), and family counseling (as related to addiction and recovery). I also conduct group therapy. I see clients of all ages and backgrounds with the exception that I do not work individually with children under the age of six.

Code of Conduct: As a counselor, I am required by state law to adhere to the Code of Conduct for Licensed Professional Counselors that has been adopted by my licensing board. A Copy of this Code of Conduct is available upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except for:

a) The client signs a written release of information indicating informed consent of such release.

b) The client expresses intent to harm him/herself or someone else.

c) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 years of age or older), or a dependent adult.

d) A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on the behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise the client of all mandated disclosures as conceivable. In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's permission. Any material obtained with a minor client may be shared with the client's parents or guardian.

Emergency Situation: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911.

FIGURE 2.1 ■ Declarations and Procedures Form *(Continued)*

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If, as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our treatment plan and any medication schedules that you are now under.

Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of the medicines that you are now taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs the client should feel free to share these concerns with me.

I have read and understand the above information

Counselor Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

I, signature of parent or guardian _____, give permission for **John Smith** to conduct counseling with my (relationship), _____ (name of minor) _____.

by the client prior to conducting counseling. If done correctly, the counselor can use this process as a rapport-building opportunity by emphasizing that it is important to them, as a professional, to ensure that the client is as fully informed as is possible. The counselor should emphasize that is their desire to provide ethical counseling services when requiring that the client become fully familiar with the elements of the counseling relationship. See Figure 2.1 for an example of a Declarations and Procedures document which includes all of the information just discussed.

PROFESSIONAL BOUNDARY-SETTING

Critical to the survival of any counseling relationship is the fact that certain boundaries must be established and not breeched. From a geographical standpoint a boundary is relatively clear. It is a line, often marked by a fence or other physical structure that clearly illuminates where one property begins and another ends. Boundaries between people, however, are often complex and not as clear. Emotions and feelings often add to the complexity making it difficult to decipher what actions are appropriate in certain situations. The concept of a power differential is what usually provides the foundation for the formation of a counseling relationship. The power differential exists because of the specialized knowledge and training the counselor possesses that is ultimately being sought by the client. It is precisely the result of this differential that certain boundaries must not be crossed. To do so, would in essence change the foundation of the relationship, which in most cases would prove harmful to the client. Especially, in light of the fact that the counseling relationship is one of the most

powerful components of the counseling process capable of fostering meaningful transformation on behalf of the client.

Transference

Not all clients, especially those within correctional settings, will be open to the concept of counseling. They may be participating as a result of court order, or in an attempt to garner a lighter sentence or an earlier release. In fact, some clients may be difficult and troublesome for the trained counselor who may at times feel abused. It is vital that counselors be able to respond to such feelings without inflicting punishment on the client. A particular phenomenon that is common in some counseling relationships is the concept of transference**. Transference** is a concept that describes the process of a client projecting onto the counselor traits or characteristics of others in the client's life (Brown & Srebalus, 2003). For example, if a client sees the counselor as possessing traits similar to those of authority figures, the client may respond to or treat the counselor similar to the way he has treated other authority figures. This could mean the client becomes hostile or openly agitated with counselor. Another possibility is the client may withdraw and become silent if the counselor is perceived as a figure of authority. This response is especially likely for some clients who have experienced abuse at the hands of caregivers and were never allowed to express feelings or emotion.

Countertransference

In the event that transference takes place in the counseling relationship counselors must be vigilant and not allow themselves to further contribute to the phenomenon through the concept of countertransference. **Countertransference** is a concept that describes the process of a counselor projecting onto the client undeserved qualities or attributes. If reacted to in a hostile fashion by a client, the counselor may respond emotionally, portraying inappropriate intensity that does not foster growth or functional learning on the part of the client. In such a case, the counselor has reacted in a manner described by the concept of countertransference. In effect, the counselor has reacted to the traits or characteristics of the client in the same way the counselor may treat others with similar attributes. As a result, counselors must be able to manage the process of transference in a manner that helps the client become more aware of their own emotion and feelings. For the counselor to become a participant, through the process of countertransference, in an unproductive exchange is damaging to the overall health of the counseling relationship.

Sexual Attraction

In correctional counseling, sexual attraction does occur between counselors and clients. The success of the counseling relationship depends, in large part, on the depth of the connection between the counselor and client. Sufficient depth within the counseling relationship is needed to foster an environment conducive to clients' sharing deep feelings and emotions. This requires trust that is established based on the counselor's genuine expressions of care, compassion and empathy. As noted by Masters (2004), however, this can sometimes result in the counselor's professional warmth being misunderstood by clients resulting in attraction and crushes. Counselors also need to ensure that their motivations for entering into a counseling relationship

are pure. In other words, counselors need to avoid trying to get their own needs met through the counseling relationship.

In reality, it is unethical for a trained counselor to engage in a sexual relationship with a client. It is not unethical for a counselor to find a client attractive; it is unethical, however, if the counselor acts on the attraction or serves to perpetuate a sexual relationship through inappropriate behavior. This is primarily because counseling relationships are not based on mutuality. In most cases, clients are more vulnerable and perceive the counselor as someone with special knowledge. When sexual relations begin, the true objectives of the counseling relationship are lost. In addition, the counselor will be held responsible. In most cases involving sexual relationships between counselors and clients in criminal justice settings, the counselors will be terminated.

Dual Relationships

Dual relationship is a concept that describes the process of a counselor and client entering into a relationship(s) that is beyond or distinguished from the counseling relationship. As mentioned above, sexual relationships certainly constitute dual relationships. In addition, nonsexual dual relationships should also be avoided. Nonsexual dual relationships include business transactions where the counselor and client engage in some type of business venture while the counseling process is still under way. For example, during a counseling session the client tells the counselor that he is a skilled carpenter. The counselor needs work done on the house and asks the client if he would be willing to make some repairs. The client agrees and the two decide that the work needed to be done would equate to approximately the same cost of three counseling sessions.

The problem with this kind of arrangement lies in the possibility of the product not being satisfactory. In such a case where the repairs are not done properly or the counselor "slacks off" and does not properly attend to the client, the counseling relationship will likely suffer. As a result, counselors should refrain from doing business or accepting gratuities from clients. In addition, due to the same ethical reasons, Gladding (2007) suggests that counselors should not enter into a counseling relationship with close friends, family members, students, lovers, or employees.

THE ADVENT OF TELETHERAPY IN COUNSELING AND MENTAL HEALTH SERVICES

Teletherapy is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for approximately two decades. Teletherapy is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. According to the Substance Abuse and Mental Health Services Administration (SAMHSA; 2021), **teletherapy** is the use of telecommunication technologies and electronic information to provide care and facilitate client–counselor interactions (see Box 2.1). It is comprised of two forms:

1. Two-way, synchronous, interactive client–provider communication through audio and video equipment.
2. Asynchronous client–provider interactions using various forms of technology.

A variety of mental health professionals (e.g., psychiatrists, primary care providers, mental health counselors, social workers, psychologists, addiction counselors, case managers, opioid treatment providers, peer workers) can implement telehealth methods. In addition, practitioners can use teletherapy with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences.

BOX 2.1: THE COVID PANDEMIC AND TELETHERAPY

Implementation and use of telehealth as a mode of service delivery has been increasing in recent years. Between 2016 and 2019, use of telehealth doubled from 14% to 28%. This trend continued between 2019 and 2020, due in large part to the COVID-19 pandemic. Telehealth visits for mental health increased by 556% between March 11 and April 22, 2020.

The use of teletherapy was steadily increasing prior to the COVID-19 pandemic. Between 2016 and 2019, substance use disorder (SUD) treatment offered through telehealth increased from 13.5% to 17.4%. Greater adoption of telehealth was associated with rural locations, as well as those that provided multiple treatment settings, offered pharmacotherapy, and served both adult and pediatric populations.

Teletherapy visits increased among rural Medicare beneficiaries, including a 425% increase for mental health appointments between 2010 and 2017. Among these beneficiaries, people living with schizophrenia or bipolar disorder in rural areas were more likely to use telehealth for mental health care than those with any other mental illness or those living in urban areas.

Source: Substance Abuse and Mental Health Services Administration. (2021). *Telehealth for the treatment of serious mental illness and substance use disorders.* U.S. Department of Health and Human Services.

Some Ethical Considerations When Using Teletherapy

When using telehealth approaches, it is important to take a few precautions. First, it is important to assess whether teletherapy may be appropriate for the client. Telehealth modalities may not be appropriate for all clients at all points of their treatment plans. Some treatment and follow-up care requires in-person visits (e.g., urine drug screenings for clients on medication for substance use disorder). Some clients may respond differently to in-person versus videoconference therapy and may benefit from a hybrid or in-person approach. Screening and assessing clients for their readiness to participate in and conduct appropriate activities using telehealth modalities can inform both care planning and delivery. In addition, it can mitigate client challenges through careful preparation and structured conversations.

As with face-to-face counseling, it is important to conduct a thorough informed consent process that includes, at a minimum, the following:

1. *What is teletherapy?*: Explain what teletherapy is and why you are using it for the client's care.
2. *Potential privacy concerns*: The presence of family members, caregivers, or roommates in the home during a telehealth visit could hinder a client's ability to fully engage in the

visit. Remind the client to be in a private space, away from other people, and assure the client that their conversation is private on the provider's side. Ensure the client knows how to mute the audio and disable video in case they want privacy during disruptions.

3. *Patient communications*: Notify clients about how electronic client communications are stored and who may access these communications.
4. *Backup plan:* Discuss protocols in the case that technology fails or clients need a higher level of care.
5. *Discuss ways to ensure client privacy during sessions:* To guarantee privacy, consider making it a practice to clarify the client's location and who is in the virtual room in case someone is off-camera. This action can affirm your commitment to the client's privacy.

