<table>
<thead>
<tr>
<th><strong>EDITORS</strong></th>
<th><strong>EDITORIAL BOARD</strong></th>
<th><strong>PRODUCTION MANAGER</strong></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Department of Counseling</td>
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<td>University of North Carolina atCharlotte</td>
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**NC PERSPECTIVES** is a publication of the North Carolina Counseling Association for the purpose of informing our members of current research and practice in the field of counseling. Both scholarly and practical application manuscripts are selected for publication through a peer review process. Manuscripts accepted for publication describe (a) research in the field of counseling, (2) review of the literature, (3) innovative approaches in the field, (4) current issues in the field, (4) multicultural understanding and influences, and (5) book reviews of North Carolina authors.

**Manuscripts:** Send to the editors electronically in a Word document. Consult the **Guidelines for Authors** included at the end of this journal.

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NC Perspectives

A Journal of the North Carolina Counseling Association

Editorial

1 From the Editors
Hank Harris and Frieda Brown

Articles

2 Cognitive Priming and Counseling: Can A Priori Cognitions Influence Counselor Perception?
Andrew B. Bradshaw, David M. Carscaddon, Bonnie M. Wright, and Willie C. Fleming

11 From “Homophobia” to Homoemasculaton: A Primer for Counselors on Sexual Language Discourse
Shannon D. Smith, Shannon B. Dermer, Kok Mun Ng, and Korenna K. Barto

21 Working with Spanish-Speaking Clients: Interpreter Use or Bilingual Counselors
Clarrice Rapisarda

Graduate Student Perspectives

30 Utilizing Stoic Philosophy To Improve Cognitive Behavioral Therapy
Sarah A. Moore Brookshire

37 A Heterosexual’s Journey through Homophobia
Jamie Powell
For Your Files

44  Keep A Lid On It: The Trashcan Of Emotions
Trish Murray

Book Review

48  Crisis Counseling and Therapy
Pat Partin
From the Editors

Hank Harris, Ph.D. and Frieda Farfour Brown, Ph. D

It is with personal pleasure and professional pride we invite you to read and enjoy this, our first new edition of The North Carolina Counseling Association Journal. Although published many years ago, the journal was discontinued due to publication expense. With the publication of this electronic journal we mark an important milestone in the history of professional development for the NCCA. Through writing and research, we support the scientist/practitioner model of practice and connect with other counselors, benefiting from their professional perspective and practice techniques. This journal also provides an appropriate model for our students in their ongoing professional development. We hope that the journal enhances understanding of counseling theory and practice, professional development, and challenges.

The goals of the journal are threefold: (1) to foster research and scholarly endeavors; (2) to provide a medium for communication among professional counselors in N.C.; and (3) to enhance continuing education opportunities for counselors throughout the state.

The Journal is divided into four content areas, each addressing an important dimension of the counseling profession. The Theory and Research section will include reviews of the literature on topics important to counseling, annotated bibliographies of key publications and research, and both quantitative research and qualitative inquiry. The Innovative Approaches section will include descriptions of activities, strategies, and techniques developed and implemented by counselors. These creative techniques support continuing growth in our counseling practice. The Current Issues section will feature papers on timely topics affecting counselors, particularly those in North Carolina. We hope to inspire lively discussion that increases understanding and inspires action in behalf of the counseling profession and those we serve. Finally, The Graduate Student Works section will provide an avenue for our students to publish their own scholarly thoughts and experiences, reflecting on growth in understanding and application of counseling practice, and describing their personal journeys toward professional identity as counselors.

We appreciate the efforts of all those who have participated in the publication of this first edition. To those who have shared their research and writing, we thank you and are truly grateful. The quality of the work brings esteem to our publication. We also thank our Editorial Board for their critical reviews and thoughtful suggestions for improving the manuscripts. Third, we sincerely appreciate the North Carolina Counseling Association for continued encouragement and support for launching this project.

We offer a special note of appreciation to Dr. Susan Furr, without whom this journal would still be an idea, not a reality. Dr. Furr has been instrumental in the creative and applied components of this project. She has provided valuable help to create guidelines, review submissions, and provide clerical and technological support in this initial publication. In the birth of this journal, Dr. Furr is clearly the midwife.

Finally, we want to encourage readers to submit their own work for publication. Any original work that has not been previously published or is under review elsewhere will be accepted for review. All work must follow the APA guidelines for research and writing. Guidelines for submission are available on the website.

We welcome any and all feedback on the organization, content, and process of publication. This is a collaborative effort. Our success is dependent on your participation, as a reader, a researcher, a writer, and a practitioner. Come, share in this exciting endeavor.
Cognitive Priming and Counseling: Can A Priori Cognitions Influence Counselor Perception?

Andrew B. Bradshaw, David M. Carscaddon, Bonnie M. Wright, and Willie C. Fleming

This study examined the effect of a priori cognitions on evaluative perceptions toward a client viewed on video tape. Participants were randomly assigned to one of three conditions whereby they were to look for client strengths, deficits, or general observations. Results indicated that participants who were instructed to look for competencies perceived greater potential for positive change in the client compared to deficit oriented observers.

