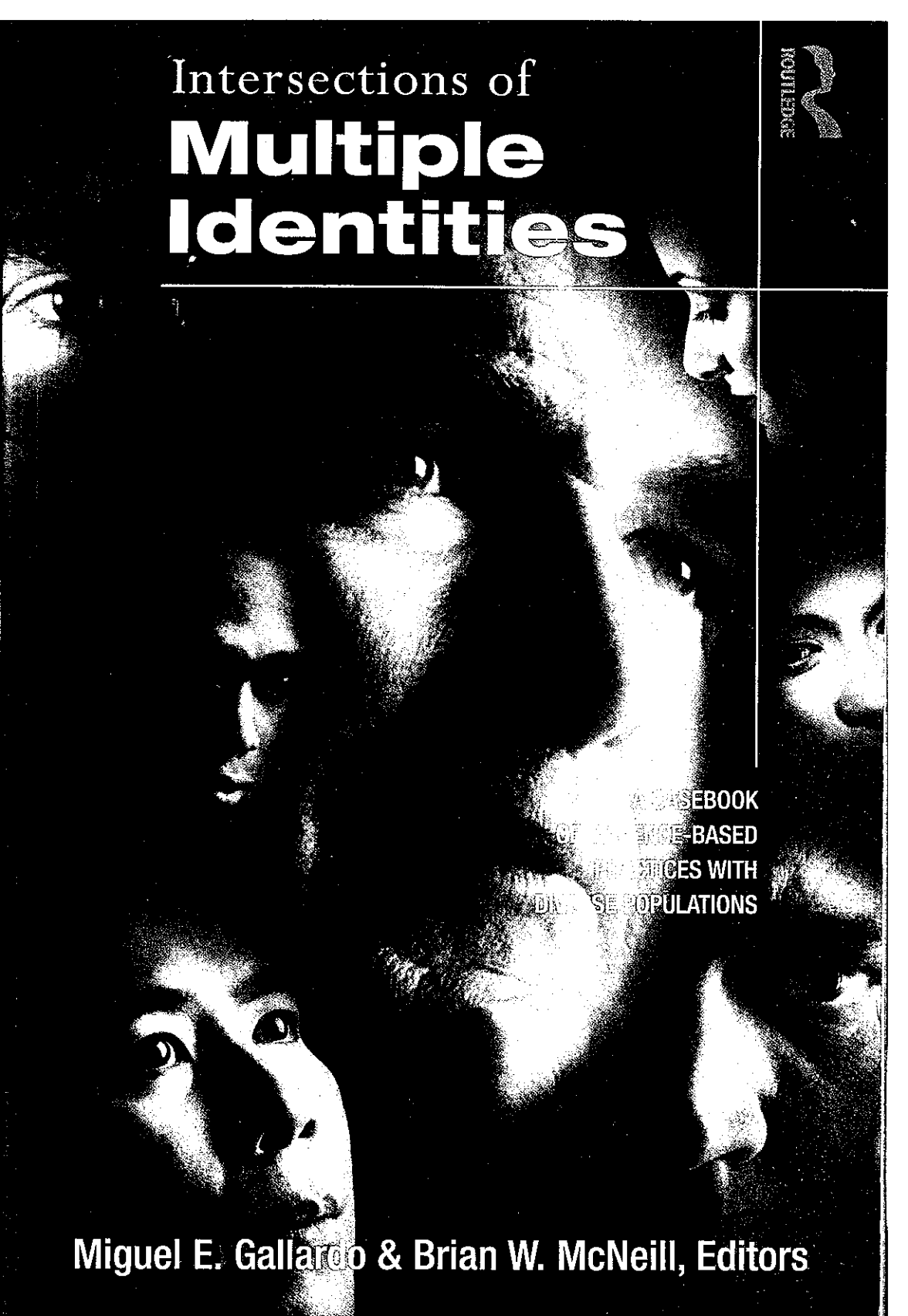
Intersections of Multiple Identities



A CASEBOOK
OF EVIDENCE-BASED
PRACTICES WITH
DIVERSE POPULATIONS

Miguel E. Gallardo & Brian W. McNeill, Editors

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Spirituality and Psychotherapy
A Gay Latino Client

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Introduction

Spirituality and religion are particularly important in the Mestizo world view (Ramirez, 2004). The religious diversity of Latinos/as may include affiliations to Christian (e.g., Catholic, Protestant, Evangelical, and nondenominational institutions) and non-Christian groups (e.g., Jewish and Muslim). The popular religiosity of Latinos/as may also include spiritual practices and beliefs in *curanderismo* (folk healing), Spiritualism, *Santería*, *brujería* (witchcraft), Buddhism, and transcendental meditation (Baez, 1996; Baez & Hernandez, 2001). For centuries, Latinos/as and other ethnic minorities have integrated these beliefs into their life, and they have attributed special meaning, including therapeutic and healing power, to their religious practices (Dudley-Grant, 2003; Mio & Iwamasa, 2003). Cultural competence entails knowing this prominence given to religion and spirituality and, more specifically, how to integrate research findings with clinical practice (Sue & Sue, 2003).

Research on Religion and Spirituality

Literature exploring the significance of religious and spiritual meaning in psychotherapy is abundant (Bergin, 1991; Bergin, Masters, & Richards, 1987; Clay, 1996; Helminiak, 2001; Pargament, 1997; Schulte, Skinner, & Claibom, 2002; Shafranske, 1996). In an extensive review of the literature published during the past century, Powers (2005) found that the number of publications on religiousness and spirituality in psychotherapy dramatically increased in the 1970s. Walker, Gorsuch, and Tan (2004) conducted a meta-analysis and concluded, among other things, that many therapists are already incorporating religion and spirituality in therapy.

In general, meta-analyses and reviews of the empirical literature on the relationship between religion and spirituality and mental and physical health have found many positive associations. Some of these include personal adjustment, recovery from physical and mental illness, control of compulsive behaviors, absence of psychological symptoms, lower mortality, and mental well-being (Bergin, 1983; George, Larson, Koenig, & McCullough, 2000; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000). Studies have also found a negative correlation with depression, anxiety, and substance abuse (Knox, Catlin, Casper, & Schlosser, 2005). Recently, an issue of *American Psychologist* specifically addressed this linkage between spirituality and mental and physical health and its importance for psychological research and practice (Hill & Pargament, 2003; Miller & Thoresen, 2003; Powell, Shahabi, & Thoresen, 2003; Seeman, Fagan-Dubin, & Seeman, 2003).

In spite of the significant role played by spirituality and religiosity for certain ethnic groups and the extensive extant research, two issues remain problematic for researchers and practitioners: how to clearly define religious and spiritual experience, and how to effectively incorporate it into psychotherapeutic practice (Steinfel, 2000; Zinnbauer, Pargament, & Scott, 1999). Without a clear scientific operational definition, most authors have conceptually differentiated the two concepts and suggested that religion or religiousness implies behavioral adherence to institutional practices and rituals and doctrinal assent to beliefs, dogmas, and precepts (Miller & Thoresen, 2003; Worthington & Sandage, 2001). Spirituality, on the other hand, is often seen as personal, subjective, emotional, inward, and unsystematic (Hill & Pargament, 2003). However, some have warned about the dangers of this conceptual polarization, claiming that it leads to simplistic categorizations (e.g., "spirituality is good," "religion is bad") and unnecessary bifurcations because many people experience spirituality within the context of organized and institutional religion (Hill et al., 2000; Hill & Pargament, 2003; Knox et al., 2005; Pargament, 1999).