Lastly, it may be important to inform the client of teletherapy norms. For instance, while the session may be taking place in the client's home, ask that the client dress appropriately. Be sure to let the client know that the camera angle and quality, screen size, and other factors can limit the ability to read a client's behavior. Ask the client to adjust the camera angle, if possible, to aid in reading nonverbal cues. Further, it may be necessary to remind clients not to multitask while engaging in the session, such as texting or using the internet. Empower the client to share if they are having difficulties hearing or engaging with the provider. Lastly, clients need to understand that while the provider may be taking notes or documenting in the medical record, the provider's attention is focused on the client. Figure 2.2 provides an example of a Teletherapy Declaration and Informed Consent page from the state of Louisiana. Many states have developed and required similar forms when counselors provide online therapeutic services within their jurisdiction. Note that this is considered an addendum to the form included earlier with Figure 2.1 of this chapter.

Using Telehealth (Teletherapy) With Serious Mental Illness and Persons in Crisis

While it can probably be readily understood how teletherapy services may be used with individuals who have general counseling needs, it was not initially clear as to whether this would be a viable option when addressing psychiatric disorders, or persons with serious mental illness. In short, ***serious mental illness*** **(SMI)** is defined as a mental, behavioral, or emotional disorder among adults ages 18 and older resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (US Department of Health and Human Services [DHHS], 2021).

Consider that among adults ages 18 or older in 2019, about 13.1 million people had an SMI in the United States (DHHS, 2021). Of those, almost half (6.2 million people) reported an unmet need for mental health services in the past year. Telehealth has the potential to address this treatment gap, making treatment services more accessible and convenient, and improving mental health outcomes. By implementing the appropriate modifications, such as provider–client agreements, and safeguards, professionals can ensure that persons with serious mental illnesses benefit from services delivered via telehealth. Providers can identify their clients' specific

FIGURE 2.2 ■ Teletherapy Declaration and Informed Consent

John Smith, LPC

Teletherapy Declaration and Informed Consent

(An Additional Document to the normal

Declaration of Practices used for In-Person Sessions)

TO CLIENTS

Licensed mental health professionals are required by their licensing boards to provide you, the client, with certain basic information. You have already received and signed the basic Declaration of Practices and Procedures from John Smith, LPC. This Teletherapy Policy & Procedure document describes certain important aspects of therapy unique to Teletherapy. I am providing you this information for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

By signing this form, you are not making a commitment to continue teletherapy therapy as a permanent modality, but you will continue to have that option should you and Robert Hanser, LPC-SA both agree that it is in your best interest.

QUALIFICATIONS OF CLINICIAN

I have completed 9 hours of live telehealth care training in addition to my professional qualifications as a clinician. This training covered the Law and Ethics and Clinical Skills specifically related to telehealth care. I will continue to receive at least three hours of continuing education in the area of telemental health every two years. All teletherapy sessions will be conducted through Doxy.me which is encrypted to the federal standard.

SCHEDULING & STRUCTURE OF TECHNOLOGY

Counseling sessions will be scheduled in 50 minute increments, unless you and John Smith, LPC, agree on a different time schedule. The next session will scheduled at the end of the current session, unless otherwise agreed upon. The structure of sessions will be dependent on the treatment plan and interventions being used.

ETHICAL & LEGAL RIGHTS RELATED TO TELETHERAPY

John Smith, LPC will not be conducting Teletherapy in any other state than Louisiana unless she specifically seeks and obtains licensure in the other state. It is important for you, as a client, to realize if you should relocate to another state, Robert Hanser, LPC-SA ability to continue to conduct teletherapy would be dependent on her decision whether or not to seek licensure in the state to which you are relocated.

RESPONSIBILITIES OF THE CLIENT

All clients should:

- Be appropriately dressed during sessions.
- Avoid using alcohol, drugs, or other mind-altering substances prior to session.
- Be located in a safe and private area appropriate for a teletherapy sessions.
- Make every attempt to be in a location with stable internet capability.

Clients should NOT:

- Record sessions unless first obtaining Robert Hanser, LPC-SA permission.
- Have anyone else in the room unless you first discuss it with Robert Hanser, LPC-SA.
- Conduct other activities while in session (such as texting, driving, etc.).

* If the client is a minor, a parent or guardian must be present at the location/building of the teletherapy session (unless otherwise agreed upon with the therapist).

FIGURE 2.2 ■ Teletherapy Declaration and Informed Consent *(Continued)*

POTENTIAL COUNSELING RISKS

When using technology to communicate on any level, there are some important risk factors of which to be aware. It is possible that information might be intercepted, forwarded, stored, sent out, or even changed from its original state. It is also possible that the security of the device used may be compromised. Best practice efforts are made to protect the security and overall privacy of all electronic communications with you. However, complete security of this information is not possible. Using methods of electronic communication with us outside of our recommendations creates a reasonable possibility that a third party may be able to intercept that communication. It is your responsibility to review the privacy sections and agreement forms of any application and technology you use. Please remember that depending on the device being used, others within your circle (i.e. family, friends, employers, & co-workers) and those not in your circle (i.e. criminals, scam artists) may have access to your device. Reviewing the privacy sections for your devices is essential. Please contact me with any questions that you may have on privacy measures.

POTENTIAL LIMITATIONS OF TELETHERAPY

Teletherapy is an alternate form of counseling and should not be viewed as a substitution for taking medication that has previously been prescribed by a medical doctor.

It has possible benefits and limitations. By signing this document, you agree that you understand that:

- Teletherapy may not be appropriate if you are having a crisis, acute psychosis, or suicidal/homicidal thoughts.
- Misunderstandings may occur due to a lack of visual and/or audio cues.
- Disruptions in the service and quality of the technology used may occur.
- While I do not file insurance claims, I can make an invoice available to you to file with your insurance company. Please check with them ahead of time to be sure your policy covers telemental health counseling.

EMERGENCY SITUATIONS

The following items are important and necessary for your safety. The clinician will need this information in order to get you help in the case of an emergency. By signing this consent to treatment form you are acknowledging that you have read, understand, and agree to the following:

- The client will inform John Smith, LPC of the physical location where he/she is, and will utilize consistently while participating in sessions and will inform John Smith, LPC if this location changes.
- In the first teletherapy session, your will provide the name of a person John Smith, LPC is allowed to contact in the case she believes you are at risk. You will be asked to sign a release of information for this contact.
- In the first teletherapy session, you will provide information about the make, model, color, and tag number of your automobile.
- In each session the you will provide information about the nearest emergency room or emergency services (such as fire station, police station, if there is not an emergency room nearby.)
- Depending on the assessment of risk and in the event of an emergency, you or John Smith, LPC may be required to verify that the emergency contact person is able and willing to go to the client's location and, if that person deems necessary, call 911 and/or transport the client to a hospital. In addition to this, John Smith, LPC may assess, and therefore require that you, the client create a safe environment at your location during the entire time of treatment. If an assessment is made for the need of a "safe environment" a plan for this safe environment will be developed at the time of need and made clear by John Smith, LPC.

FIGURE 2.2 ■ Teletherapy Declaration and Informed Consent *(Continued)*

- In the case of a need to speak to me between sessions, please call, or text, and leave a
- message. I do not provide emergency services on a 24-hour basis. If your emergency is after hours, please contact your nearest emergency room. Typically contact between sessions is limited to arranging for appointments.
- If you are in need of the services of other professionals, I am happy to consult and coordinate with them. Clients should not routinely be meeting with more than one counselor, unless the two counselors have agreed to coordinate your care.

BACKUP PLAN IN CASE OF TECHNOLOGY FAILURE

A phone is the most reliable backup option in case of technological failure. It is, therefore, highly recommended that you always have a phone at your disposal and that I know your phone number. If disconnection from a video conference occurs, end the session and I will attempt to restart the session. If reconnection does not occur within five minutes, call me at the contact number I have provided. If, within 5 minutes, I do not hear from you, you agree (unless otherwise requested) that I can call the provided phone number.

CONSENT TO TELETHERAPY TREATMENT

I have read this Declaration of Telehealth Policies and Procedures and my signature below indicates my full informed consent to services provided by Robert Hanser, LPC-SA via teletherapy treatment.

Client Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

Clinician's Signature: _____ **Date:** _____

Parental Authorization for Minors I, _____, give permission for _____ (clinician's name) to conduct counseling with my (relationship), _____, (name of minor) _____

(Options for recording your signature:

- You may sign this document while I am watching via video; or
- You may scan the signature page and send it via text to me; or
- You may snap a picture and send it via text to me.

barriers to participating in telehealth appointments (e.g., access and comfort with technology, ability to have private or confidential conversations, safety of the home environment) and inform conversations with their clients on strategies to address these barriers.

Further, this approach to counseling can reduce the likelihood of stigma that some individuals with mental health issues face when accessing treatment. Through telehealth, clients can disclose their SUD or SMI from the privacy of their own home. In rural communities with fewer behavioral health providers, telehealth can connect clients with providers in other geographic locations, which can increase their privacy and protect their anonymity when accessing care. Likewise, there is some research that demonstrates that telehealth counseling generates similar client satisfaction outcomes as are found with in-person treatment approaches. Thus, despite some initial client hesitancy toward using telehealth, clients often report comparable satisfaction between telehealth and in-person care.

It should be intuitively obvious to the reader that persons who have serious forms of mental illness also tend to be prone to experiencing crises on a more frequent basis than most other

individuals. Indeed, it is important when assisting persons with serious mental illness to have effective supports that are readily available as rapidly as possible. Teletherapy modalities can increase the availability of these needed crisis services, ensuring these services are available to anyone, anywhere, at any time. Crisis services are an effective strategy for suicide prevention and resolving acute mental health and substance use crises, as well as for reducing psychiatric hospital bed overuse, inappropriate use of emergency departments, inappropriate use of law enforcement resources, and the fragmentation of mental health care.

