Individual and Cultural-Diversity Competency: Focus on the Therapist

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The Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology was held in Arizona in November 2002. One of the workshops, Individual and Cultural Differences (ICD), focused on racism, homophobia, and ageism. The consensus was that self-awareness and knowledge about the three “isms” are critical components in the education and training of psychologists. This article, authored by four of the workshop attendees, is a review of the current research and theoretical literature. Implications that address both content and context in graduate programs and training sites are presented. This is one of a series of articles published in this issue of the Journal of Clinical Psychology. Several other articles that resulted from the Competencies Conference will

The authors wish to thank Robert G. Hall, Ph.D., ABPP, and Karen M. Taylor, Ph.D., for their thoughtful feedback on an earlier draft of this manuscript. The members of the Individual and Cultural Diversity Workgroup were Drs. Norman Abeles, Jeff Baker, Cyndy Boyd, Robin Buhrke, Jessica Henderson Daniel (work-group leader), Kelly Ducheny (recorder), Linda Forrest (steering-committee member), Robert Hall, Robert Knight, Gargi Roysirkar, Juan Jose Sanchez Sosa, Derald Wing Sue, and Karen Taylor. Correspondence concerning this article should be addressed to: Jessica Henderson Daniel, Ph.D., ABPP, Department of Psychiatry-Fegan 8, Children’s Hospital—Boston, 300 Longwood Avenue, Boston, MA 02115; e-mail: Jessica.Daniel@childrens.harvard.edu.
Introduction

Clinical literature has focused primarily on the patient’s history, presenting problem, and diagnosis, with the goal of ascertaining and implementing an appropriate treatment plan/intervention. Individual and cultural-diversity (ICD) competency broadens this perspective to include the psychologist’s historical and professional persona. The emphasis is on learning domains relevant to diversity responsiveness in education and training to increase therapists’ (a) awareness of their own assumptions, values, and biases and (b) knowledge of research, assessment, and practice. These two ICD competences are addressed in this article.

Individual and cultural diversity includes persons who may experience discrimination based on race and ethnicity, age, sexual orientation, gender identity, disability, religion, language, and social class. While this article will discuss only the first three sociocultural categories, many concepts presented here apply to the other categories of ICD.

The rationale for addressing diversity competencies in trainees and psychologists is derived from present contexts in the United States (US). First, the level of racial/ethnic diversification in the US, as reflected in the U.S. Census (United States Bureau of the Census, 2001), continues to change. The current combined populations of persons of color have increased; the Caucasian population has decreased. Second, clinical-, counseling-, and school-psychology program training content has been based on Eurocentric perspectives and European American research subjects (Guthrie, 1976; Ohye & Daniel, 1999). Given current demographics, such an approach is no longer a valid source of knowledge and meaning for various groups living in the US. Third, the reality of discrimination and prejudice in the lives of many marginalized groups impacts their access to institutions such as health-care resources (Collins et al., 2002; United States Department of Health and Human Services, 2001a). Fourth, the conceptualization of individual and cultural differences as a multidimensional construct has expanded the variables that need to be included in analyses and assessments, that is, historical, sociopolitical, and cultural factors, as well as the individual’s views and experiences (Dana, 2000; Kurasaki, Okazaki, & Sue, 2002). Fifth, the legal and ethical issues raised in the Surgeon General’s report document the disparities along racial and ethnic lines in both mental-health access and service delivery (United States Department of Health and Human Services, 2001b).

Individual and cultural diversity matters in psychology. Surveys of licensed psychologists have shown that most practitioners will work with at least one lesbian, gay, or bisexual (LGB) client in their careers (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Murphy, Rawlings, & Howe, 2002). Psychologists of color (Black African descent, Asian American, American Indian, and Latina/o) are only 6% of all psychologists (American Psychological Association, 1997). Consequently, the likelihood of a person of color (POC) receiving services from a non-POC is very high. People are living longer. In addition, older persons are an integral part of extended families and increasingly provide care for their grandchildren (Jimenez, 2002). Consequently, not just geropsychologists, but child, family, and school psychologists, among others, will provide services to older persons.
The lack of ICD competency can result in inappropriate and even harmful case conceptualizations and interventions in therapy. In the 1984 survey of 2,544 American Psychological Association (APA) members by a task force appointed by the APA Committee on Lesbian and Gay Concerns (Garnets et al., 1991), psychologists reported inappropriately using a heterosexual frame of reference when working with same-sex couples, encouraging clients to change their sexual orientation, and erroneously focusing on sexual orientation as the cause of the client’s problems.