Integration of religiousness and spirituality into psychotherapy can be a challenging task, especially in our era of empirically supported treatments

or evidence-based interventions (Chambless & Hollon, 1998; Pargament, Murray-Swank, & Tarakeshwar, 2005). Many practitioners have reported that they are not adequately trained to work sensitively and effectively with clients whose world views and lifestyles are deeply spiritual or religious. Some may also be ambivalent about bringing religion and spirituality into the psychotherapeutic setting because of fears of imposing their own values (Mack, 1994). Their uncertainty may be related as well to the minimal coursework, supervision, and training regarding the place of religion and spirituality in therapy (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Richards & Bergin, 2000; Schulte, Skinner, & Claiborn, 2002; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). More important, religious and spiritual experiences are very complex and multidimensional, and they usually occur in interaction with other important aspects of one's culture and identity (Walker et al., 2004).

This chapter offers some considerations on the integration of religiousness and spirituality and psychotherapy in the context of a culturally diverse client. Religiousness and spirituality are basic dimensions of the human condition (Sue, Bingham, Porché-Burke, & Vasquez, 1999) and particularly salient for the optimal human functioning of people of color (Constantine & Sue, 2006). A case is presented, followed by a detailed discussion of the main issues revolving around three main themes: culture, seropositive status, and religion and spirituality. The case exemplifies the complexity of psychosocial, cultural, and spiritual dimensions often embedded in clients' experiences. A theoretical conceptualization of the issues is described, along with specific interventions used. Discussion of interventions is informed by empirically based perspectives (Pargament et al., 2005) and evaluated from the perspective of the Principles of Empirically Supported Interventions (Wampold, Lichtenberg, & Waehler, 2002), with special emphasis on multicultural perspectives (Quintana & Atkinson, 2002).

Case

Gabriel, a 25-year-old Mexican American male, came to therapy and, during the first session, after some initial rapport building, hesitantly revealed to the counselor that he was gay. However, Gabriel reported that he was not out to most of his family and friends for fear of being shunned from family reunions, social gatherings, and church activities. He considered himself fairly acculturated (bicultural) and speaks Spanish, especially with his mother, who is an immigrant from Mexico. He described his family as relatively traditional in gender issues, sexuality, and religious values (i.e., Catholic). He reported feeling self-conscious in family interactions, especially when interacting with the other males in the family, whom he described as *muy hombres* (very manly) and often telling homophobic jokes. He mentioned that he is dreading the reaction they might have when they find out his true identity. He feared being stigmatized by the family and ostracized from his close family and friends.

The client was prompted by his physician to see this counselor after becoming infected with HIV. He indicated that he most likely contracted it while having sex with other Latino men who consider themselves to be heterosexual. He reported feeling emotionally and spiritually conflicted. He indicated that recently he had been attending a Buddhist temple where he was learning about mindfulness and acceptance. He highlighted the fact that he considers himself spiritual, but not necessarily religious. He described his spiritual journey as conflicted and isolated. He noted that he felt like he had to live a double life, hiding his sexuality from a judgmental community and vengeful God. He also learned that homosexual acts were sinful, and thus he had struggled to reconcile his spirituality and sexuality. He characterized his life as one of sexual silence, internalized homophobia, and anger at God. He also possessed a strong sense of shame, fear of rejection, fear of judgment by God, and low self-esteem.

The client expressed a need for self-acceptance, a sense of belonging, and meaningful relationships. He yearned for intimacy with others, in which he could be his true self and reveal his gay identity without the fear of rejection. Given his recent diagnosis, he expressed existential concerns about his future, the meaning of life, and the prospect of effectively coping with the possibility of failing health and possible death. He found it challenging to rid himself of deeply entrenched negative self-views and damaging self-talk.

Multilayered presenting problems require multilevel interventions. Gabriel's presentation includes at least these important world view components: ethnicity, acculturation, family cultural dynamics, religion, spirituality, sexual orientation, gender roles, homophobia, seropositivity, perceived stigma, and psychological distress. The therapeutic approach consisted of (a) spiritually oriented and multiculturally sensitive psychotherapeutic interventions, (b) mindfulness-based suggestions, and (c) cognitive-behavioral strategies.

Theoretical Orientation: Multiculturally Informed and Spiritually Integrated

In the context of Gabriel's ethnic identity, it is important to keep in mind the following principles of Mestizo psychology (Ramirez, 2004) when addressing Gabriel's complex clinical presentation: (a) the person is an open system (i.e., inseparable from the physical and social environments in which he or she lives); (b) the spiritual world holds the key to destiny, personal identity, and life mission; (c) community identity and responsibility to the group are of central importance in development; (d) the foundations of a good adjustment to life (mental health) are liberation, justice, freedom, and empowerment; (e) total development of abilities and skills is achieved through self-challenge (i.e., endurance of pain and hardship); (f) the search for self-knowledge, individual identity, and life meaning is a primary goal; and (g) duality of origin, life in the universe, and education within the family play a central role in personality development (i.e., polar opposites—male and female, good and evil, God and human, sin and virtue, illness and health—were often fused in Latino/a indigenous cosmologies).

From the perspective of the Principles of Empirically Supported Interventions, several principles can aid in selecting empirically supported interventions. Interventions can be identified at various levels depending on their level of efficacy (Wampold et al., 2002). Both qualitative and meta-analytic reviews provide substantial evidence supporting general efficacy of cognitive-behavioral approaches and mindfulness-based interventions. However, there is less empirical evidence supporting the use of these interventions with Mexican Americans. Further research needs to demonstrate clinical success with clients from ethnic and sexual minority backgrounds struggling with specific problems, as with the case of Gabriel (Bernal & Scharrón-Del-Rio, 2001; Quintana & Atkinson, 2002). Ethical guidelines suggest that existing psychotherapies be modified to become culturally appropriate for ethnic minority persons. Nagayama Hall (2001), for example, identified interdependence, spirituality, and discrimination as constructs that are particularly salient for ethnic minorities and can be incorporated in culturally sensitive theoretical models of psychotherapy for multiple ethnic minority groups.

There has been some psychological literature that has favorably presented the use of cognitive-behavioral interventions with Latinos/as (Organista & Muñoz, 1996). However, outcome research on the efficacy

of cognitive-behavioral therapy (CBT) with Latinos/as has been extremely limited. It could be especially helpful with Latino/a clients whose expectations include immediate symptom relief, guidance and advice, and a short-term, problem-centered approach (Miranda, 1976; Torres-Matrullo, 1982). Comas-Díaz (1981) found CBT to be significantly efficacious in treating depression with Puerto Rican mothers. In addition, Organista, Muñoz, and Gonzalez (1994) found significant pre-to-posttreatment reductions in depression in a sample of Latinos/as. Elligan (1997) reported the successful integration of CBT to treat a bicultural male client (Mexican Palestinian) with dysthymia. Hendricks and Thompson (2005) successfully treated a Latina woman suffering from bulimia nervosa by integrating both CBT and interpersonal psychotherapy. Gelman, Lopez, and Pérez-Foster (2005) found significant before–after treatment improvement in a 12-session CBT protocol for depression with Latinas. In their analyses of evidence-based interventions for diverse populations, Muñoz and Mendelson (2005, p. 791) concluded, "Despite the fact that CBT was originally developed and tested with predominantly European American populations, we predicated that its core principles would be applicable to diverse groups provided that they are presented in a culturally sensitive manner."