Crisis services are an effective strategy for suicide prevention and resolving acute mental health and substance use crises, as well as for reducing psychiatric hospital bed overuse, inappropriate use of emergency departments, inappropriate use of law enforcement resources, and the fragmentation of mental health care (DHHS, 2021). Crisis call hotlines and other similar features provide synchronous telephonic crisis services, text, and online chat technology to triage needs, assess for additional needs and preferences, and coordinate connections for additional post-crisis support. In addition to telephone calls and live online chats or texts, regional crisis call centers can also make use of the following technologies to support an individual's well-being. These services can even be useful when individuals express suicidal ideations. Figure 2.3 provides an overview of some potential online telehealth tools to assist with individuals who are suicidal.

FIGURE 2.3 ■ Teletherapy Modalities for Suicide Screening and Assessment

Suicide Screening and Assessment

Telehealth modalities provide an effective alternative to in-person suicide screening and assessment. The following suicide screening and assessment tools can be implemented through telehealth modalities:

- The Ask Suicide-Screening Question Toolkit (ASQ) from the National Institute of Mental Health (NIMH) is an evidence-based, 20-second, four-question suicide screening tool.
- The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based intervention to assess, treat, and manage clients with suicidal ideation in a range of clinical settings.
- Columbia-Suicide Severity Rating Scale (C-SSRS), also known as the Columbia Protocol, can be used to determine whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support the person needs.

If a client is at risk of imminent harm:

1. **Assess immediate danger.** If the client is in immediate danger and the provider is unable to detain or physically intervene, the provider must contact emergency services.
2. **Identify the client's location** in case emergency services are necessary.
3. **Work with other care providers (e.g., suicide prevention coordinators) when contacting emergency services.** Remain connected with the client as the client connects with emergency services or while arranging hospitalization.
4. **Support clients as they navigate the triage process at an emergency department.** Treatment programs should have safety protocols to mitigate risks and create a workflow to support the client; providers should determine the suicide risk level with criteria that identify the appropriate clinical response.

Naturally, suicidal thoughts are a serious matter and while distance approaches to intervention can provide quick real-time responses, the counselor will want to get the client within a physical vicinity of safety if there is a likelihood that an attempt may occur. Though online methods of intervention may not be sufficient, in and of themselves, they are expedient and effective tools to add to the repertoire of responses the counselor might have available. Later in Chapter 15, discussion related to suicide and appropriate means of intervention will be provided in significant detail. Such a discussion will not be provided here. However, students are encouraged to refer back and reflect on Figure 2.3 when they are reading through those sections of Chapter 15. This may help to further reinforce the usefulness of telehealth and the emphasis on ethics may be helpful when considering the clinical topics that are included in Chapter 15, as well.

Telehealth as a Means of Reaching Underserved Populations

Students may recall from Chapter 1 that Crethar and Ratts (2008) pointed toward the importance of *access* and *participation* as two of four key principles when striving for socially just mental health services for underserved and marginalized populations. Further, there is substantial research that demonstrates that various cultural and ethnic groups suffer from disparities in access to health-care services; this include mental health services, as well (National Alliance on Mental Illness [NAMI], 2021). In addition, some minority groups may have specific belief systems that keep them from accessing these services. Indeed, Negative attitudes and beliefs toward people who live with mental health conditions is pervasive within the United States, but they can be particularly strong within the African American community (NAMI, 2021). One study by Ward and colleagues(2013) showed that approximately 63% of African Americans believe that a mental health condition is a sign of personal weakness. As a result, people may experience shame about having a mental illness and worry that they may be discriminated against due to their condition.

For Latinx Americans ages 18 to 25 with serious mental illness, more than half will not receive treatment. This inequality puts these communities at a higher risk for more severe and persistent forms of mental health conditions, because without treatment, mental health conditions often worsen. Add to this the challenge of finding Spanish-speaking mental health professionals for clients who are not fluent in English, and the issues becomes even more complicated.

Going further, Asian Americans have the lowest rate of access to mental health assistance of any racial/ethnic group, with only 23.3% of Asian American/Pacific Islander (AAPI) adults with a mental illness receiving treatment in 2019 (NAMI, 2021). This is due to the many systemic barriers to accessing mental health care and quality treatment. It may also be driven by stigma and lack of culturally relevant and integrated care that addresses mental health in a more holistic way. These disparities can lead to worsened symptoms and poorer quality of life due to the lack of or delayed treatment.

Many Native Americans live in rural and isolated areas, reducing access to mental health services to meet their needs. While most of the clinics and hospitals of the Native Health Service are located on reservations, the majority of Native American people live outside of tribal areas. Further, Native American groups are quite varied and spread out throughout broad areas of

the United States. This makes it difficult to provide any type of comprehensive intervention to these disparate groups.

Naturally, other minority and marginalized groups, such as the LGBTQ community, disabled people, and veterans also tend to be underserved. This is also the case with those who live in poverty and those who are unhoused. The next feature provides a look at a telehealth program that provides effective mental health and addiction services to underserved minority populations using a variety of counseling approaches (see Box 2.2).

BOX 2.2: CULTURALLY COMPETENT USE OF TELETHERAPY SERVICES

The Citywide Case Management Program (Citywide) is a division of the University of California San Francisco's (UCSF) Department of Psychiatry and operates under direction of Zuckerberg San Francisco General Hospital (ZSFG). Citywide has been in operation since 1981 and became part of ZSFG in 1983.

Citywide has 170 staff and is the largest provider of intensive case management (ICM) services in San Francisco. Citywide's mission is to support the recovery of adults with SMI in San Francisco, reduce their use of institutional and acute care (e.g., psychiatric emergency services, hospital care, jails), and help maximize their ability to maintain stable, productive, and fulfilling lives in the community.

Citywide ICM teams are interdisciplinary teams of social workers, nurses, psychiatrists, employment specialists, and peer counselors, providing services to around 100 to 200 clients per team.

To appropriately meet the clients' needs, Citywide has four culturally and linguistically focused ICM teams:

- Hong Ling Team (Chinese and Vietnamese)
- Cross Currents Team (LGBTQ and women)
- Kujichagulia Team (African American)
- Senderos Team (Latino and Korean)

In addition, Citywide has teams that specialize in working with justice-involved individuals, including individuals on probation and parole.

Further still, Citywide provides psychosocial treatment, medication-assisted treatment (MAT), substance use treatment groups, and socialization groups, and utilizes a combination of behavioral therapies, including cognitive behavioral therapy (CBT), CBT for psychosis, behavioral activation (BA) therapy, cognitive processing therapy (CPT), dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT).

The population of focus is adult clients with serious mental illness (SMI) who are experiencing unstable housing or homelessness. Citywide serves approximately 1,500 clients at any given time. Citywide clients primarily experience SMI (e.g., schizophrenia, schizoaffective disorder, and bipolar disorder), co-occurring SUD, and significant psychosocial challenges. Most clients experience poverty, with approximately 90% of clients subsisting on social security or county general assistance. Most clients also experience unstable housing and cycle in and out of homelessness, living in single-room occupancy hotels or shelters. Many clients have experienced extensive trauma from their housing instability and often persistent and lifelong encounters with child welfare and justice system institutions.

Citywide clients are disproportionately racial minorities; for instance, while San Francisco's Black population is below 5%, Citywide's client population is 30% Black. Note that this program is particularly important later in this chapter when we discuss cultural competence and services for a variety of diverse populations.

Source: Substance Abuse and Mental Health Services Administration. (2021). *Telehealth for the treatment of serious mental illness and substance use disorders.* U.S. Department of Health and Human Services.

Perhaps, to some extent, the use of telehealth services can address the *access* and *participation* principles that were proposed as integral to achieving social justice in counseling and mental health services (Crethar & Ratts, 2008). This important as we transition into our discussion about cultural competence in the counseling process.

Despite these potential benefits, concerns with access still remain, particularly in regard to technology literacy or those with disabilities. In fact, Americans ages 65 and older (18% of the population) are most likely to have a chronic disease, but almost half (40% to 45%) do not own a smartphone or have broadband internet access (SAMHSA, 2021). People experiencing poverty report lower rates of smartphone ownership (71%), broadband internet access (59%), and digital literacy (53%) compared to the general population (SAMHSA, 2021). People who are African American or Latinx American report having lower computer ownership (African American, 58%; Latinx American, 57%) or home broadband internet access (African American, 66%; Latinx American, 61%) than European American respondents (82% and 79%, respectively), although smartphone access is nearly equal (SAMHSA, 2021). While teleservices do not ensure that counselors will be culturally competent and while they do not ensure that these populations will be reached, this approach does open up avenues for accessibility for the underserved that were not fully realized in times past.

DEFINING CULTURAL COMPETENCE

Students may recall from Chapter 1 the idea of multicultural counseling as an integral component of achieving social justice in mental health services. The remainder of this current chapter further elaborates on some concepts related to cultural competence as an aspect of providing effective services to diverse racial, ethnic, and cultural groups. Cultural competence describes the process of effectively attending to the needs of individuals through proper consideration of the salient components of their particular culture. One definition that is congruent with our assertion that cultural competence is a theoretical construct is provided by the Department of Health and Human Services (DHHS, 2003) in its report titled *Developing Cultural Competence in Disaster Mental Health Programs*:

> **Cultural competence** is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time. (p. 12)

This definition was chosen because its essence implies a philosophy that is meant to incorporate all necessary components of providing quality mental health services to all individuals including minorities.