Over the years, various administrative structures within the discipline of psychology have addressed ICD issues. Since 1999, four APA Divisions (Division 17—Counseling Psychology; Division 35—Society for the Psychology of Women; Division 44—Society for the Psychological Study of Lesbian, Gay and Bisexual Issues; and Division 45—Society for the Psychological Study of Ethnic Minority Issues) have hosted the biennial Multicultural Summit and Conference. Over the course of the three summit conferences, the focus has expanded from race/ethnicity, gender, and sexual orientation to include persons with a disability. The APA Council of Representatives has approved three major documents: in 2000, The Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients (American Psychological Association, 2000); in 2002, The Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (American Psychological Association, 2003a); and in 2003, The Guidelines for Psychological Practice with Older Adults (American Psychological Association, 2003b). In addition to the guidelines, the APA Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) specifically address ICD issues in the standards of Competence (standard 2) and Human Relations (standard 3).


The above documents are important, as ICD issues become more prominent in education and training in psychology. It is reasonable to assume that therapists: (a) more likely will recognize biases and question assumptions about clients/patients if they have professional guidelines for self-monitoring, and (b) will acquire knowledge about diversity characteristics of their clients to be in compliance with APA and Association of Psychology Postdoctoral and Internship Centers (APPIC) accreditation requirements.

Self-Awareness of Attitudes, Biases, and Assumptions

All three APA Guidelines (American Psychological Association, 2000, 2003a, 2003b) address the importance of self-awareness about the three isms—racism, heterosexism, and ageism. While each has a unique history in the US in terms of visibility, stigmatization, marginalization, and social activism, all have stereotypes that frequently lead to attitudes and behaviors based on biases and unwarranted assumptions. Therapists who reside in the US are highly likely to have been exposed to the stereotypes and actually may subscribe to them, consciously or unconsciously. In this article, the guidelines that address sexual orientation will be referred to as the LGB guidelines, the guidelines that deal with issues related to older persons as the geropsychology guidelines, and the guidelines that focus on a range of multicultural matters as the multicultural guidelines. It is noteworthy that all three guidelines refer to attitudes at the beginning of the documents.

The therapist’s persona and self-awareness are critical to the development of the therapeutic alliance. Self-awareness requires a therapist’s understanding of the interface
between therapist and client worldviews; therapist self-examination of reactions to race, sexual orientation, and ageism along with issues of defensiveness, racial-identity attitudes, White privilege, and differential power status in therapy; and how these impact the client (Richardson & Molinaro, 1996; Roysircar, 2003). Self-assessment to identify attitudes and behaviors may include the use of self-report standardized measures, journaling, process notes, self-reflection skills, and critical incidents (Brislin, 1986; Carter, 2003; Pedersen, 1994; Roysircar et al., 2003). Other sources of feedback are patients, supervisors, peers, faculty members, and collateral colleagues (Constantine, 2001; Fuertes & Brobst, 2002; Roysircar, Gard, Hubbell, & Ortega, 2005; Worthington, Mobley, Franks, & Tan, 2000).

**Homophobia**

As a heterosexist perspective is pervasive in western culture, Brown (1996) proposed that all counselors must assume that heterosexist and homophobic biases are part of their worldview. In order to ensure appropriate treatment of LBG clients and students, it is essential that psychologists fully explore their own identities and belief systems before practicing psychotherapy or teaching (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000; Phillips, 2000).

Sexual orientation is a construct applicable and relevant to all. A well-grounded heterosexual identity development model can be highly effective in facilitating self-awareness for therapists of any orientation. Such models (Mohr, 2002; Worthington, Bielstein Savoy, Dillon, & Vernaglia, 2002) highlight the concept that heterosexual counselors can and should be aware of their own identity formation and how their developmental process may affect their work with LGB clients.