Research on the clinical efficacy of mindfulness practices with Latinos/as has been more limited. Gillispie (2006) found positive mental health outcomes among Latinos using mindfulness procedures. More specifically, the use of mindfulness-based interventions was related to decreased trait anxiety levels and significantly related to biculturalism, that is, a more flexible acculturation transition. At the broadest level of extant empirical evidence, the combination of mindfulness-based cognitive therapy has considerable empirical support in treating personality disorders (Huss & Baer, 2007). Several studies have found mindfulness to be associated with psychological well-being (Brown & Ryan, 2003). Mindfulness, in combination with CBT interventions, significantly reduced relapse in recovered depressed patients (Teasdale et al., 2002). A special issue of *Clinical Psychology: Science and Practice* critically reviewed clinical interventions based on mindfulness (Baer, 2003; Hayes & Wilson, 2003; Kabat-Zinn, 2003; Roemer & Orsillo, 2003; Teasdale, Segal, & Williams, 2003). After an extensive and empirical review of the literature using meta-analytic techniques, Baer (2003) concluded that some mindfulness-based interventions may be helpful in the treatment of several disorders. Kabat-Zinn (2003) highlighted the importance of mindfulness-based interventions and how they can be sensitively used in cross-cultural settings. Mindfulness has been heavily influenced by

spirituality, primarily Eastern meditative and Christian contemplative traditions, and thus can be suitably integrated into psychotherapy in the form of meditation practices (e.g., sitting and walking meditation) and other forms of mindfulness practice (e.g., mindfulness of eating, breathing, etc.) (Dimidjian & Linehan, 2003).

Treatment Implications

For clarity, this section describes treatment considerations along three major dimensions that are considered to be the main areas of therapeutic emphasis. Critical issues are highlighted in the form of questions at the end of each dimension.

Cultural Dimension

As a second-generation gay Mexican American male, Gabriel has learned to navigate between two different ethnic and cultural world views: the Euro-American culture and the Mexican culture. Mexican culture differs from Euro-American culture in many ways. For example, Hofstede (1980, 2001) ranked 53 cultures along four value-based dimensions. On the Individualism dimension, Mexico ranked 32nd and the United States ranked 1st. As noted by others (e.g., Díaz-Loving & Draguns, 1999), Mexican culture is relatively collectivistic, with a strong emphasis on close family and social relations. Loyalty in a collectivistic culture is paramount, especially to the family. For Mexican and Mexican American gay and lesbian people, this is an especially important factor as they may feel conflict because of values of respect (*respeto*) and family honor and loyalty (*familismo*). It can make the identification and integration of one's sexual orientation (coming-out process) even more difficult. In addition, possible family rejection deeply affects these Mexicans and Mexican Americans, who are rooted in these family values. Thus, the loss of the family as the primary support group is paramount to Mexican American clients.

Among other value differences, Mexico ranked much higher on the Power Distance dimension (tied for 5th) than the United States (38th), suggesting a greater acceptance of unequal power and status in Mexican culture. Cultural institutions (e.g., church, traditions) enjoy a certain status and influence as well. Mexico also ranked higher (6th) than the United States (15th) on the Masculinity dimension, perhaps reflecting the greater differentiation of gender roles in Mexican society. Masculinity (*machismo*) enjoys a certain status in the culture (Díaz-Guerrero, 2001). On the Uncertainty Avoidance dimension, Mexico ranked 82nd and the United States ranked 43rd, indicating the Mexican society's low level of tolerance for uncertainty. In an effort to minimize or reduce this level of uncertainty, strict rules, laws, policies, and regulations are adopted. The ultimate goal of this culture is to control everything to eliminate or avoid the unexpected. The combination of Catholicism and the cultural dimensions may reinforce a world view predicated in the belief that there is an absolute Truth (Hofstede, 2001).

Moreover, according to Díaz-Guerrero (1967), every culture develops a system of interrelated historic-socio-cultural premises (HSCPs) which give shape to most psychological processes of the individual. An HSCP is an affirmation underlying the specific logic of the group (Díaz-Guerrero, 2001). These premises are typically endorsed by the majority of the culture's members because they embody the culture's values, norms, beliefs, traditions, and prescriptions for behavior (Díaz-Guerrero, 1992). Díaz-Guerrero (1993) categorized the HSCPs as prescriptive or as related to coping style. Nine HSCPs were derived in a factor analysis of 123 belief and value statements: machismo (male supremacy over women), affiliative obedience (obedience toward parents and figures of authority), value of virginity, abnegation (sacrifice of personal needs for the sake of others), fear of authority, family status quo (women's faithfulness to husbands, and children's emulation of parental traits), respect over love (attitudes toward parents based on respectful obedience), family honor, and cultural rigidity (parental strictness and restrictions on women's work and courting) (Díaz-Guerrero, 1982).

Based on these cultural dimensions, the following critical questions warrant exploration in therapy: What is Gabriel's level of acculturation and relative endorsement of traditional Mexican values? Which HSCPs can be used as a framework to understand his intrapersonal conflict with religion and spirituality? To what extent are his values and sexual orientation conflicting? How can Gabriel be assisted to integrate his cultural values and sexual orientation?

Seropositive Status

As a self-identified gay Mexican American male with seropositive status, Gabriel has encountered stereotypical and homophobic views that have brought up considerable shame, guilt, and psychological distress (Carballo, 1989). This set of psychosocial experiences (i.e., oppression, stigma,

homophobia, and discrimination) has been identified as extremely devastating for sexual minorities, particularly for ethnic minority groups (Díaz, Ayala, Bein, Henne, & Marin, 2001; Díaz, Ayala, & Bein, 2004; Hoffman, 1993). Some have suggested that the relatively high prevalence of HIV infection among Latinos/as may be due to social context and internalized sociocultural experiences, which likely affect sexual behavior and sexual risk management (Zea, Reisen, & Díaz, 2003). Traditionally, sexual behavior has been conceptualized as highly personal and individualistic. The emphasis has been placed on the person's sense of identity, knowledge, attitudes, beliefs, and perceptions. This results in assessment, treatment, and prevention models for HIV that lack cultural sensitivity and validity.

On the other hand, Díaz (1998, 2000) proposed a theoretical model that explains the sexual behavior of Latino gay men as a personal dialectic between cultural values and the internalization of these into sexual scripts. Not only are sexual orientation and identity about the individual, but in a highly collectivistic culture, sexual identity also reflects the family and the social group. Sexual categorization is also dependent on cultural notions of masculinity and femininity. In European American culture, individuals self-identify themselves in sexual categories (e.g., gay, bisexual, and straight), whereas Latinos' sexual categorization, especially in the case of gay male relationships, is primarily based on the relational category within the dyad (e.g., active or passive, top or bottom). Therefore, some gay Latino males may not necessarily refer to themselves as gay, especially in more traditional cultural settings, and yet prefer sex with other men (Díaz, 2000).

Thus, from a clinical perspective, several critical issues need to be considered: What messages or scripts regarding gender identity and sexual orientation has Gabriel internalized, and how much do they influence his sexual behavior? What role, if any, have these external sociocultural forces and internalized psychosocial scripts played in putting him at risk for contracting HIV? What cultural images of sexual minorities was he exposed to in his ethnic sociocultural context, and what characteristics (positive, negative, neutral, contradictory) did these images evoke for him? How does Gabriel relate to and cope with the broader gay community, which may not necessarily hold similar sociocultural constructions of gender and identity?