Much of the information that follows relies heavily on a 2001 report produced by DHHS titled *Mental Health: Culture, Race and Ethnicity-A supplement to Mental Health: A Report of the Surgeon General*, as well as information from a follow-up article by López (2003). This supplemental report was created in an attempt to directly address the issue of cultural competence as it applies to mental health services through better understanding the nature and extent of mental health disparities, providing evidence of the need for mental health services, and providing possible avenues of action aimed at eliminating mental health disparities. Four groups will be directly addressed: African Americans, Hispanic Americans, Native Americans and Alaska Natives, and Asians and Pacific Islanders.

Why Cultural Competence Is Important

Mental illness is a concept that refers to mental disorders, which are considered health conditions characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning (DHHS, 2001). Roughly 21% of the U.S. population suffers from or has suffered from some type of mental illness. Among racial and ethnic minority populations, the rate is also approximately 21%. This is important to note, primarily because minority populations do not have proportionate access to mental health services. Essentially, racial and ethnic minority populations contain the same percentages of individuals suffering from mental illness as nonminority populations, however, access to services are not equitably distributed between the groups. This results in many minority individuals going untreated for mental illness and also suggests that unmet mental health needs are disproportionately higher for minority populations in relation to white Americans.

One important reason for studying cultural competence is to acquire a better understanding of different cultures and the corresponding barriers to mental health services that may exist due to cultural differences or misunderstandings. Some of the most common barriers to treatment must first be illuminated in order to have a chance at removing or minimizing them while also improving the quality of services that are provided to minority clients once they reach treatment providers. Some of the more common barriers include cost of mental health services, societal stigma attached to mental illness and the need for help, no clear organization of service providers, clinicians' ignorance concerning cultural issues, bias, and inability to speak the client's native language (DHHS, 2001). Mental health practitioners who provide services must understand cultural issues salient to their clients and those issues' impact on cognition and behavior, particularly when the clients racial or ethnic background is different from that of the provider. In addition, mental health providers who are unable to adequately appreciate cultural issues must have the courage to admit such and properly refer clients to another provider better equipped to effectively provide competent service.

Culture of the Client

Prior to examining the impact of the culture on a client's mental health issues it is important to note that there is significant diversity within cultural groups. In fact, as mentioned by DHHS (2001), there is more diversity within groups than there is diversity between groups. This is an important point and is meant to highlight the fact that none of the information provided should

be used to stereotype any particular group or culture. The counselor should accumulate as much knowledge on a given racial or ethnic group yet at the same time, the counselor should follow the client's lead in distinguishing the degree of racial or cultural affiliation that exists. In other words, let the client lead the way to determining what is culturally relevant and that which is not.

Once baseline cultural underpinnings are established in the therapeutic process, the counselor should integrate the resulting knowledge with their own presentation of mental illness as a concept. Indeed, the manner in which the counselor presents mental illness (indeed, the very use of the term itself) can be critical to getting clients to consider therapeutic possibilities. One of the most problematic issues underlying an individual's perception of the term *mental illness*, is the pervasive stigma that still exists in regard to that term. Stigma is a concept that describes the process of feeling shame or disgrace due to a circumstance or possession of some imperfection. According to Lin and Cheung (1999), Asian patients will often report somatic symptoms such as fatigue or dizziness while omitting emotional symptoms such as fear, shame, or sadness. It is important that counselors be aware of cultural beliefs in order to decipher symptoms that are likely being presented in ways acceptable to a particular culture. In the foregoing example it is likely that somatic symptoms of distress are more culturally acceptable and carry less stigmatization than emotional symptoms which may be interpreted as personal weakness.

Indeed, some social groups may emphasize a need to be "tough" or strong in the face of adversity. Though this may not necessarily be the best approach in coping, it may actually be the most adaptive response available to these groups under the circumstances that they find themselves in. Simply put, there may be no other alternative for the person and the social group but to simply make do with their circumstances. When an entire group is traumatized, it may be difficult to provide extended support since all persons are equally taxed emotionally. Thus, the need for individual members to be "strong" and "adaptive" may be a matter of survival for other members of the group as well as the individual in question since other members may be well beyond their stress threshold and incapable of providing extended empathy. Further, when few resources exist, a sense of helplessness may exist among other family members and friends who might desire to help the individual afflicted by coping challenges but find themselves unable to do so. In such a case, the emphasis on "bucking up" may be the most suitable option that the family member has. In such cases, it is likely that individuals having difficulties will be viewed as lacking self-discipline, mental toughness or weakness, perseverance, and other such characteristics commonly reinforced in these communities. Such individuals that display vulnerability to trauma and depressive related disorders will then tend to be viewed as "weak," "thrown off," or inadequate in functioning. This is unfortunate in light of the fact that once biological changes related to some mental illnesses have occurred, the only viable solutions are in-depth interventions, in some cases coupled with medication. Amid this reality, the social or cultural group undermines the ability of the therapist to effectively administer effective services due to the stigma of shame and embarrassment that is attached to seeking mental health assistance.

Another factor that counselors should thoroughly explore is the client's family environment. Indeed, it is widely known that "many features of family life have a bearing on mental health and mental illness" (DHHS, 2001, p. 27), both genetically and due to social learning mechanisms that are passed down from generation to generation. Supportive families characterized by healthy relationships among members can provide protection against the development of symptoms of mental illness. Conversely, where familial relationships have broken down and are instead sources of stress

symptoms of mental illness can be activated or exacerbated. For all cultural groups, it tends to be true that marital discord, overcrowding or occupancy with inadequate space, as well as general abuse and neglect all tend to exacerbate mental illness (DHHS, 2001). Thus, counselors should attempt to explore family-of-origin dimensions to determine sources of support and to determine sources of familial stressors that may contribute to mental illness.

One useful tool that could be implemented is the use of a family-of-origin genogram. The **genogram** is similar to a family tree illustration, but the client and the counselor construct the illustration in a collaborative fashion, with the client providing input while the counselor details and fills out the illustration with information pertaining to family relationships, interactions, history, and issues. The use of the genogram allows the client to compare relationships, to reexamine family-of-origin issues, and to essentially discuss the future of the family system. If used during the beginning phases of the counselor–client relationship, this can be a very effective means of establishing a rapport. Further, because genograms include both immediate and extended family members, its use may be especially useful in preventing relapse among minority men who desire to repair the bonds in their families (Suzuki & Ponterotto, 2008).

One barrier to the receipt of mental health services is that of inherent mistrust that many members of racial and ethnic minority groups may have of social service agencies and mental health practitioners (particularly practitioners of another racial or ethnic group). **Minority mistrust** is a concept that describes the process of being suspicious or having little confidence in mental health services due to a history of negative experiences with mental health providers such as negative and excessive diagnostic labeling by psychologists, overmedication by psychiatrists, and removal of children from the home by state social workers. Mistrust of counseling among racial and ethnic minority members is widespread (Harper & McFadden, 2003; Sue & Sue). One study conducted by Sussman et al. (1987) reported that almost half of Blacks expressed fear of mental health treatment as opposed to just 20% of whites. In a 2000 research report specifically examining cultural issues and minority perceptions of mental health treatment, Senturia et al. (2000) identified several factors that limit the ability of African American women to seek intervention services. These factors included racism; lack of economic resources; lack of availability of services; the perception that such services were for white women; hesitancy to involve persons other than their family or local community due to fear of ostracism or being viewed as disloyal to their race. Subjects also indicated fear that stereotypes about race would be reinforced by the system at large (Senturia et al., 2000). This again demonstrates that stereotyping has led to serious impairments in developing therapeutic connections with racial and ethnic minority communities. In fact, from this research, the impairment exists before the counselor even has a chance to meet with the client. Because of this, counselors must be aware of this, approach this issue with concern, and be willing to meet the client where they are at that point and time.

Because of the inherent mistrust that may exist, the priority issue that must be taken into consideration by all correctional counselors, but especially those providing cross-cultural therapeutic services, is the stigma often attached to the helping professions. In fact, this stigma has been reported to be the most formidable obstacle to better acceptance and progress within the area of mental illness and mental health (DHHS, 1999). Corrigan and Penn (1999) accurately note that there are still widespread beliefs and attitudes, pertaining to mental illness, that foster negative attitudes, fear and general discrimination and avoidance of people suffering from

mental illness. All of these issues are commonly encountered within the incarcerated population and naturally will impact the prognosis of the clients on the correctional counselor's caseload.

Culture of the Counselor

To begin, it is important to understand that there are two broad and comprehensive cultures that tend to influence most trained counselors. When considering this, it should be kept in mind that culture is a concept that describes the process of groups sharing a set of beliefs, norms, and values. Going from this point, counselors need to understand that they are impacted by the counseling culture itself. Indeed, the first broad component of culture that influences a trained counselor is directly related to their training. In the United States, most educational programs offering training in counseling consist of theories and concepts rooted in Western medicine (Harper & McFadden, 2003). In essence, Western medicine focuses on the human body in attempting to understand and uncover causal factors related to disease. As pointed out by Porter (1997), the ideologies of Western medicine are different from many other healing systems that focus on the relationship and balance between human beings and nature. Many people of varying cultures view the harmonious relationship between themselves and nature as paramount to their overall mental health (Harper & McFadden, 2003; Pedersen, 2003; Sue & Sue, 1999). A counselor's dismissal or lack of attendance to these important cultural views is likely to result in the client terminating the relationship and not receiving proper care for their mental health problems (Harper & McFadden, 2003; Pedersen, 2003; Sue & Sue, 1999).