The counseling process is affected by a complex set of interactions between the counselor and the client. The relationship the client and counselor share is perhaps the most important predictor of counseling outcome (Day, 2004; Teyber, 2006). According to Brown (1970), research reveals that the relationship between the counselor and client is affected directly by the counselor’s inclinations or perceptions of the client. Therefore, the counselor’s perception of the client is an important factor into the counseling relationship. For the present research, perception is a broad term that includes speculative judgments like diagnoses, prognoses, and strengths.

One could argue that the counselor perception of the client could be organized along two dimensions: passive and active. On the passive end counselor perception of the client would include all those factors and variables that the counselor reacts to that emerge from interacting with the client and from the larger counseling context. Passively, the counselor receives information about the client and responds accordingly to that information (e.g., first impression). On the active side, perception is colored by what the counselor presupposes on the front end of treatment regarding the client. These a priori constructs (e.g., theoretical orientation, personal beliefs, etc.) can organize the counselor’s thoughts and may predetermine various aspects of counseling. It should be noted that the dimensional description of perceptions is somewhat artificial for several reasons, not the least of which is the logical possibility that a counselor could perceive the same client from both sides of the active and passive dimension. The dimensional aspect is presented here as a way to begin to discuss the complexities of counselor perceptions within the counseling context. In addition, the authors are not arguing that counselors create reality through imposing mental constructs on clients but that constructs may influence how we perceive our clients whether or not these constructs or perceptions are correct.

Related Research

Does the counselor’s impression of the client have an impact on the actual counseling process? From a passive perspective, first impressions would seem to be an important factor in not only determining how the counselor will view the client, but even in determining the outcome of the counseling process. There has been
at least fifty years of evidence on the influence of primacy effect and first impressions (Anderson & Barrios, 1961; Asch, 1946; Brown, 1970; Goldstein, 1960; Luchins, 1957; Park, 1986). Asch (1946) reported that under certain experimental conditions the primacy effect could be demonstrated in personality impression formation. Anderson & Barrios (1961) found the primacy effect to be very strong in personality impression formation through using adjectives supposedly describing a person. Luchins (1957), following up on Asch’s work, reinforced what Asch found concerning priming and the primacy effect connecting it to impression formation.

Arguably, much of the research on the topic of primacy and first impressions can be related to counseling. Brown (1970) reported that how counselors initially viewed the client and their relationship related to how the counselor viewed counseling outcomes. Kerr (1998) describes the primacy effect showing that when visual stimuli are presented one tends to remember more of the first items shown. Primacy effect is even stronger after long retention intervals and stronger than the recent effect (Kerr, 1998). Park’s (1986) study showed information that one first learned about a person would be recalled disproportionately compared to information learned later. These results suggest that information acquired first tends to be remembered better and resists modification even over a long period of time.

Do the counselor’s a priori cognitions related to client functioning at the time of the first encounter influence the counselor’s perception of the client? Previously stated research has shown us how important first impressions are in shaping a counselor’s view of a client and even how the counselor views success in the process. Rosenthal (1966) suggested that when one expects specific actions from another person he could act in a way that will increase the probability of the expected response. Harris and Rosenthal (1986) showed how different aspects counselor and client personality can lead to counselor’s expectancy effects.

While organizing impressions of clients is inevitable and important there are other factors to consider when examining ways in which counselors interact with clients. Besides passively organizing first impressions, counselors actively bring into each session beliefs, attitudes, and other cognitive structures that can influence the way in which they perceive clients. Rosenthal and Rubin (1978) conducted far-reaching research that consistently demonstrated how one’s beliefs and biases can affect research outcomes. Counselors are not immune from such influences. For example, Rosenthal and Berven (1999) found that counseling graduate students tended to negatively perceive African-American clients when it came to educational achievement and employment success compared to European-American clients. Rosenthal (2004) also found similar perceptions in professional counselors. African-American clients were perceived more negatively for educational potential and clinical symptoms compared to European-American clients. Racial stereotyping is an example of actively imposing cognitive constructs to form conclusions about others based on simplified and error prone beliefs and attitudes.

Closely related to primacy effect is cognitive priming. Fazio, Powell, and Herr (1983) showed how participants’ attitudes can be primed, or activated using a puzzle paradigm. This was explained by the authors as priming (activating) a certain category which increases its accessibility for a short time, which can be reflected by the participant’s view of an ambiguous stimulus (Fazio, Powell, & Herr, 1983). Cognitively, primes act like cues for memory or for attitudes and are thought to operate utilizing semantic memory processes (Tulving & Schacter, 1990).