Spiritual and Religious Struggles

Gabriel indicated that religion and spirituality have played an important role in his life. Historically speaking, most Latinos/as have ancestry in Latin America, a continent known for its devout religiosity. Catholicism has been an influential institution shaping the world view of a large number of Latinos/as. It has defined theological notions such as God and sin and instituted certain moral codes. Of particular relevance to our case are moral precepts regarding sexuality. Official Catholic teaching has consistently judged all homosexual activity as "gravely sinful" (McBrien, 1994). Gay Catholics who may experience a difficult time accepting the institutional moral teachings may report a greater sense of alienation, higher degree of anxiety about their sexuality, cognitive dissonance, or the inability to integrate seemingly contradictory identities (Loseke & Cavendish, 2001; O'Brien, 1991).

When struggling with seemingly contradictory identities, some Catholics opt to leave the institutional practice of Catholicism and may join religious groups or institutions with a more accepting and tolerant view of homosexuality (McNeill, 1993). Such is the case of Dignity, a Catholic community for lesbian, gay, bisexual, and transgendered (LGBT) people. Wagner, Serafini, Rabkin, Remien, and Williams (1994) found that involvement in Dignity fosters positive attitudes in integrating one's homosexuality and religious identity.

It would be a distorted view to claim that all religious institutions promote teachings or views that are characteristically homophobic or in some way oppressive and marginalizing of LGBT people (Bouldrey, 1995). Although some positive pastoral developments have been made toward the inclusion and acceptance of LGBT people into religious communities, some of the largest religious bodies (e.g., Catholicism, Islam) continue to struggle theologically regarding the acceptance of more progressive views on gay and lesbian issues (e.g., same-sex partnerships, ordination of openly gay and lesbian individuals, etc.). Some religious writers have advanced positive theological views that have the human dignity of LGBT people as a basic premise, saying they deserve respect and human rights (Alexander & Preston, 1996; Balka & Rose, 1989).

From the analysis of the literature and from clinical experience working with gay and lesbian clients struggling with religious and spiritual issues, one may find three broad levels of affiliation: religiously committed, religiously compliant, and religiously conflicted. The religiously committed would include most LGBT people who are associated with a religious group, active in the respective religious practices of the institution, and, for the most part, are receptive to the religious views on sexuality and specifically the institutional teaching on homosexuality (Greene & Herek, 1994; Tigert, 1996). The religiously compliant may include the LGBT people who self-identify as

members of the religious institution and adhere to the general religious rules and practices (Comstock, 1996; Glaser, 1996). This level especially occurs in the case of family tradition (e.g., nominal gay Catholic versus observant or truly practicing gay Catholic) where it is mere compliance and generally lacking deep, personal commitment. The religiously conflicted refers to LGBT people who are members of a religious institution or who have left the religious institution for a variety of reasons. This may include dissenting views on sexuality, homophobic practices or beliefs, religious discrimination and bigotry, and other forms of marginalization (Buchanan, Dzelme, Harris, & Hecker, 2004; Shallenberger, 1998).

These three categories are not mutually exclusive, but they help us to understand some of the intrapersonal and contextual dynamics of clients. Some religiously committed clients, for example, may have recently been exposed to a bigoted statement in their church community, and despite their dedication to their faith, they may feel internally conflicted. One may also encounter closeted religious individuals who profess a certain religious affiliation publicly and comply with some religious practices, but deep in their conscience are on the verge of abandoning or relinquishing their religious affiliation. These levels of affiliation and commitment might also be associated with different emotional reactions and ways of coping, which range from spiritual self-surrender and conscious acceptance to negativism, rage, resentment, and other forms of distress (Barret & Barzan, 1996).

Therefore, these therapeutic considerations deserve clinical attention. In Gabriel's experience, how can he reconcile his two seemingly contradictory identities, and would he ultimately want to be devoutly religious and proudly gay? How can he heal from his perceived sense of moral condemnation? How can he continue to strengthen his spirituality vis-à-vis his religiosity and experience self-acceptance, a sense of belonging, intimacy, and meaning in his life?

Analysis of Sessions and Rationale for Interventions

Structurally, psychotherapy consisted of seven sessions, with two sessions mainly dedicated to assessment and exploration of issues, approximately four sessions incorporating specific spiritual and cognitive-behavioral interventions, and one session for the conclusion of therapy. Because the psychotherapeutic process is a fluid and dynamic process, it is difficult to have a clear delineation of clinical issues and session goals and interventions. Yet, for illustration and training purposes, I have briefly outlined the main foci and goals of every session, followed by some of the exchanges with the client. I also discuss the main interventions utilized and the rationale for their implementation.

First Session

The focus of this session was (a) to establish rapport and to develop a therapeutic relationship, (b) to evaluate coping skills and current resources, (c) to assess suicidal potential and other crisis issues, and (d) to be culturally sensitive and to offer support. I initially engaged in a small casual conversation (*plática*) with Gabriel about the hassle of parking around our facility. After I introduced myself, I proceeded to explain how I approach counseling and to find out what expectations he had, especially because he had been referred by a physician and did not have prior experience with psychotherapy. Confidentiality and its exceptions were explained.

Gabriel introduced himself, and at one point he interrupted the conversation to inquire about my ability to speak Spanish, to which I responded in Spanish and briefly disclosed about my Mexican background. He was visibly engaged and described his family as originally from Mexico. He then explained the reason of his referral. Upon further inquiry on my part, he elaborated about his recent medical diagnosis and hesitatingly disclosed his sexual orientation, identifying himself as gay. During this sensitive time of self-disclosure and rapport building, I consciously made use of appropriate attending skills while maintaining moderate levels of eye contact, being aware of cultural experiences, and listening with a third ear (listening attentively to verbal and nonverbal messages).

In terms of actual content, he reported feeling isolated from his family, community, and God. He described the diagnosis of seropositivity as catastrophic and feared being stigmatized, though he was still in the early stages of the disease and therefore relatively asymptomatic. He presented with negative attributions and perseveration. He feared employment and housing discrimination. He saw this as a major transition in his life and appeared confused as to how he was going to cope. He noted that some of his peers believe that becoming HIV infected is the individual's "own fault," and it is frequently stigmatized as highly contagious and repulsive. He talked about some of the unknowns that lay ahead regarding the progression of the disease and the likelihood of premature death.

Specific interventions used during the session included an assessment of interpersonal and institutional support systems. Gabriel reported feeling confused as to where to turn to for help. He expressed fears of rejection, abandonment, and the loss of existing relationships. He indicated that, paradoxically, he was emotionally and physically distancing himself from friends, family, and colleagues as a way of keeping his status a secret and yet having a stronger desire for support.

Given my client's seropositive status, I consulted with my supervisor regarding ethical dilemmas, specifically about the limits of confidentiality and duty to warn (*Tarasoff v. Regents of the University of California*, 1976). Apparently, dishonesty regarding one's infectious state is common and may represent a threat to uninformed partners. Suggestions from my supervisor included an assessment of potential harm (e.g., the extent to which my client engages in behaviors that carry a high risk of transmission) and inquiring about potential identifiable victims.

Rationale

Rapport building with Latino/a clients is essential. Initiating the session with a small *plática* can be seen as part of the Latino/a cultural value referred to in counseling as *personalismo*, which involves listening to others, having a genuine interest in getting to know others, and demonstrating good social skills. My intentional decision to selectively self-disclose about my background is also part of being personally caring and respectful (showing *respeto*).