Two additional concepts that have particularly significant impact on the mental health of members of minority groups are racism and discrimination. Racism and discrimination are concepts that describe the process of adversely treating individuals or groups based primarily on certain characteristics, such as skin color, other aspects of appearance, age, gender, religion, or ability. For our purposes, there are two categories of racism and discrimination that are of particular interest. The first deals with racism and discrimination on the part of the counselor directed toward a client. The second category of racism and discrimination that must be understood is the consequences or effects of an individual's sustained exposure to racist and discriminatory views from the society in which they live.

Racist and discriminatory views of a counselor have the potential to destroy any possibility of establishing a meaningful and helpful relationship with a client. Underlying racism and discrimination is the concept of judgmentalism. The primary component of judgmentalism, and what makes this phenomenon so destructive, is the concept of superiority (Elliot & Elliot, 2006). Racism and discrimination stem from feelings of judgmentalism, which is based on an individual's perception of being superior to another based on race, physical characteristics, or societal status. If a client perceives the counselor as judgmental, the client's likely reaction will be to shut down emotionally thereby limiting any potential growth as a result of the counseling relationship. As is mentioned in various places throughout this text, one of the best ways to guard against judgmentalism is to work toward becoming more open to differing views and methods.

The second component of racism and discrimination that counselors must understand is that many incidents that minority client endure as a result of discriminatory perceptions are empirically real. The consequences of racism and discrimination will often manifest in mental disorders such as depression and anxiety. Sadly, when clients who are members of one or more groups that

tend to be discriminated against present with these disorders, the counselor may tend to ignore or disbelieve the client's contentions regarding discriminatory actions or the effects of institutional racism within the justice system. Members of minority groups in the United States are seldom able to fully distance themselves from the overt or covert implications of racism and discrimination. The cumulative effect is often increased stress which is likely to lead to elevated levels of both anxiety and depression. Counselors should be aware of this phenomenon and be able to work with clients to reduce the effects of racism and discrimination. It is unacceptable for nonminority counselors to simply dismiss the effects of racism and discrimination, on minority clients, due to erroneous beliefs that racism and discrimination no longer exist.

African Americans

One of the most important components of providing effective mental health services to clients who are members of minority racial groups is to appreciate the historical context of their particular group. As of 2020, there were approximately 41 million African Americans, roughly 12% of the population, living in the United States (U.S. Census Bureau, 2021). Most African Americans currently residing in the United States can trace their ancestry to the slave trade from Africa. It is estimated that millions of Africans, over a period spanning two centuries, were kidnapped or purchased to be brought to the United States in order to perform manual labor in brutal conditions. These African slaves were considered personal property of their owners. Even after the Fourteenth Amendment extended citizenship to African Americans in 1868, many continued to live in poverty due to discrimination, difficulty in obtaining education, and local laws that limited opportunity.

Despite civil rights legislation and court rulings, neighborhoods remain notably segregated by race throughout the country, and Black neighborhoods tend to be poorer than white areas. In these neighborhoods, there tend to be fewer resources and higher rates of unemployment, homelessness, crime, and substance abuse (Shusta et al., 2018; Wilson, 1987). In addition to overt acts of discrimination, Black Americans of all social classes generally endure regular, subtle acts of racism known as microaggressions—white people holding their purses a little tighter when they pass, store clerks keeping a closer eye for shoplifting—that can over time have a significant impact. It is important that counselors understand that due to these circumstances many Black Americans have a deep sense of personal vulnerability. These perceptions of vulnerability and attendant psychological and emotional consequences that originate at the community level will often overpower individual control (Shusta et al., 2018; Sue & Sue, 1999). Fundamentally, it is important that counselors of other races truly appreciate the environments and conditions of many Black Americans and embrace these factors as part of the counseling process and not limit their roles within the clients' decision-making process.

Although poverty rates are decreasing, African Americans are more than three times more likely than whites to live in severe poverty. Currently, there is sufficient evidence indicating that poverty is one of the most frequent correlates with criminal behavior (Shusta et al., 2018). In order to be effective, counselors need to be aware of the effects of poverty and how these effects manifest themselves into cognition and behavior. The historical adversity experienced by African Americans through slavery, exclusion from educational, as well as social and economic resources is largely responsible for many of the socioeconomic disparities they face today. Socioeconomic status is linked to mental health. In essence, poor mental health is more common among the impoverished than those who are

more affluent (DHHS, 2001). Poor mental health will often translate into criminal behavior especially among those who are unhoused or have substance abuse problems.

Important Considerations When Counseling African Americans

There is extensive literature that compares therapeutic outcomes between African Americans and European Americans. Amid this research, numerous studies have sought to determine whether common counseling techniques are equally effective for both European Americans and African Americans (McGoldrick et al., 1996; Sue & Sue, 1999). One of the most salient components that must be understood by correctional counselors is that the cultural history of minorities is often different from whites. To add to this enigma is the fact that most, if not all, counseling modalities were created by white, Judeo-Christians to address psychological and emotional problems experienced by mostly nonminority clients. In essence, many of the counseling modalities are not equipped to specifically address some of the most salient issues affecting members of minority groups. For example, most counseling modalities stress the importance of introspection and assuming responsibility for one's decisions. The problem with this when attempting to work with clients who are members of a minority group is that often times minority clients have a clear understanding of their identity as a member of a historically oppressed population (Brown & Srebalus, 2003). Essentially, they are able to identify social issues that are independent of themselves as the underlying mechanism of much of their struggle (Brown & Srebalus, 2003), thereby creating a real conflict between counseling theory and group identity among minority populations.

This lack of congruence between counseling theory and characteristics specific to cultural history is surely part of the reason Blacks are half as likely as whites to seek out and receive counseling services. In addition, Blacks are much more likely than whites to prematurely terminate counseling and generally express greater dissatisfaction with the entire helping process (Sue & Sue, 1999). In reality, many of the counselors responsible for providing services to Black populations, as well as other minority populations, are white and are ill-equipped to provide culturally effective services largely because they do not fully understand the cultural history and identity of minority populations.

Hispanic Americans

Hispanic is a term generally used to describe people of Spanish-speaking origin (Gladding, 2007). Before discussing the central components related to Hispanic Americans' mental health issues it is first necessary to distinguish the different groups commonly classified as Hispanic. Currently, the U.S. Census Bureau asks respondents who identify as Hispanic to classify themselves as either Mexican, Mexican American, or Chicano; Puerto Rican; Cuban; or of another Hispanic, Latinx, or Spanish origin. As will be illuminated below, Hispanic Americans are very heterogeneous including in the circumstances that led to or contributed to their or their families' migration. And, the Hispanic American population is rapidly expanding. According to U.S. Census Bureau projections, by 2050, the number of Hispanics will be roughly 97 million, or one fourth of the U.S. population.

Mexicans

There are several important factors (both historical and therapeutic in nature) to consider when counseling Mexicans or Mexican Americans. First, it is useful to remember that after the Mexican War, large territories of Mexico became part of the United States. This included land from Texas

to California in which many Mexican citizens chose to stay, thereby becoming Americans citizens. Many more Mexicans have emigrated in the 170 years since, so it is important to differentiate individuals who themselves have immigrated from those whose parents or more distant ancestors did and whose ties to Mexico and Mexican culture may range from strong to nonexistent. In recent years, and as noted by DHHS (2001), there are a myriad of both push and pull factors that heavily influence the flow of Mexicans into the United States. Poor economic conditions in Mexico contribute to the push factor and the need for laborers in the United States influence the pull factor. It is important to note that much of the reasoning behind the origins of migration among all of the Hispanic groups is closely tied to economic factors, but also to political conditions in their countries of origin. The overwhelming majority of Hispanics who choose to migrate to the United States do so in hopes of providing better circumstances for themselves and their family.

Mexican Americans are by far the most populous subgroup of Hispanics living in the United States, largely because the two countries share a border. Research has shown that there are important difference between those born in the United States and those who emigrated from Mexico. Some research has found that Mexican Americans born in the United States reported higher rates of depression and phobias as compared to those born in Mexico. This is an important component that counselors need to understand especially since this finding is far from obvious. In other words, most people might imagine that people born in Mexico who later came to the United States would suffer greater degrees of mental illness due to whatever conditions led to their immigration or because of the challenges or adjusting to a new country. In fact, according to Vega et al. (1998), those Mexican immigrants living in the United States for at least 13 years suffered higher rates of mental disorders than those living in the United States less than 13 years. This consistent pattern of findings among independent investigations raises the question, Why? Why is it that Mexican immigrants who have been in the United States the longest suffer from mental illness at greater rates? Some have pointed to the process of acculturation but it is not clear what aspects of acculturation are related to higher rates of disorders.

Puerto Ricans

One of the characteristics that distinguish Puerto Ricans is that as of 1917, by way of the Jones Act, Puerto Ricans are American citizens and can therefore enter and exit the mainland of the United States at their will. After World War II, many Puerto Ricans began migrating to the mainland in order to find work. Rising populations on the island of Puerto Rico contributed to the high unemployment. As the work force began to age, many Puerto Ricans who had come to the United States began to return home creating a circular pattern that commenced in the early to mid-1980s (DHHS, 2001).

Cubans

The most significant migration of Cubans began in 1959 after Fidel Castro toppled the Batista government and assumed control of the country. Many of the initial Cuban immigrants were well-educated professionals who fled Castro's communist regime and have since become well established in America. Many Cubans who immigrated in the next few decades were poorer and more desperate, boarding boats bound for Florida and hoping they were seaworthy. These refugees are known as *Balseros*. Many of the Cubans who have come to the United States, even the Balseros, have received citizenship due to their declared status as political refugees.

Central Americans

Central Americans, from countries such as El Salvador, Guatemala, and Nicaragua, are the newest Hispanic subgroup in the United States, as their distinction is relatively recent. Many of the Central Americans who have come to the United States did so due to political turmoil and massive atrocities carried out by rivaling political factions in their homeland. A large number of Central Americans arrived during the 1980s. As with all of the subgroups, however, it is important to understand that migration is a constant process with ebbs and flows. Historical and political events in both the United States and Latin American countries over the past decades that have contributed to spikes or shifts in the flow of immigrants but below these peaks lies the relatively stable fact that large numbers of individuals travel toward and often into the United States each year.