To address the need to train therapists on issues related to sexual-orientation awareness, courses and workshops designed for this purpose are critical. (Stein & Burg, 1996; Whitman, 1995). Central to these courses must be an affective–attitudinal component incorporated to facilitate the confrontation of one’s own homophobia, heterosexist bias, and sexism (Whitman, 1995). Whitman (1995) and Phillips (2000) highlighted the specific need to help students recognize and address their more subtle and covert heterosexist behaviors, in addition to their more obviously homophobic reactions. Role plays with direct feedback and the provision of examples of the more institutionalized forms of heterosexism have been noted as powerful teaching tools.

**Ageism**

Robert Butler stated that he first used the word ageism in 1968 when he served as chairman of the Washington, D.C. committee on aging. He described ageism “as a systematic stereotyping of and discrimination against people simply because they are old, just as racism and sexism accomplish this with skin color and gender” (U.S. Congressional Senate, 2003, p. 15). He cited the underlying basis for ageism as a fear of growing older and no longer being able to take care of oneself. Negative stereotypes result in discriminatory practices in the workplace and elsewhere, including elder abuse. Some common myths about older adults include assumptions that older adults generally are isolated, depressed, and unable to cope, and consequently need to depend on others. Older adults are seen as forgetful and cognitively impaired (Abeles et al., 1998). Falk and Falk (1997) cited a Harris poll that found that only 8% of people found the word “old” acceptable.

Gatz and Pearson (1988) suggested that most practitioners do not hold globally negative biases, but instead may have specific misconceptions, that is, older people do not
warrant long-term therapeutic interventions. Specifically, some practitioners may believe that depression is part of aging and thus does not warrant treatment. Alternatively, practitioners may believe that complaints about memory imply the presence of early Alzheimer’s disease. Paradoxically, older adults performing well are seen as the exception rather than the rule.

**Racism**

Racism is a complicated phenomenon in that its manifestation may vary for different groups of racial and ethnic minorities in the US. Heterogeneity within the particular groups adds to its complexity. Stereotypes abound in the popular culture about ethnic/racial-minority persons based on phenotype, perceived intellectual functioning, and English-language usage.

Psychologists who reside in the US are not immune from the prejudice that has been so inextricably woven into the fabric of the society. Given the segregated housing patterns and consequently segregated elementary and high schools (Massey & Denton, 1993), it is possible for persons of European-American descent to grow up in the US with little or no personal contact with persons of color (POC). The media—print, electronic, and cinematic—are the primary information sources about POC in the US. The images often fail to portray the heterogeneity of a racial and ethnic minority group, focusing instead on stereotypes.

Therapists’ self-reports on their racial attitudes and diversity competence, with many studies controlling for social desirability (Ladany, Inman, Constantine, & Hofheinz, 1997; Roysircar et al., 2005; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998), suggest that diversity training interventions may prove ineffective unless a trainee or supervisee believes that racial and cultural differences are important to them and to therapy. In addition, trainees need to consider developing a collectivist orientation, respecting external and interpersonal meanings and attributions of people of color (Worthington et al., 2000).

Predoctoral interns, doctoral practicum students, and psychologists (Sodowsky et al., 1998) who gave greater endorsement to collective actions taken by African Americans or to societal changes than to personal efforts of individual African Americans self-reported more diversity competence, greater degree and types of diversity training, and higher self-esteem in social and interpersonal contexts (Sodowsky et al., 1998).

Research suggests that Caucasian trainees’ self-reported racial-identity attitudes are related to their self-reported diversity competence (Helms, 1990; Ladany et al., 1997; Roysircar et al., 2005; Sodowsky, Taffe, Gutkin, & Wise, 1994). Connections to POC clients were related to positive Caucasian racial-attitude scores, as were high levels of positive racial identity to high diversity competence.

Therapists can benefit from regular feedback from their racial and ethnic clients regarding their effectiveness. The types of cultural knowledge that clients identified as important included specific knowledge of family relationships and expectations, racism and discrimination, acculturation, sexism and gender-role issues, communication styles, cultural beliefs about counseling, cultural issues related to sexual orientation, ethnic and cultural identity, and norms for behavior.

**Knowledge**

With respect to “knowledge,” ICD-competent therapists know and appreciate

(a) the growing and multidisciplinary theoretical and empirical literature on the topic of therapy with culturally diverse individuals;
that there is more than one way to conceptualize and deliver diversity-sensitive services, and that at this point there is no evidence suggesting that one perspective is more effective than another;

c) that diversity perspectives do not supplant a theoretical and technical approach to helping;

d) that these perspectives all suggest that race, ethnicity, sexual orientation, and issues of age are dynamic and thus are present and operate within the therapy session;

e) that these perspectives address an important common factor in diversity-competent therapy, namely core conditions of safety, support, rapport, and the relationship; and

f) the intersecting fabric of personality, which includes individual, cultural, GLB, age-related, and universal components.