Regarding appropriate assessment and interventions for seropositive clients, Hoffman (1991) proposed a psychosocial model that is sensitive to cultural minorities. Some of my interventions in this first session—for example, assessing the client's prediagnosis or presymptom social support system versus his or her postdiagnosis support system—are derived from Hoffman's model.

Second Session

This session focused on (a) further assessing his emotional reactions to HIV infection and diagnosis, (b) exploring strategies to increase and maintain sources of support, (c) building support through effective coping, and (d) further examining spiritual and existential issues. When asked about how his week had been, he quipped, "As my abuelita used to say, '*Ayúdate que Dios te ayudará*' " (Help yourself and God will help you). To which I responded, "*Dios mediante*" (God willing!). I asked him to tell me the story of his grandmother and his upbringing. He briefly chronicled his life story growing up in a predominantly Latino neighborhood with a large immigrant presence. He also recounted growing up in a close-knit family that instilled values such as loyalty to the family, love for God, and respect for elders.

Gabriel attributed blame to himself, others, and God for his current situation, which had generated feelings of self-loathing and guilt. He also experienced a drop in self-esteem as a result of multiple psychosocial stressors. He attributed his self-condemnation to an overly rigid church that, in his opinion, unjustly labeled him a sinner. In addition, he felt marginalized in a Latino *machista* community and in an overly pious Catholic Church.

Specific interventions utilized during this session included discussion of community services for seropositive clients for example, referral to a support group at the local gay and lesbian support center. I continued to assess for attributions (cognitive appraisal), psychosocial competence, and his ability to function in the various social and cultural contexts in which he was living and working. An assessment of general coping revealed that he was not abusing substances or resorting to self-destructive or reckless behaviors, and he did not display suicidal ideation.

Rationale

My initial question suitably prompted Gabriel to respond with a *dicho*, or Spanish proverb. Comas-Díaz (2006) recommended the use of sayings in psychotherapy because they embody the wisdom of the culture and reveal life outlook, beliefs, attitudes, and feelings. One cannot fail to notice the sense of spirituality that is linguistically encoded in these Latino sayings about God and the internal locus of control. By purposely responding with a saying that metaphorically captures the equivalent meaning of God being in control, Gabriel proceeds to talk about religious and spiritual struggles. A theme emerges; Gabriel's religious upbringing instilled in him an image of himself that conflicts with his sexual orientation, and he would like to reconcile these two aspects of his identity.

Asking Gabriel to tell me the story of his family is an intervention supported by Arredondo et al.'s (2006, p. 18) *Psychohistorical Approach to Psychotherapy*. Arredondo et al. generally invited clients to tell the family story, while the counselor listens for "themes of identity conflict, acculturation stress, loss and grief, homesickness, guilt, and other emotions." It continues the rapport-building process, as I continue to learn about him as an individual,

while at the same time assessing for the influence of family history and values on the presenting issues.

Third Session

This session focused on (a) further exploring Gabriel's sense of identity and supporting him in the development of his gay identity development, (b) discussing his coming-out process, and (c) assessing potential sources of prejudice and discrimination and coping. Gabriel described his experience with homophobia, stereotypes, and other negative influences. I encouraged Gabriel to speak about his feelings and reactions to stigma and homophobic attitudes and behaviors, specifically coming from his family, his religion, and society in general. I was especially interested in the internalization of these negative social influences and how they have impacted his self-concept and self-esteem and contributed to his emotional distress.

He indicated that he has been very selective about his coming-out process, disclosing his true sexual identity to those individuals he considers safe and nonjudgmental. We discussed the pros and cons of coming out to other people in his life; for example, his family and close friends. Regarding his church, I offered information about the various groups and pastoral outreach programs available. I also offered resources not directly associated with the church (e.g., GLSEN: Gay, Lesbian, and Straight Education Network). I also provided him with some education brochures, including bilingual resources for LGBT people.

Rationale

Research consistently confirms that LGBT people are vulnerable to stereotypes, bigotry, abuse, and violence. Research has suggested that higher rates of mood disorders, anxiety disorders, and substance abuse among LGBT are mainly attributed to such psychosocial stressors and pressures. Thus, I considered it very important to listen to Gabriel and to assess to what extent he had been exposed to these negative influences and determine the negative emotional impact on him.

Fourth Session

Our goals were (a) to continue evaluating emotional coping (access to resources and support, and suicidal potential), (b) to discuss specific spiritual practices, and (c) to cognitively appraise self-explanations. Gabriel had just returned from a local Buddhist temple, where he had briefly met with a Zen master, and had been participating in meditative practices. I listened attentively as he shared his interest in Buddhism and asked him to share with me how he initially got involved with it. He enthusiastically described how meaningful he found the teachings and practices of Buddhism at this point in his life. Displaying a respectful, receptive, and inquisitive engagement, I asked him to share with me what he had found particularly striking. "Compassion, community, and care ... the three Cs I've been longing for," he emphatically stated. He explained that he saw Buddhism as different from most religious institutions because it teaches tolerance and sees all human beings as belonging to a universal, loving community. Moreover, this universal human family is afflicted by suffering stemming from attachment to transient things in life. With a jovial demeanor, he shared that his meditative practices are giving him a sense of belonging and a deeper understanding and awareness of his own suffering.

Specific interventions included positive reinforcement and validation of current meditative practices. I also introduced a psychoeducational approach and explained the concept of mindfulness, which involves intentionally bringing one's attention to the internal and external experiences occurring in the present moment. We identified some specific issues (existential concerns, despair, isolation, images of God, and negative self-attributions) and discussed them in light of the new insights and experiences he derived from Buddhism. He was able to gradually reframe some of these issues using the concept of enlightenment, which he understood as the path toward ultimate peace and human happiness, obtained through detachment from transient realities and the exercise of meditation and study. He was going through a transformation from relating to what he had experienced as the institutional, vengeful God to his current experience of the loving presence within him and a feeling of being connected with all of creation.

Rationale

Integration of spirituality into psychotherapy requires a respectful attitude, and I have consistently exhibited this for the client. This is evidenced in my receptive demeanor, genuine inquisitiveness, and validating affirmations. These interventions are an integral part of the therapeutic alliance and pave the way for integration of spirituality. From a cognitive perspective, we used

mindfulness to explore the client's thinking and underlying cognitions that may be very adaptive for Gabriel.

A cognitive therapist is especially alert to cognitive distortions, which often develop as a result of life experience and form the basis for personality and the way one construes the world. These schemas are usually formed during the early and influential years of childhood and adolescence and are later reinforced by experiences. One of Gabriel's interpretative tendencies seems to be "I am a worthless and sinful person in God's eyes." Some of the intervention strategies used included collaborative empiricism and Socratic dialogue.

Collaborative empiricism refers to a collaborative relationship in which dysfunctional or distorted cognitions are identified, evaluated, and gradually modified (reframed). In this process, one should not tell the client that these beliefs are wrong, especially if these beliefs are religiously derived; rather, it is the client's decision regarding what beliefs will be maintained and what beliefs will be discarded. Empathy, genuineness, and warmth are used to foster the progression of the collaborative relationship (Beck, Rush, Shaw, & Emery, 1979; Beck & Weishaar, 1989).

In Socratic dialogue, the therapist asks questions with the purpose of helping the client examine his or her thinking and formulate additional interpretative alternatives. When done correctly, Socratic questioning will not trap the client into a specific answer or put the client on the defensive. In this process of guided discovery, the therapist helps the client to discover experiences in the past that are affecting his or her current thinking (e.g., early religious experiences or concepts). All of these techniques help clients learn to interpret information in a more neutral or adaptive manner (Beck & Weishaar, 1989).