Important Considerations When Counseling Hispanic Americans

One key reason for at least briefly describing in broad strokes the circumstances surrounding each community's migration is because we are able to glean valuable insight into their experiences and possible mental health needs. The common immigration story for a given group may not be true for any individual member of that group, but it is likely to be relevant for some of their family members, their community, and how they are perceived by others. Indeed, how these groups have been received once in the United States is also important. For example, Puerto Ricans, are U.S. citizens but may face the same discrimination as other Hispanic groups, viewed as outsiders who can't be bothered to learn English or who have come to the country to either steal Americans' jobs or go on welfare at the expense of hardworking Americans. Many Cuban immigrants, on the other hand, are viewed more positively because of longstanding American opposition to the Cuban government and have been granted an easier path to permanent residency and citizenship than refugees from many other countries.

Mexican and Central American immigrants, however, are much less likely to be granted permanent residency or citizenship. Many Central American immigrants were and are fleeing violence and persecution in countries mired in political turmoil. Despite these circumstances, Central American immigrants are not automatically granted refugee or asylee status. Therefore, many Hispanics migrating to the United States arrive without proper documentation. Central Americans are also likely to suffer symptoms of posttraumatic stress disorder (PTSD) as a result experiencing trauma and terror prior to their departure and during their migration. Also, those immigrants who are undocumented endure constant fear of deportation. The lack of documentation combined with the fear of discovered makes it difficult to find and sustain housing or employment, let alone advance in one's career. In addition, due to their undocumented status, such immigrants are at risk of exploitation by landlords and employers and often hesitate to report abuse and other crimes because they want to avoid contact with law enforcement for fear of deportation.

It is important for correctional counselors to understand that many of their clients may have family members who have entered the United States without documentation or may themselves been undocumented. The cultural variables associated with this type of extra-legal existence must be taken into account. Likewise, the levels of acculturation and assimilation may vary from one client to another. Furthermore, language can be a barrier unless the counselor speaks Spanish sufficiently well to conduct therapy sessions. Though the number is growing, there are not enough Spanish-speaking counselors to meet demand. In some cases, the use of an interpreter may be necessary.

Native Americans and Alaskan Natives

Native Americans and Alaska Natives occupied North America long before Europeans made their way to this continent. The oppression Native Americans and Alaskan Natives endured since European settlers first landed in America is profound. First, Native Americans were greatly affected by the various diseases spread through their initial contacts with early European settlers. These diseases, to which the Indigenous population had never before been exposed, killed millions. Native Americans were slaughtered, enslaved, removed from their lands, and forced to relocate sometimes hundreds of miles on foot. European Americans consistently betrayed agreements made with Native peoples and worked to quash Native customs under the guise of "civilizing" Indigenous groups. One common theme in counseling this group is the need to address what is called **historical trauma**, the generations of suffering and traumatic experiences they have endured.

According to the United States Department of Health and Human Services (DHHS; 2019), Native Americans and Alaska Natives are the most impoverished ethnic minority group in the United States. Oppression, discrimination, and removal from native lands must be considered among the correlates of the group's relative lack of educational attainment and economic opportunities and high rates of mental illness and disorder. It has been found that a majority of adult of Native American males met the guidelines for a lifetime diagnosis of alcohol disorders (DHHS, 2019). Alcohol problems and mental disorders often occur together as evidenced in the fact that about 70% of Native Americans suffering from alcohol disorders were also found to be suffering from psychiatric disorders (DHHS, 2019). Because of this, substance abuse treatment is one of the most common forms of therapy required for incarcerated members of this cultural group.

In general, studies have found that Native Americans and Alaska Natives experience greater psychological distress than the overall population. Almost 13% of Native Americans and Alaska Natives report experiencing psychological distress as compared to 9% of the general population (DHHS, 2001). Evidence in support of the above postulations is gleaned from the prevalence of suicide which is often an important indicator of need. The suicide rate among Native Americans and Alaska Natives is estimated to be 1.5 times the national rate. Rates are particularly high among Native American males between the ages of 15 and 24.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders are extremely diverse groups. Lee (1998) reports as many as 43 different ethnic groups would be classified as Asian Americans and Pacific Islanders. Individuals of Asian descent now account for approximately 6% of the U.S. population, according to the U.S. Census Bureau. Further, roughly 57% of Asian Americans were born outside of the United States, though the figure varies dramatically by subgroup as migration from various countries rose and fall due to historical and political forces.

Though this population is highly heterogeneous, it is important for a counselor to keep several factors in mind. Shusta et al. (2021) note the following considerations:

1. Generational status in the United States (first, second, third generation)
2. Degree of acculturation and assimilation
3. Comfort with and competence in English

4. Religious beliefs and cultural value orientation
5. Family cultural dynamics

Each of these five noted characteristics can hinder the ability of correctional counselors to develop an effective rapport with Asian American clients if the counselor makes declines to investigate them, though some are more relevant than others to specific groups.

As was noted earlier, lack of proficiency in the English language can cause serious misunderstandings between counselors and clients. This issue is somewhat tied to the generational status of the individual Asian American since those groups that have immigrated most recently tend to be those with lower percentages of individuals who are proficient in English. Second-generation Asian Americans—those whose parents were immigrants—are much more likely to be fluent.

Asian families tend to be close-knit, though second- and third-generation immigrants tend to become increasingly acculturated. Correctional counselors should remember that family issues may be seen as a "private matter." Thus, it should not be surprising that the use of genograms and other instruments designed to gain insight into family dynamics are likely to produce limited results. This is especially true if the correctional counselor is not of the same cultural group as the Asian client. Asian clients who have been convicted of domestic abuse are likely to present unique challenges that will require patience and savvy on the part of the correctional counselor.

European Americans

When counseling incarcerated persons who are European American, there are some considerations to be considered (Mizelle, 2014). First, in today's society, most European Americans do not necessarily identify with their European cultural backgrounds; indeed, many are not even aware of what that background might entail. Further, many people who fall within this category tend to use generic expressions such as "White" or "Caucasian," or they may refer to their geographical understanding of their identity with terms like "American" or "Southerner." Even though this may be the case, Americans of European origin remain the numerically largest cultural group in the United States (Mizelle, 2014). One important point to note about most mental health theoretical orientations is that they are nearly all grounded in Eurocentric origin of thought. This not only means that the applicability of these perspectives may have limits with other cultural groups previously discussed, but it also means that these approaches may not quite fit as well with European-origin Americans who no longer identify with their European origins. Further, the implication for the correctional counselor is that models for interpersonal negotiation and gender role flexibility that are part and parcel to contemporary counseling may not have a good fit with some areas of the United States, particularly in more tradition-based areas such as the southeastern United States. In some cases, European American clients may not be familiar with concepts related to the privilege they (or their ancestors) enjoyed in the United States; sometimes not realizing how this benefit has compiled, over generations, to create a culture of advantage and disadvantage for different racial or cultural groups. Further, Mizelle (2014) notes that there has been a lack of focus on having European American clients explore their own cultural identity or consider their own past cultural history. This is a disservice to this population and also ignores the considerable ethnic variety that may exist from region to region of the United States, much of which is vaguely known by white clients or is simply a historical footnote to eras that have since seemingly disappeared (Mizelle, 2014). This then ignores the

historical impact of the individual's identity development in modern times. Doing so, in and of itself, runs completely counter to any notion that one might have of being culturally competent with the client population.

DISABLED PEOPLE AND DISABILITY DISCRIMINATION

In starting this section of the chapter, we should first distinguish between an impairment and a disability as this is fundamental the idea that disabled people are a specific minority group. An **impairment** refers to the loss of regular human functioning. Impairments come in various forms ranging from limitations of cognitive, emotional, and physical attributes. This might include a lack of physical functioning (e.g., loss of limbs, paralysis, blindness), mental impairment (e.g., autism, Alzheimer's, intellectual disability, cognitive deficits), and emotional impairments (e.g., depression, schizophrenia). A **disability**, in contrast, is a socially constructed concept that captures the relationship between the person with the impairment and the society in which they live. Impairments become disabilities when those who have the impairments cannot meet the demands of the society. Figure 2.4 provides definitions for different types of disabilities.

Although the differences in the terms *impairment* and *disability* are subtle, knowing the difference illustrates why those with disabilities are considered a minority group. Those who are disabled, by definition, are unable to perform at the level desired by society in general. These persons do not have the capabilities for work and civic participation that are expected by the culture, so have historically been relegated to a lesser social role. Inherent to the idea that persons are "disabled" is the notion that discrimination is common to the system in which the impaired person lives. Discrimination is the way in which a system caters to some members while excluding others. The effective correctional counselor will be aware of the potential ways a client who is disabled may be perceived by society—for instance as incompetent, as childlike rather than a full adult, as in need of pity—and the mental health burdens such perceptions can cause.

FIGURE 2.4 ■ Definitions for Different Types of Disabilities

- **Hearing:** A person who is fully deaf or has serious difficulty hearing.
- **Vision:** Being fully blind or serious difficulty seeing even when wearing glasses.
- **Cognitive**: Serious difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional problem.
- **Ambulatory**: Serious difficulty walking or climbing stairs.
- **Self-care**: Difficulty dressing or bathing themselves.
- **Independent living**: Difficulty doing activities on their own, such as preparing meals, going outside, making and keeping appointments, going to classes, or attending programs because of a physical, mental, or emotional problem.