In psychology graduate education and training programs, students and trainees might not be taught about invisible systems of dominance in U.S. society. A Caucasian person’s skin, a heterosexual person’s sexual orientation, and the assets of a person young in age open doors of privilege, which often are unseen by those who are privileged. While psychologists may not choose this state of affairs, systems of dominance inherent within the structure of society are enforced subtly by the notion of equality in a democracy that allows one to deny power differentials or dismiss evidence of inequality (McIntosh, 2001). Therapy sessions are a subsystem of society and are influenced by societal values, attitudes, and practices. Some therapists deny the existence of inequality or injustices. When therapists do that, they enhance the illusion that racism and exclusionary isms do not exist in the larger system and within therapy itself.

Keeping in mind how stereotypes shape intellectual identity (Steele, 1997), professional psychology can take it upon itself to communicate to marginalized groups that they can expect equality, success, and identification both within the academic domain for trainees and within the therapy domain for clients. Similarly, professional psychology can provide an environment where all trainees can identify with achievement in cultural-diversity competence in the sense of its being a part of one’s self-definition—a personal identity to which one is self-evaluatively accountable. Indeed, trainers must prevent the risk of overestimating or underestimating the level of ICD competence in trainees that result from halo effects, negative self-fulfilling prophecy, or stereotype threat (in this case, Caucasian trainees feeling threatened by being seen as racially insensitive).

Racism

Knowledge of and respect for the worldview of a culturally different client are fundamental in creating trust with the therapist and therapist credibility (Sodowsky, 1991; Sue, Arredondo, & McDavis, 1992). Problems occur when therapists do not know and respect the client’s worldview and value-based goals. Clinical work in cultural diversity that endorses interventions in which therapists use manipulation, persuasion, and assimilation into the Caucasian-dominant society shows a lack of knowledge of the client’s worldview and is flawed.
During the therapy process, issues of discrimination, nature of immigration, cultural confusion, language barriers, guilt, and grief may emerge as the patient attempts to define herself/himself in a different culture, redefine her/his ethnic identity, or integrate two cultures that can clash. The therapist may experience such a process as a complicated course on cultural knowledge. The therapist may need to add to this knowledge the complexity of contextual and idiographic data; although knowledge of diversity may be complicated and entirely new, it is essential that therapists learn about the cultures with which they work. They cannot expect clients to educate them when in fact clients have come to them for help.

Findings indicate that therapists (Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002) with a knowledge of racial-identity theory (Helms, 1990) and awareness of its central role in their clients’ lives were able to make statements about their clients’ racial identity. They also were able to describe their clients’ interpersonal concerns as deeply intertwined with factors such as racism, homophobia, and poverty. Concerning the therapy process, therapists reported better rapport, increased intimacy, and disclosure on the part of their clients, some risk taking with respect to clients’ disclosures in aspects never before discussed, and overall improved client involvement in therapy. All therapists reported appreciable gains for their clients.

A one-semester multicultural psychology course taught at three predominantly Caucasian state universities in the Midwest and on the East Coast and West Coast (Neville et al., 1996) was related to Caucasian trainees’ adoption of more positive Caucasian racial-identity attitudes and with stronger endorsement of diversity competence, whereas higher levels of negative racial-identity attitudes were related to lower levels of self-reported diversity competency. Changes in racial-identity attitudes were sustained over a 1-year period. There are other studies that show that multicultural counseling training has an impact on developing a positive Caucasian racial identity, as well as increasing interracial comfort, (e.g., Parker, Moore, & Neimeyer, 1998; Roysircar et al., 2005; Vinson & Neimeyer, 2000).