Fifth Session

To a certain degree, this session was a consolidation of the previous session and so the focus was (a) to continue some of the cognitive focused work we initiated, specifically examining some of the images he had internalized and their emotional associations; (b) to review some of the insights he had acquired from participating in a support group; and (c) to continue integrating spiritual practices into his life.

He expressed gratitude for the referral to the support group for seropositive gay males. He shared some of the topics the group had been discussing, which included coping skills, mastery, grief work, cognitive reframing, and

reordering of priorities. We spent some time connecting some of the skills and insights he had learned to our therapy, and he noted that he had found cognitive reframing particularly helpful.

I creatively included the intervention of "progressive image modification," which is the process by which damaging perceptions of clients might be gradually transformed into more rational perceptions. I asked Gabriel to concentrate on the key pattern connected with his images of God and self-concept and asked him to describe them fully. I asked him to form the emerging themes into visualizations to the extent that it was possible. After employing some relaxation to help him concentrate, I asked him to imagine the themes again, but to change some component of the pattern (e.g., by incorporating some of the new images he has learned in Buddhism). I suggested that he could change some visual or emotional component or some other aspect of the pattern. Gabriel engaged in this progressive image modification, and we discussed the experience and emotions associated with it.

Rationale

Progressive image modification has been successfully used by cognitive-behavioral theorists (Lazarus, 1977; Singer & Pope, 1978). The purpose of progressive shaping is to get clients to disrupt their thinking patterns just enough to remove the source of negative emotion. The client is gradually led through a process of changing various components in his or her general belief structures until the person is able to isolate the source of distressing emotions.

Sixth Session

The focus of this session was to (a) evaluate progress made in therapy and anticipate setbacks, (b) continue assessing self-efficacy (e.g., personal belief that he can control certain events) in several areas of his life, (c) monitor affect regulation, and (d) integrate spiritual practices in his life. Gabriel and I revisited some of the mutually agreed-on goals and discussed other areas that needed to be explored. He expressed concern about two specific issues: potential setbacks in the future and medication compliance. He expressed feeling a deeper sense of meaning in his life and a more accepting attitude of his seropositive status. He also reported a more positive relationship with the transcendent and sacred dimensions of his life and a forgiving and embracing

attitude toward others. He noted that recently he had been meeting with the Zen master at the temple and having spiritual direction. It is surprising that he had also participated in an ecumenical prayer meeting for world peace that brought together people of various faiths, and he felt a sense of community support, even when praying to, what he called, the "God of Christianity."

I asked Gabriel to identify specific strengths and skills he had learned and setbacks he may potentially encounter. We created a hierarchy of situations in which he felt the least and most efficacious. With his help, we prepared a self-talk dialogue to be used during the vulnerable situations. We realistically anticipated negative emotions and reviewed steps to follow to overcome these situations. We rehearsed the dialogue for each item on the hierarchy. Regarding his prescribed medication, for example, he expressed mixed feelings about adherence to the recommended regime. We reviewed some of the mindfulness strategies to be more aware of fear-based responses and reactions and to identify stressful situations.

Rationale

Many clients expect to fail miserably. Bandura (1977) and others have described this expectation as "low self-efficacy," the belief that one cannot execute the behaviors required to produce positive outcomes. Clients exhibiting this expectation consistently underestimate their ability to cope with various situations. After a while, these expectations tend to become self-fulfilling prophecies. However, coping statements can avert this pattern, helping improve clients' self-efficacy. Rehearsing the dialogue with the coping statements is a modeling procedure (Meichenbaum, 1977) that can be very effective for clients to use when the need arises.

Seventh Session

The sixth session suitably set the tone for the exploration of existential issues. By this time, Gabriel had confronted negative feelings related to his faith and sexual orientation. With more insight into the underlying issues affecting him, the primary focus of this session was (a) to discuss his fears of progressive physical illness and possible death, (b) to further clarify some value conflicts, and (c) to introduce conclusion of therapy and discuss posttherapy plans. Gabriel reported dreading to confront the prospect of dying and death. He kept asking one existential question: Why me? His existential

concerns appear to be aggravated by the fear of early death associated with HIV. I asked Gabriel to think about the meaning of his life in the context of his family and the Buddhist concept of a universal community. He described the meaning of soul and afterlife. His sharing seemed to gradually put his existential concerns into perspective and attach meaning and purpose to his life. We then read a passage from Viktor Frankl's *Man's Search for Ultimate Meaning* (1975/1997) and reflected on it. The passage dealt with meaning in suffering, based on Frankl's own testimonial of survival from Auschwitz.

Rationale

It is common for clients dealing with terminal and serious illness to confront existential themes related to death, freedom, meaning, and isolation (Shepherd-Johnson, 2003; Yalom, 1980). Feeling connected to a transcendent reality was especially helpful for Gabriel (Simoni, Martone, & Kerwin, 2002). This relationship with a spiritual and infinite reality, through meditation and reflection on his spiritual gifts, helped him put his personal struggles into perspective. He reported feeling a sense of peace by surrendering his attachments to health and accepting and embracing each moment as it came. My approach in dealing with Gabriel's existential and spiritual questions regarding mortality is consistent with Rousseau's (2000) palliative approach, which includes seven steps: (a) controlling physical symptoms; (b) providing a supportive presence; (c) encouraging life review to assist in recognizing purpose, value, and meaning; (d) exploring guilt, remorse, forgiveness, and reconciliation; (e) facilitating religious expression; (f) reframing goals; and (g) encouraging meditative practices, focusing on healing rather than cure.

Eighth Session

This session was devoted to (a) reviewing the course of therapy and the insights and skills learned, (b) providing additional resources for support, and (c) discussing contingency plans and future potential challenges. I encouraged Gabriel to continue attending the support group and to continue accessing community resources. I reframed this last session from being a "termination" to being a "passage" into a different phase in his "life journey" or "pilgrimage." We used these metaphors to process the session and to put it in context. I was especially cognizant of his previous struggles with isolation and separateness from others. After reviewing his goals for therapy and what he had addressed,

I provided him with some resources in the community and mentioned to him that he could return at any time. I mentioned this is just a passage into a different phase, to which he jokingly replied with a very popular Mexican saying: *Borrón y cuenta nueva* (Erase and start a new account).

Rationale

For a religiously oriented client such as Gabriel, who also struggles with existential concerns related to finality, I purposely used widely used metaphors in the spiritual traditions. Life is usually seen as a journey or pilgrimage. Journey connotes a final and purposeful destination. The human person is not an aimless wanderer, but rather a spiritual pilgrim with a purpose. Therapy can be seen as a stopover or passage along this meaningful path.

Case Conceptualization

Values are cognitive representations of desirable goals. Similar to needs, motives, and goals, values motivate actions. They vary in their importance as guiding principles in people's lives (Schwartz, 1992). From a cultural perspective, cultural schemas (values, beliefs) are dependent on cultural learning. In Gabriel's case, the following cultural values and HSCPs, characteristic of the Mexican culture, appear to be very salient: familism (family loyalty), Catholicism, affiliative obedience, family honor, and abnegation. As a self-identified Mexican American individual with a fairly high level of acculturation, he also reported a relatively strong level of endorsement of some traditional Mexican values, especially the cultural mandates referring to family relationships (obedience, honor, and *respeto*), due in part to his close relationship with his mother, who was Mexican born and Spanish speaking.