Other non-physical disabilities and disorders are defined as follows:

- **Attention deficit hyperactivity disorder (ADHD)**: Individuals with ADHD tend to have trouble paying attention or controlling impulsive behaviors, or they may be excessively active.
- **Learning disability**: These are usually associated with neurological disorders such as physical disorders of the brain or nervous system. People with learning disabilities are almost always born with their disabilities but do not usually become aware of them until they reach school age and has to learn to read, write, or compute. Learning disabilities tend to be permanent conditions.

To protect individuals with disabilities, legislation has been adopted that prohibits the most overt discriminatory practices. These laws follow the model set by legislation passed to protect the rights of other minority groups. Probably the most significant law, and the one that has done more to advance the needs of minority groups, is the Civil Rights Act of 1964. The **Civil Rights Act of 1964** ushered in a new era of workplace and civil protections that prevented discrimination based on race, religion, sex, national origin, and other characteristics. As an extension of the protections of the Civil Rights Act, the **Americans with Disabilities Act of 1990 (ADA)** was passed to afford similar protections to those with physical and mental impairments.

The Americans with Disabilities Act (ADA)

Uzoaba (1998) notes that in the United States, correctional administrators are required by law to comply with the provisions of the Americans with Disabilities Act (ADA). This act grants certain rights to individuals incarcerated in the United States. The Act has been the catalyst for a landslide of lawsuits claiming that various prison systems in the United States are in violation of the law (Uzoaba, 1998). The purpose of the ADA was clearly articulated by Congress. The elements of their rationale that apply to this chapter are

1. to provide clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and,
2. to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities.

Though the ADA has two separate titles, it is Title II of the ADA that is most applicable to inmates. This section involves physical plant conditions as well as access to programs and services. It is often the physical plant issues that most concern correctional administrators because of the cost to renovate existing facilities.

Accessibility of Programs and Services

Perhaps most germane to the correctional counselor is the impact of the ADA on access to programs and services for the incarcerated population. Corrections administrators will need to survey the programs, services, and activities offered to ensure accessibility. For instance, providing sign language or Braille assistance, running computers to open education programs to all inmates, and providing books on tape in the libraries. Access to specific programs, such as education, addiction treatment, and vocational training can result in increased satisfaction and health while in the prison. Further, participation in these functions can increase the likelihood of receiving early discharge through good-time accumulation, and this participation can improve the individual's later integration into the community after release. Though dated, an article by Rubin (1995) is one of the very few that provides specific comment on this issue. According to Rubin (1995), some of these programs and services might include the following:

Educational Programs: While agencies can establish their requirements for educational programming, they should ensure that these requirements do not adversely affect

individuals with learning disabilities or physical disabilities. Specifically, these programs must offer accommodations that account for the learning disability as well as any issues with accessibility due to a physical disability.

Substance Abuse and Mental Health Treatment: Treatment programs for substance use disorder or for mental health issues should be accessible to all individuals in the facility. This means that there should be no obstruction to accessibility due to physical impairments/disabilities and, just as important, mental health symptoms that might make it difficult for the individual to participate in treatment should be addressed, as well. Further, those who are deaf or hard of hearing may require a sign language interpreter, while those who are blind or have impaired vision must be given assistance, particularly when visual aids or curricular-based assignments are involved.

Library Services: Individuals in prison who are blind or have vision impairments must be given access to the prison library just as others do. Accommodations are mandatory in these cases, unless there are some type of overwhelming security concerns, in which case such restrictions would apply to all individuals, whether or not they have a disability. Prison libraries can use a number of approaches to provide required accommodations, such as providing approved and qualified readers, having the book on audiotape, or providing written materials in Braille.

Work Programs: In cases where these types of programs provide some type of 'good time' credit or early release benefit, agencies may be required to "create programs where none exist in order to give inmates with disabilities the same opportunity for early release" that exists for those who do not have a disability. (p. 118)

From the information above, it is clear that people who are disabled have certain rights and privileges that are legally protected, whether in the prison facility or in a community corrections program. Correctional counselors should keep this in mind if, and when, they have clients who are disabled in their individual or group sessions, or when they are assigned to any variety of prison-based therapeutic programs, including therapeutic communities. Even further, in Chapter 3, we will discuss case management processes, particularly when these functions are performed by the correctional counselor. It is important to remember that the above accommodations are just as important in that context with external communities with whom we partner to provide comprehensive services for individuals who seek reentry into society after having been incarcerated.

Serious Mental Illness and Forced Medication

Earlier in this chapter, we discussed people who have serious mental illness (SMI), explaining that these individuals are impacted with serious functional impairment that significantly limits one or more major life activities. We revisit this issue, once again, in the context of SMI being a disability and to bring to the student's attention legal parameters related to the use of medications to treat people disabled by SMI who are incarcerated. In many cases, correctional counselors will not necessarily be involved, directly, in the process of medicating clients. However, in some states they may find themselves conducting mental health evaluations that include information that will be used by medical staff to make decisions regarding treatment, including decisions regarding prescriptions

medications for mental health issues. Indeed, it is not uncommon for mental health professionals to be asked to evaluate and provide a diagnosis that serves as the guide for future medication as a part of their routine duties. Thus, we cover one area of knowledge that, sometimes, is not always understood by correctional mental health staff: the involuntary administration of mental health medications.

During the 1990s, the United States experienced a "prison boom" in building facilities as well as a marked rise in incarceration rates. Much of this was sparked by the War on Drugs, at that time and, along with this era were several legal developments. Among these was the issue of whether psychotropic medications could be administered to people with mental illness, even when they refused such medications. This question involved both when the medication was part of a formalized treatment plan (a somewhat routine circumstance) and when the court wished to restore an individual's competency so that they could stand trial.

The case of ***Washington v. Harper*** (1990) addressed the legality of forced medication by psychiatrists employed by the prison system. The state of Washington sought to medicate Mr. Harper, a mentally ill man who was incarcerated and refused to be medicated. In this case, the state of Washington was able to show that Harper was a bona fide danger to himself and to others. Prison officials were able to demonstrate the need for the forced administration of antipsychotic medications as necessary to ensure Harper's safety and the safety of other inmates and staff. The Supreme Court cited the Fourteenth Amendment right to refuse medications but noted that this right sometimes needed to be juxtaposed with the responsibility that the state of Washington had to treat the severely mentally ill and to also ensure the safety and security of everyone within the prison facility. As such, the Supreme Court ruled it legal that Harper was involuntarily medicated because the state was able to demonstrate the necessity of the medication. In addition, the Supreme Court added that the decision to forcibly medicate individuals in prison did not require a judge's ruling. Rather, it was noted that an individual's medical welfare would be better addressed by medical professionals rather than judicial professionals.

In 1992, just two years later, the Supreme Court case of ***Riggins v. Nevada*** again brought up additional questions regarding forced medication of people with mental illness who are incarcerated. However, in this case, Riggins had not been convicted but was detained in a jail awaiting the outcome of his trial. The state of Nevada medicated him despite the lack of a conviction and despite Riggins' claim that his forced medication would affect his ability to appropriately focus during his upcoming trial and, therefore, provide any effective assistance or participation during his own defense. While the Supreme Court did overrule the state of Nevada, the Court noted that this would have been legal if the state had established both that there was not a less invasive process available to restore competency and also that the medication was necessary for the safety of the patient or others. It is important to again point out that both of these conditions must be met for forced medication of individuals who are incarcerated, whether in jail awaiting trial or after conviction while serving a sentence in prison.

In one last case, ***Sell v. United States*** (2003), the Supreme Court further refined the conditions under which a criminal defendant can be forcibly medicated as a means of restoring the defendant's competency to stand trial. In this case, the Court noted that forced administration of antipsychotic medications to render a criminal defendant competent to stand trial was allowed, but "only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests"

(p. 166). It is important to note that, when purposes of establishing competency are for "important" governmental interests. The subjectiveness of this standard was determined to be best met on a case-by-case basis among trial courts, there being no specific criteria otherwise set.

CONCLUSION

In order to effectively provide mental health services to all clients, correctional counselors must be culturally competent. Especially among minority group members who are incarcerated, counselors must understand the impact of their cultural experiences and how these experiences influence cognitions and behavior. Correctional counselors must do more than be simply sensitive to cultural issues, they must be able to competently address cultural differences and they must be able to incorporate these differences into their treatment approach. Importantly, correctional counselors must understand the implications of stigma often attached to mental health services and needing help "from the outside," as well as historical events that heavily impact current behavior. Given the prevalence of minority group members within the prison population, it is clear that any person working in correctional treatment will be inept if they fail to make at least a cursory attempt to familiarize themselves with the various cultural issues associated with various minority groups.

KEY TERMS

ACA Code of Ethics
Americans with Disabilities Act of 1990 (ADA)
Civil Rights Act of 1964
countertransference
cultural competence
disability
duty to warn
ethics
genogram
Healthcare Insurance Portability & Accountability Act
historical trauma
impairment
informed consent
minority mistrust
Protected Health Information (PHI)
Riggins v. Nevada
Sell v. United States
serious mental illness (SMI)
SOAP notes
Teletherapy
Washington v. Harper
42 CFR, part 2

END OF CHAPTER ESSAY QUESTIONS

1. How would you define *cultural competence*? In your own words, describe why it is so important that counselors understand the essence of cultural competence, especially within the incarcerated population.
2. Explain and describe two of the most common barriers to treatment.
3. Define the concept of stigma. What are some of the origins of stigma especially as it relates to counseling?

4. What is the difference between covert and overt racism? Provide two examples of each. Is one type of racism more destructive than the other? Why or why not?
5. What are some of the benefits of utilizing teletherapy for clients who are comfortable with this approach?
6. Identify and explain how the Americans with Disabilities Act (ADA) has impacted treatment and opportunities for people who are disabled in correctional environments.