**Homophobia**

Despite the obvious necessity for training on LGB issues, many students and professionals report inadequate preparation for work with LGB clients (Buhkhe, 1989; Murphy et al., 2002; Phillips & Fisher, 1998). Even when training is offered on lesbian and gay issues, it often omits bisexuality, pathologizes it, or denies its existence (Murphy et al., 2002; Phillips & Fisher, 1998). As a reflection of past education and training of psychologists, in a survey of 456 psychologists from the members of APA Division 29 (Psychotherapy), respondents were asked about 83 different behaviors with regard to the degree to which they have engaged in them and the degree to which they consider the behaviors to be ethical (Tabachnik, Keith-Speigel, & Pope, 1991). Slightly more than one in five of the respondents reported treating homosexuality as pathological, either rarely (12.7%) or more often (10.8%). However, over half (55.7%) viewed such a practice as unethical. In their survey of 125 licensed psychologists, Murphy et al. (2002) found that this lack of therapist training can have many serious consequences, including unfamiliarity with the coming-out process, the effects of discrimination, and the process of identity formation.

When supervision on these issues was provided, it was endorsed as a primary source of training. Half of those supervised reported that their supervisors had limited or inadequate knowledge of LGB issues (Murphy et al., 2002). The same study found that the most popular form of training was reading articles, which is not surprising since students often report a lack of confidence in the knowledge held by supervisors and faculty (Burhke, 1989; Pilkington & Cantor, 1996).
Searching the literature for adequate training can be problematic however, because reviews of mainstream clinical and counseling journals have revealed that articles with a significant focus on LGB issues represented from only 0.8% to 2.11% of all articles during a given period of time (Murphy et al., 2002; Phillips, Ingram, Smith, & Mindes, 2003). Even less perceptible is the amount of literature published specifically on bisexual issues (Bowman, 2003; Phillips, 2000). Morrow (2003) added that scholarship with a focus on LGB people of color, LGB people with disabilities, and transgendered individuals are underrepresented greatly in the literature, thereby rendering individuals with multiple oppressions virtually invisible.

The literature emphasizes that a safe learning environment be in place before training can occur (Buhrke & Douce, 1991; Phillips, 2000). Important components of a safe environment include open objections to anti-gay jokes and comments; understanding and minimizing the oppression faced by LGB students and faculty; initiating discussions of LGB issues; and recruiting LGB faculty (Buhrke & Douce, 1991). In a broader view, Bieschke, McClanahan, Tozer, Grzegorek, and Park (1998) asserted that LGB affirmative attitudes are critical at the university, as well as at the departmental level, such that university policies and practices should be assessed and advocated in order to promote a facilitative climate. Therefore, it is necessary to address the context in which learning takes place, as it is to determine the particular content.

As strategies for imparting information about LGB issues, both creating a separate course on the topic (Phillips, 2000; Stein & Burg, 1996; Whitman, 1995) and infusing the issues into already existing courses (Burhke, 1989; Burhke & Douce, 1991) are recommended. To structure training, three basic areas of focus have been suggested: (a) information about sexual orientation and community resources; (b) the interface between the LGB client and the effects of living in a heterosexist or homophobic society; and (c) the interaction between feelings, attitudes, and sexual orientation of the clinician and client (Murphy, 1992). Other suggested topics to be highlighted in training include the interactions of racism (Greene, 1997; Phillips, 2000) and sexism (Herek, 1993) with homophobia and the effects on LGB individuals, the validity of the construct of bisexuality (Morrow, 2000), and healthy functioning in same-sex couples and LGB families (Green, 1996).

Trainers may consider using a variety of teaching modalities. For instance, Croteau and Kusek (1992) and Nelson and Krieger (1997) have found evidence of effectiveness for the use of panel presentations to reduce homophobia in students. Although not designed to provide therapy training, the panels so serve to introduce students to LGB people and the issues associated with these sexual orientations.

As training is prioritized in this area, outcome measures must be administered in order to ensure effectiveness and to demonstrate the acquisition of basic competencies. For this purpose, Bidell (2003) has introduced the Sexual Orientation Counselor Scale (SOCS), which assesses awareness, knowledge, and skills and for which reliability and validity have been established. Dillon and Worthington (2003) also have introduced recently the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI). It is designed as a self-report measure to assess the following affirmative counseling behaviors: application of knowledge, advocacy skills, self-awareness, relationship, and assessment skills.