Whereas most of these values are socially and culturally desirable and usually serve an adaptive role, a cognitive assessment of Gabriel yielded the hypothesis that some of them may have been contributing to his intrapersonal conflict. As a religiously compliant individual, Gabriel grew up Catholic, following a long family tradition of strict adherence to religious practices and teachings. However, a value conflict was apparent between his religious affiliation and his sexual orientation. Being sexually active with other men and being exposed to family and church views forbidding homosexuality was

extremely conflicting for him. He once stated, "I pride myself on being *bien educado* [well raised]", and he didn't want to bring shame to his family, yet he couldn't deny his sexual orientation. Thus, feelings of guilt and loneliness resulted from living a double life. On the one hand, he was trying to adhere to family values and cultural expectations, and on the other, he was involved in gay relationships and wanted to be able to live an authentic lifestyle.

We were also able to identify some cognitive distortions. Gabriel's dichotomous thinking was apparent when he tended to classify himself as either good or bad, sinful or virtuous, or adequate or inadequate (i.e., self-efficacious), depending on whether he had managed to observe or follow certain religious or cultural prescriptions. The diagnosis of HIV had a tremendous negative impact on his self-concept. This resulted in self-blame and personalization (i.e., making a connection between some other event and himself, without supporting evidence), unfairly assuming that he was solely responsible for his actions and seropositive status. Gabriel was encouraged to see, without relinquishing total responsibility, other sociocultural factors contributing to his circumstances. Special relevance was given to stigma, oppression, and negative stereotypes, particularly in the Latino community, as affecting his sexual identity and self-concept.

Additional Clinical Considerations

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000) has included a new diagnostic category titled religious or spiritual problem under Other Conditions That May Be a Focus of Clinical Attention. For the first time, there is acknowledgment of distressing religious and spiritual experiences as nonpathological problems (Turner, Lukoff, Barnhouse, & Lu, 1995). This category (V62.89) is usually used "when the focus of clinical attention is a religious or spiritual problem." Some examples include "distressing experiences that involve loss or questioning of faith" and "questioning of spiritual values." In Gabriel's case, the use of this label would be an accurate diagnostic assessment because part of the distress he is experiencing seems to be directly associated to his religious beliefs. In addition to this, Gabriel's presenting problems met DSM-IV criteria for major depressive disorder, and I initially obtained authorization (release of information) to consult with his treating physician.

Identification of Personal Dimensions of Diversity and World View

Being aware of oneself as a cultural being has been considered a competency and a prerequisite for competent multicultural counseling (Sue, Arredondo, & McDavis, 1992). More specifically, Sue et al. (1992) indicated that it is crucial that one is aware of one's own cultural heritage, values, and biases and is comfortable with differences that might exist between therapist and client in terms of race, gender, sexual orientation, and other sociodemographic variables. Differences should not be seen as being deviant. The term cultural countertransference has been coined to describe the therapist's reactions (affective, cognitive, and behavioral) to cultural experiences in therapy that might potentially impede the therapeutic endeavor (Stampley & Slaght, 2004).

From my first encounter with Gabriel, I gradually became aware of our identity similarities and differences. Similarities in background and values can be helpful in relating to and understanding the client. It can also present some challenges. Supervision was very important in examining some of my reactions, assumptions, and ethnocultural biases. For instance, I identified the potential risk of ethnic overidentification, which I experienced as the affective and cognitive tendency to misperceive Gabriel as overly similar to me. I was mindful that every client is unique and may share some similarities in values, beliefs, and attitudes. However, objectivity and competence may be compromised by one's selective perceptual and attitudinal focus on what is common, similar, and familiar.

Values and belief systems are core elements of one's identity. Most people take pride in these defining characteristics because they describe one's total outlook on life, including society and its institutions. They also serve as guiding principles for one's behavior. In many ways, our values are the interpretative lens one uses to understand reality and one's existence within it. Some of Gabriel's problems stemmed from conflicts with his cultural and religious value orientations. It was a delicate balance between clarifying the conflict and not imposing my own biases or assumptions. My approach was to initially explore where the source of the conflict was and then gently and gradually guide Gabriel in his own discernment and sorting out of underlying conflicts. It was a matter not of altering his values or beliefs, but of primarily working with the feelings ("I feel like a worthless sinner") stemming from the value conflict and the self-punitive and self-loathing assumptions

("God hates all gays like me"), interpretations ("This means the church condemns all gays"), and extrapolations ("I wonder if I will be saved") made from some of these values.

Integrating spirituality and religiosity presented its own challenges. These are some of the most sacred and profound experiences that human beings are capable of having. They may become a rich repertoire of meanings and fulfillments, aspirations and longings, and, paradoxically, conflict and distress. As a person of faith, and someone who strives for therapeutic mindfulness, I have been able to learn to observe my experience, to become more aware of my process, and, in gaining a sense of separateness and reflexivity, to be accepting of others. I bring this mindful and meditative stance to my therapeutic work, thus opening a holding space for my client that is, to the extent that it might be possible, devoid of my own agenda.

Therapeutic Recommendations

1. Use multidimensional assessment and conceptualization of issues (ethnicity, acculturation, sexual orientation) and think holistically in structuring treatment goals.
2. Develop an integrative approach that incorporates both culturally appropriate and evidence-based intervention strategies that you can effectively use when working with LGBT Latino/a clients.
3. Know that Latino/a families handle LGBT topics, especially when a family member discloses a gay or lesbian sexual orientation, in different ways. Psychologists have to be well prepared to work with different family experiences.
4. Attend to your own personal definitions and experiences of religiosity and spirituality, and know how they differ or overlap with your client's.
5. Focus on differences between you and your client regarding sexual orientation and ethnicity and how you would address these differences.
6. Recognize that clients with different religious experiences (e.g., religiously committed, religiously compliant, and religiously conflicted) present different issues in psychotherapy and require different psychotherapeutic approaches.
7. Become aware of your response to homophobia and religious systems that promote intolerance and religious beliefs found to be detrimental to LGBT clients.

8. Establish consultative relationships with spiritual and religious leaders and consultants in the LGBT community.
9. Learn about sexual identity development and models of spiritual and religious development and clinical implications.
10. Explore the source of internalized homophobia (e.g., societal, religious, cultural, family), and facilitate the description and expression of these negative messages in a supportive therapeutic environment.

Conclusions

I would like to offer two caveats regarding the content of this chapter. First, although the primary objective is to offer considerations for the integration of religiosity and spirituality, my clinical experience has been primarily with gay and lesbian people affiliated with religious groups within the Christian tradition. Therefore, the spiritual struggles of the client presented in this chapter, and corresponding clinical conceptualization and interventions, may or may not generalize to clients with similar conflicts and concerns from non-Christian traditions. It is the ethical responsibility of the culturally sensitive therapist to judiciously discern what considerations may be applicable to a specific case.

Any kind of therapeutic integration requires a keen perspective into what compatible and discrepant components might fit into a workable theoretical whole. With this mind, the ethically responsible and culturally helpful practitioner will use sound clinical judgment to incorporate spiritual practices and interventions that are consistent with the client's desired therapeutic goals and conceptually compatible with the therapist's theoretical orientation. In this case, Gabriel sought out Buddhist practices and integrated them into his life through meditation and spiritual support. This may not be the case for all religiously oriented people. Some LGBT people may find a pastoral support program within their own faith traditions.