CASE VIGNETTE 2.1: AN EXAMPLE OF AN EFFECTIVE CASE NOTE AFTER COUNSELOR COMPLETES SESSION

Sonya, the intern therapist, sat across from Michael Wheeler as he explained to her that he felt that much of his substance abuse was interlaced with trauma that he had experienced as a child and teenager. He noted that there had been a good deal of family violence in his household and that his mother felt guilty about this. His father had beaten his mother on numerous occasions and one case in particular had been particularly traumatic. During this session, Michael was not really talking about any of the trauma, his family, or other more pertinent matters, but seemed to stay focused on whether he was going to use methamphetamine, or not.

Michael, looking at Sonya: "They call it 'meth-am-friend-of-mine,' but it really ain't no friend."

Sonya: "Michael, I know that you have told me that you are not willing to discuss this while we do group counseling, and I respect that. But, if we are going to do individual sessions, I think that we should use that time to address these other problems rather than the substance abuse issues that you are comfortable discussing in group."

Michael: "Yeah, I know. That was the point in me coming to see you individually, it is just that the other stuff is so heavy and I don't always like talking about it."

Sonya, noting to Michael that she understands: "You feel anxious talking about the violence in your family because it is extremely troubling for you to recollect those events."

Michael: "Yeah, that's right."

Sonya, providing some encouragement: "You know, Michael, you have started to sleep better since you have had these individual sessions. Also, others in the group and officers on the dorm have noticed that your mood during the week is more optimistic, even though they have no idea what we are talking about in here."

Michael: "I know . . . I guess that I need to quit wasting time."

Sonya: "Well, we will go at your pace . . . but I think that we need to stay conscious and mindful of where we are at and what is going on."

Michael: "Okay, well, so the big incident happened when I was 14 years old . . ."

Sonya: "Okay."

Michael: "And, um, I was in my room. We lived in a double-wide trailer at the time, in the middle of west Texas flatland. You could hear stuff through the thin walls and all. I could hear my old man yelling and hear my momma crying."

Sonya: "Yeah, I bet it was kind of scary."

Michael: "Well, it was but at that age and time I was not going to admit it."

Sonya: "Right, it is not manly and, at 14, you were expected to be a man?"

Michael: "Exactly! Where I grew up, men do not cry, and they don't get afraid."

Sonya, indicating with understanding: "Right, back home, it was important to stay strong and not show weakness."

Michael, looking down at the ground: "Yep, that's right. But this time, he was really hurting my mom, she kept sobbing out loud and asked him to stop."

Michael continuing, after a pause: "My old man said he was going to make it stop for her and I heard him move around in the closet, I heard my mom say, 'Mitch, please NO, put that away.' I heard my dad say, 'You little bitch, I am going to end this all right. I am going to splatter your brains all over the bedroom,' and then it got quiet while my mom cried."

Sonya: "What happened then?"

Michael: "I knew my dad had one of his guns, so I grabbed my .22 rifle out of my closet, then I ran down the hall to their bedroom . . . the door was locked but it was thin wood, so I used my body and ran into and got it open . . . and kind of stumbled into the room."

Sonya: "What did you see, Michael?"

Michael, stammering: "I saw my mom on her hands and knees on the floor with a bunch of blood on the floor by her face. My dad was standing over her and had a shotgun in his hands."

Sonya: "What happened next?"

Michael: "I ran into the room and pointed my .22 rifle at my dad and said, 'Leave her alone!' My dad laughed at me and with the shotgun, knocked my .22 aside before I could react, and then he hit me between the eyes with the butt of his shotgun."

Sonya: "That must have hurt."

Michael: "Yeah, it did, and while I was kinda stunned he pushed me so hard I flew back in the hallway about 5 feet, landed on the ground and had my breath knocked out. I was just clutching my chest."

Sonya: "That must have hurt, and you must have wondered what else could happen . . ."

Michael: "Yeah, but as I laid there, my dad took his gun, stepped over me, and said, 'Fuck both of you,' and walked out the door and did not come back that night."

Sonya, reframing the story from one where Michael had been hurt, to one where Michael had helped his mother after all: "So, he just left after that? After you had stood up for your mom?"

Michael, looking up at Sonya with tears in his eyes: "Yeah, I guess so. I guess it did keep things from getting worse . . . I just always thought I was a failure for not pulling the trigger . . . I hate that son-of-a-bitch."

Sonya, strengthening the reframing further: "Michael, I hear that you hate your father, but if you had pulled the trigger, things might have only been worse for you and your mom. You were 14 and your dad was a huge bear of a man. The fact that you stood up to him was very, very, very brave."

Michael: "Yeah, that's what my momma says, also, but I don't know what I think about it . . . I keep having dreams, nightmares, really, about this stuff and other stuff that happened. It fucks with me all night and I am always on edge."

Sonya: "Well, those dreams, your anxious and angry emotions, and self-protective behavior are what we will work on down-the-road, but . . . your mother is still alive, right? And, I believe it was after that incident that she decided to break away from the abusive marriage, once and for all, is that correct?"

Michael, looking at Sonya with eyes bright with insight: "Yeah, I guess you are right. Damn, Ms. Sonya, you listen and figure things out really fast!"

Sonya, smiling: "Michael, thank you, but my role is to just take the work that you do and highlight it for you to see, for yourself. Maybe you are the one who is really figuring things out."

Michael, looking at the wall and letting a breath out: "Maybe, maybe so . . ."

Later that evening, Sonya compiled her case note for that session. When doing so, her notes were in the SOAP format and were as follows:

CASE NOTE

NAME: Michael Wheeler
DATE: Sept. 2nd, 2020

SUBJECTIVE: Michael presented with apprehension regarding the topic for this session. After considering the reasons for being apprehensive, he provided a detailed description of a violent encounter between his father and his mother wherein his father had beaten and severely injured his mother. Michael explained that his father had brandished a firearm and was threatening to shoot his mother. Michael then indicated that he burst into their room, armed with a .22 rifle and was then assaulted by his father. The assault ended with Michael sustaining injuries, his father leaving the premises, and his mother going to the hospital.

OBJECTIVE: Michael presented with a degree of hesitance to talk about substantive issues related to traumatic events in his childhood. When Michael did disclose about these events, he was in tears and expressed self-doubt as to his efforts to help his mother. Michael also has rigid gender expectations, instilled in him from his upbringing and from norms specific to the area where he grew up that keep him from easily getting in touch with the emotions associated with these experiences. He suffers from some degree of guilt, embarrassment, anger toward his father, and a perceived sense of failure. Michael does seem open to exploring these issues and is also open to alternative interpretations of their outcomes.

ASSESSMENT: Michael exhibits symptoms of posttraumatic stress disorder both in behavior and through disclosures while in session. Michael also has expressed a feelings of low self-worth, depression, and guilt. He masks underlying depression with anger in his living environment. Michael's substance abuse is likely a form of self-medication to numb himself from these feelings that are rooted in his childhood and teenage years.

PLAN: Michael will continue to address his substance abuse issues in group counseling. He will continue individual sessions but these will focus on his clinical issues that underlie his substance abuse. In addition, when practical, sessions will include participation with his mother, Joyce Wheeler, whether during times that she visits the prison or by phone conference on days when she cannot attend in person. Michael will specifically focus on the CO-OCCURRING ISSUES and the FAMILY SUPPORT areas of his treatment plan.

VIGNETTE DISCUSSION QUESTIONS

1. In your opinion, how well does Sonya's case note capture the essence of what was discussed between her and Michael?
2. From the vignette above, does it seem like the PLAN section of the case note addresses the primary issues that seem to confront Michael?

CASE VIGNETTE 2.2: THE CASE OF CHUNG MING

During this exercise, the student must consider the case of Chung Ming and provide a discussion of how they might approach the problems that face Ming's family. Consider all of the issues relevant to acculturation and assimilation, paying particular attention to the dynamics between the younger and the older generation of the Chung family.

Chung Ming is a teenager, 14 years old. His family immigrated from China when Ming was roughly 9 years old. Ming's parents have not yet mastered the English language and in some cases, he has had to translate for his family. Lately, Ming has been skipping school and he has been hanging out with a group of other Asian (mostly Chinese) youth that have established a small gang. Ming's parents are humiliated by his behavior and do not act as if they are really ready to conduct counseling. They express that they are very troubled by Ming's behavior and even that he brings dishonor on his family. Ming, on the other hand, is much more Westernized than his parents and he notes that many of his friends have forsaken much of their Chinese views for those more consistent with mainstream American society.

Ming seems indifferent as you watch him while his parents talk, noting that Ming stays out late, drinks at age 14, and he has even stolen small items from various stores in the neighborhood. You can tell by observing that Ming's father has difficulty with English and is a bit withdrawn. The mother is also withdrawn and does not offer any thing to the conversation throughout most of the session.

Ming is on juvenile probation, and he seems to meet the requirements of his supervision. The mere fact that he is on probation is problematic with his parents and is also a source of shame for all members of the family.

After the session, you are fairly sure that Ming is still engaged in illegal activities with his prior gang. You make it a point to ultimately contact his probation/parole officer during the next week.

Given the dynamics of this traditionally Chinese family, Ming's advanced acculturation in U.S. western culture, and the lack of concern that Ming has, you realize that there are many more factors at play than Ming's simple misbehavior. You consider the cultural dynamics and begin to develop a plan.

VIGNETTE DISCUSSION QUESTIONS

1. List and discuss at least five cultural considerations that you would employ and place them each in order of priority, noting those that you would address early and those that might remain on the periphery of your clinical concerns.
2. From the vignette above, explain what the PLAN section of your case note might look like after meeting with Chung Ming?