**Ageism**

Palmore (1999) has developed a questionnaire, The Facts of Aging, to assess ageism. This three-part instrument samples knowledge about aging and attitudes toward the aged. Palmore (2001) also has developed an ageism survey that lists 20 types of ageism. He
notes that ageism is common in the US, observing no differences in respondents over 75 years of age and respondents under 75 years of age. No gender differences were found. However, some 23% of all the respondents stated that they had not experienced ageism.

Ragan and Bowen (2001) studied negative attitudes about older adults associated with ageism using college students as participants. Three groups were examined: the first group was provided information only, the second group included information plus innocuous discussion, and the third group involved information plus reinforcement to change. Results showed that initial changes to ageism were produced in all groups. However, only those groups who received the reinforcement to change maintained positive attitude changes at a 1-month follow up.

Gatz and Pearson (1988) suggested that Alzheimer’s disease, with its accompanying media exposure and the public’s concern, may result in its over diagnosis. They reviewed a number of surveys conducted with several different populations of younger and older individuals (including caregivers), all of whom tended to overestimate the prevalence of Alzheimer’s disease. They concluded that this supports the existence of bias and suggest that the media may have contributed to the general public’s perception of the prevalence of Alzheimer’s disease. Even some professionals may contribute to this by estimating that 20% of those over 80 have Alzheimer’s disease when that figure represents all demen- tias including those that are reversible. They suggest that Alzheimer’s disease in itself may be a form of ageism.

Palmore (1999) concluded that health professionals are more familiar with pathology than with normal processes and have biased experiences with older adults because the patients they treat are more impaired than other older adults. Additionally, health professionals who deal with death and dying are more likely to associate age with death. Uncapher and Arean (2000) found that primary-care physicians are less willing to treat suicidal patients if the patient is described as older and retired, believing that suicidal ideation in older patients was rational and normal.

Edelstein & Semenchuk (1996) suggested that the deleterious effects of ageism can be prevented by increasing exposure to older adults and knowledge about the impact of physical and mental changes as aging occurs. Abeles et al. (1998) pointed out that older adults develop coping mechanisms that assist them despite any age-related physical or cognitive changes. Making people aware of these coping mechanisms can materially reduce beliefs and erroneous assumptions that tend to be at the heart of ageism.

Whitbourne and Sneed (2003) emphasized the theoretical construct of identity processes that assume most adults attempt to view themselves in a positive, competent, and ethical fashion. Identity accommodation has the risk of buying into social stereotypes of aging and may result in an over accommodation to changes associated with aging. Consequently, the individual may internalize negative stereotypes that can make life even more painful as these attitudes become self-fulfilling prophecies. On the other hand, many can accommodate by becoming actively engaged in programs that may help them adjust more adequately and realistically and if needed, seek physical and psychological interventions.

Gender Across Racism, Heterosexism, and Ageism

Initially, the women’s movement in the United States highlighted the plight of mainly Caucasian middle-class women in relation to powerful Caucasian males. While issues related to equal employment, compensation, and representation were dominant, the omission of a focus on class and color led to the exclusion of both WOC and poor Caucasian women. The broadening of the women’s movement to include a range of women has been an on-going process (Worrell & Johnson, 1997).
Women of color often experience discrimination based on both gender and race/ethnicity. Comas-Diaz and Greene (1994) addressed the importance of the integration of both ethnic and gender identities in the provision of therapeutic services. For some racial/ethnic groups, the emblematic person is male, resulting in the invisibility of the female. The particular challenges of this combination need to be both acknowledged and addressed. The heterogeneity among women of color is substantial. Chin (2000) and Jackson and Greene (2000) respectively portrayed the lives of a range of Asian-American and African-American women.

Whitbourne and Sneed (2003) noted that women are frequent targets of ageism based in part on social definitions of attractiveness. Woolf (1997) noted that while both genders experience ageism, women also experience sexism. While the differential effect of ageism on women has not been examined thoroughly, women in general are perceived as being more hypochondriacal and less healthy even though women have a longer life span than do men. Woolf characterized this labeling of women as myth. Edelstein and Semenchuk (1996) suggested that ageism often is compounded in older women because of sexism and the tendency to view them as stereotypically sick and alone. The geropsychology guideline 5 addresses issues related to older women, including the reality that women are more likely to be care providers.