Second, not every intervention and therapeutic approach herein presented met a rigorous scientific test of empirical validation according to the strict criteria of empirically supported criteria. I carefully reviewed the existing literature on empirically supported therapies for Latinos and LGBT clients. One has to be mindful that most psychotherapies have been developed with Euro-American and heterosexual participant samples or with samples where ethnic minority identity or sexual orientation was unknown. Transferring

the use of these therapy approaches to LGBT and ethnic minority clients should be done closely following the best practice guidelines developed by the American Psychological Association. Theoretically, most of the interventions included in this chapter can be conceptualized from a cognitive-behavioral approach, multicultural perspective, and use of mindfulness-based strategies. The efficacy of the interventions, instead of being solely evidence-based practices, is mostly supported by practitioner-based evidence. My client reported a generalized sense of improvement in various areas of functioning.

Discussion Questions

1. Why is it meaningful to distinguish between religion and spirituality? Consider some of the descriptors from popular usage and experiences associated with each. What would be some of the clinical issues associated with someone who experiences a conflict between religion and spirituality?
2. Discuss how aspects of identity (ethnicity, acculturation, gender, sexual orientation) interact with religion and spirituality. To what extent are they related, and how complementary or incompatible are they?
3. Discuss some issues of oppression, homophobia, and discrimination in relation to HIV. What psychosocial factors make ethnic minorities especially vulnerable and at risk for HIV infection? What biases would make current models of diagnosis, prevention, and treatment not suitable for ethnic minorities?
4. What criteria should psychotherapists adopt for implementing effective interventions for specific clinical issues in complex cases? To what extent are manualized treatments appropriate for ethnic minorities?
5. For the culture or ethnic group that you know best, discuss any specific beliefs, stereotypes, stigmas, or prejudices they may have about sexual minorities. How do they differ from the case presented in this chapter in regard to (a) family dynamics, (b) religion and spirituality, and (c) attitudes toward HIV?
6. Why are some therapists reluctant to integrate religion and spirituality into psychotherapy? If the therapist has previously felt ambivalent or hesitant about spirituality in psychotherapy, how could he or she deal with a client who unexpectedly introduces spiritual or religious material into the session? Consider ethical implications.

7. What are some of the potential risks, abuses, or detrimental experiences for clients in regard to (a) involvement in spiritual or religious practices and (b) pseudoscientific claims attached to "spiritually based psychotherapies"?
8. What is your ethnic, cultural, and/or religious heritage? Is there anything about your value or belief system that you find conflicting, distressing, salutogenic (promoting or enhancing health and well-being), or pathogenic (causing impairment or disease)? What parts do you embrace? What parts do you reject?
9. Discuss how a self-identified nonreligious therapist might treat a client who (a) prays every day and lives a devotional and pious life (e.g., frequent church attendance, observance of religious holidays, adherence to spiritual guidance of religious leaders or pastors), (b) makes moral decisions guided by a religious code (e.g., commandments, virtue, grace), and (c) makes sense of events in life in general by referring to spiritual entities (God and heaven, devil and hell, saints and demons, soul and spirit). What helpful approaches might this therapist follow to be sensitive and respectful of this world view?
10. Read the following scenarios about cultural countertransference to religious clients: (a) a therapist is thinking that a female client sounds "narrow minded," "overly traditional," and/or "cognitively inflexible" when she decides not to have an abortion because for her this is a sinful crime; (b) a therapist is feeling uncertain or ambivalent or has mixed feelings regarding a client who believes homosexuality is a sin; and (c) a therapist personally thinks celibacy is a "repression" of sexuality, and she is currently working with a seminarian who struggles with masturbation and would like to stop because for him this is a breach of his vow to a celibate and chaste lifestyle. Discuss how these issues could be addressed or resolved in the context of therapy.

Cultural Resources

Suggested Film

Philadelphia (1993) is a historically important film in raising consciousness about AIDS. Tom Hanks plays a lawyer dismissed from his firm, apparently for incompetence, but really he has AIDS. Denzel Washington, a personal injury attorney, is initially homophobic. He agrees to take on the case and learns about his misconceptions about the disease, about those who contract it, and about gay people in general. He ends up overcoming his intolerance and fighting for justice.

The Wedding Banquet (1993) is about Wai-Tung (Winston Chao), an undocumented Chinese immigrant, who meets Simon (Mitchell Lichtenstein), and they begin dating. However, Wai-Tung's parents have not the slightest inkling of Wai-Tung's sexual orientation. The movie creatively portrays the interaction of ethnicity, sexual orientation, and the coming-out process.

Suggested Readings

Comas-Díaz, L., & Griffith, E. E. H. (Eds.). (1998). *Clinical guidelines in cross-cultural mental health.* New York: John Wiley & Sons.

This excellent resource offers very practical guidelines for working with clients from diverse ethnocultural backgrounds. It addresses specific cultural dimensions (ethnicity, language, religion, family values) and their relation to mental health.

Garnets, L. D., & Kimmel, D. C. (Eds.). (2003). *Psychological perspectives on lesbian, gay, and bisexual experiences.* New York: Columbia University Press.

The book has readable chapters on the meaning of sexual orientation, psychological dimensions of sexual prejudice, discrimination and violence, identity development and stigma management, and diversity among lesbians, bisexuals, and gay men. Some chapters also have a focus on sexual orientation throughout the life span.

Greene, B. (Ed.). (1997). *Ethnic and cultural diversity among lesbians and gay men.* Thousand Oaks, CA: Sage.

This is part of the series *Psychological Perspectives on Lesbian and Gay Issues*, sponsored by the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, Division 44 of the American Psychological Association. This edited book brings together some fine papers by multicultural authors on various ethnic populations (e.g., Native American, Jewish, Black South African, older African American males, Greek American lesbians) and their struggles with ethnic identity, racism, acculturation, and the coming-out process.

Pargament, K. I. (1997). *The psychology of religion and coping.* New York: Guilford.

The author provides a comprehensive analysis of religion and coping. Examples of chapters include the sacred and the search for

significance, when people turn to religion, when they turn away, when religion fails, and problems of integration in the process of coping. The author is a well-published scholar, and he integrates scientific theory with clinical practice.

Stern, M. E. (1985). *Psychotherapy and the religiously committed person.* New York: Haworth.

This practical and readable book includes chapters from several authors who provide a balanced explanation of important spiritual issues and how they can be integrated into psychotherapy.

Velásquez, R. J., Arellano, L. M., & McNeill, B. W. (Eds.). (2004). *The handbook of Chicana/o psychology and mental health.* Mahwah, NJ: Lawrence Erlbaum.

This is a great reference on mental health issues affecting Chicanas/os. Topics include Mestiza and Chicano/a psychology, acculturation, ethnic identity development, stereotypes, folk healing, psychological assessment, domestic violence, substance abuse, and folk healing. It covers these topics with scholarly discussions and yet is very readable and applicable.

Suggested Web Sites

http://www.apa.org/about/division/div44.html

This Web site of Division 44, the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues of the American Psychological Association focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and affecting professional and public policy.

http://www.ac.wwu.edu/~culture/readings.htm

This site offers online readings in psychology and culture from the Center for Cross-Cultural Research at Western Washington University. This is an outstanding compilation of readings from multicultural and cross-cultural experts dealing with topics of culture and psychology. Every reading includes discussion questions and resources.

http://www.fetzer.org/

This is the official Web site of the Fetzer Institute, which conducts rigorous scientific research on religion and spirituality. It brings together renowned scholars and leaders to scientifically study religion and spirituality. Their research projects have specific applications; for example, current investigations include altruism in America, racial healing, and end-of-life research.

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