The LGB guidelines (American Psychological Association, 2000) specifically include women, that is, lesbians and bisexual women. While lesbians, gays, and bisexuals are discussed in all the guidelines, number six specifically addresses the topic of lesbian mothers. It is noted that there has been more research on lesbian mothers than on gay fathers. Guideline three reports the lack of research on the impact of “social stigmatization” in the lives of lesbian and bisexual women.

Banks and Kaschak (2003) have expanded the discussion to include women with both visible and invisible disabilities. The text is about intersections in all their complexities, therefore, gender, disability, ethnicity, and class.

In the provision of psychological services, gender-free discussions about racism, heterosexism, and ageism effectively limit perceiving women as integrated persons. Women deserve services that acknowledge that perceptions about gender have and continue to make differences in the lives of women.

Multiple Identities and ICD

People have multiple identities. All three of the APA Guidelines (American Psychological Association 2000, 2003a, 2003b) recognize the interconnections among the isms. Greene (1994) noted that lesbian women of color are in triple jeopardy due to racism, homophobia, and sexism. LGB guidelines 9, 12, and 13 (American Psychological Association, 2000) address lesbian, gay, and bisexuals at three identity intersections: (1) race/ethnicity; (2) age; and (3) physical, sensory, and/or cognitive/emotional disabilities. In the multicultural guidelines (American Psychological Association, 2003a), the heterogeneity within various racial/ethnic groups is highlighted in guidelines 2, 3, and 4 which encourage psychologists to become familiar with minority, racial, ethnic, and multiracial/biracial identity models; the effects of acculturation on generational differences in immigrants and on the oppressed status of Native Americans; and gender-related concerns involved with immigration and refugee status. The geropsychology guideline 5 (American Psychological Association, 2003b) encourages psychologists to consider gender, ethnicity, socioeconomic status, sexual orientation, disability status, and urban/rural residence factors when working with older persons. While the current old population is mainly Caucasian, it is estimated that by the year 2050, POC will be one third of the older adults in the United States. The discrimination faced by POC in their youth will impact the lives
of older POC. It already has been demonstrated that POC older adults have more problems than Caucasian adults.

Knowledge about individual ICD variables is the beginning of a potentially extensive process. The challenge is to be able to discriminate among the relevant ICD variables to ascertain their possible connections to the current presenting problem.

Implications

The research literature on self-awareness and knowledge about the three *isms*—racism, homophobia, and ageism—supports the use of more self-awareness assessments, as well as expanded instruction about persons who are marginalized. Faculty members and supervisors who are both role models and providers of instruction and training may benefit from raising the level of their own self-awareness and knowledge base about issues of race, sexual orientation, and age. Stereotypes for all three marginalized groups are long-standing in the US. Consequently, most people have been exposed to them and even had them reinforced by their family, friends, and the media.

Therapists who are unaware of their feelings about members of marginalized groups may burden their patients who consequently take care of their therapists, that is, patients monitoring their disclosures in order to protect the therapist (Daniel, 2000). Such behaviors may compromise the effectiveness of the therapy. The inclusion of ICD-awareness tasks in the curriculum increase therapists’ receptivity to issues and events related to the *isms*.

Graduate programs and training sites that are experienced as safe learning environments may be more suited to tackle such emotionally laden topics. The reduction and, ideally, the elimination of racial epithets (i.e., saying the “Black student” but never saying the “White student” or saying the “lesbian student” but never the “heterosexual student”), racial slurs (i.e., such as the “n” word for persons of African descent), the assumption of affirmative-action acceptance for only Blacks as opposed to acceptance based on merit, and homophobic comments, including jokes, would be a priority. The increased presence of students and faculty who are members of marginalized groups can facilitate discussions about the *isms* and provide opportunities for interactions with persons who heretofore may have been met only via literature and media. For both homophobia and ageism, contact with individuals from those groups has been effective in decreasing negative feelings.

Various ICD forms of assessment provide a broad picture of this complex construct. Each may measure a different component; the sum of the assessments may be more informing than a single global measurement. The information yielded can be a source of knowledge and reinforcement for providing quality services from any number of perspectives.

Finally, when the therapist is self-aware and has information about the particular *isms*, she/he is more likely to see the patient in context, including information about development—both racial and sexual orientation, as well as age.

The various guidelines are important steps toward moving the discipline of psychology in the direction of education and training with a focus on ICD. Progress can be facilitated by understanding the process of achieving ICD competency. It begins with self-awareness and knowledge.

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