In the past, mental health systems have encouraged a deficit based view of clients focusing on dysfunction and weaknesses instead of competencies and strengths (Cantor, 2003; Cowger, 1994; Ivey & Ivey, 1998; Magnusson & Mahoney, 2003). Seligman and Peterson (2003) asserted that counselors have performed under a disease model which fails to consider the importance of human competencies. Arguably,
there is more to a person than their worst problem or worst act. Therefore, to actively look for and organize one’s thoughts only on deficits is to miss a significant amount of data that could be utilized in facilitating change.

Recently, there has been what could be described as a paradigm shift toward strength based counseling and positive psychology (Seligman & Csikszentmihaly, 2000; Seligman & Peterson, 2003; Smith, 2006; Caprara & Cervone, 2003; Fernández-Ballesteros, 2003; Wong, 2006). Seligman and Csikszentmihaly (2000) appealed to psychologists to focus more on human strengths and challenged them to broaden their focus of research and practices. As an example of those that responded to Seligman’s call, Smith (2006) produced a strength based model for counseling at-risk youth and further indicated that not much has been done to systematize the strength based perspective into a theoretical orientation and test it empirically. The author also called on counselors to research the validity of several strength-based principals. A key principal is that people will be more inclined to change when practitioners focus on strengths rather than weaknesses and the quality of the therapeutic alliance will increase (Smith, 2006). Interestingly, while the paradigm shift may be new the content of strength-based counseling is not. Fernández-Ballesteros (2003) reported that many of the ideas that the new field of positive psychology focuses on have been around in some form for decades. Wong (2006) argued the notion that the emphasis on positives and strengths is not a new idea and that it has a long history in counseling psychology.

Research Questions

Taking a strength-based perceptive when approaching a new client would appear to provide for a more positive view of the client and better facilitate the counseling relationship as proposed by Smith (2006). The central question for the authors was whether or not a competency-based view of a new client leads to a significantly different perception of the client, her ability to change, and her prognosis by the research participant. Specifically, the current study was designed to examine whether a specific cognitive orientation in the context of a first encounter with another person can influence the perception of another. The authors attempted to prime the participants’ cognitions to attend to competencies, deficits, or neutral observations as they encountered a client for the first time through a video clip. The following hypotheses were examined.

1. Participants who were cognitively primed for competencies would have a more positive view towards client change/prognosis.
2. Participants cognitively primed for deficits would have a more negative view of client change/prognosis.
3. There would be no effect on the control group who were only asked make general observations, primed for neither competencies nor deficits.

Method

Participants

The research participants were comprised of 59 undergraduate students at a private Christian based university in Western North Carolina. Of the total participants 48 (81%) identified themselves as female and 11 (19%) as male. Twenty seven participants were in the undergraduate day program while 32 were students in the evening undergraduate program. Out of the 59 total participants 69.5% were Caucasian, 28.8% African-American, and 1.7% identified themselves as other. The mean participant age was 27.2 years. All of the participants were enrolled and tested in a psychology class. All received extra credit for their participation in the study.

Materials

A video clip (Nevid, 2006) was used as a stimulus in the experiment. The clip was 2 minutes
and 26 seconds long and was shown via a projector through a computer to each group of participants. In the video an African-American female with HIV and diagnosed with an adjustment disorder is speaking with the interviewer about her issues.

A survey form designed by the experimenters was given to assess the participant’s thoughts and feelings about different aspects concerning the client. The same form was given to each of the three groups. Besides demographic information the form contained three main questions each of which were scored on a Likert type scale. All three questions focused on the participant’s evaluation of the client’s potential for positive change. The first question was: “Realistically, how much change do you believe this client is capable of?” The second question that was used was “If this person received counseling, do you believe they will change for the better?” These two questions asked the participant to respond on a scale of 1 to 4, one being “None” or “No, not at all” and four being “Considerable” or for the latter question, “Yes, definitely.” The last question pertained to how the student viewed the prospects of the client getting better. It was answered on a scale of 1 to 7 with the choices ranging from “Extremely Poor” to “Extremely Good.” Higher scores on these three questions would indicate a more positive perception of the client’s potential to change and improve. Chronbach’s alpha coefficient for the three questions measuring perceived potential for change of the client was .83 indicating high internal consistency. Pearson Product Moment Correlations for the three items ranged from .68 to .71.

Procedure

Students were tested in their psychology class. An informed consent form was signed by each participant letting them know the responses would be kept anonymous and the right of each participant to withdraw at anytime. Students were randomly assigned to one of the three conditions. All of the participants were assigned to a group and each group was tested separately. The next phase consisted of all groups observing the same video clip. Following the video clip each group was asked to write down observations based on the instructions for that group. The first group (A) was asked to try to find at least seven competencies or strengths and record each before completing the attached form. The second group (B) was asked to search for at least seven deficits or weaknesses and list each of these before completing the attached form. The last group (C) recorded at least seven general observations of the video segment. After writing their observations participants then answered the same questions regarding client’s potential for change and prognosis. All participants were debriefed and told when and where results would be made available.

Results

The questionnaire data was analyzed for each experimental condition on each of the perception items. Table 1 provides the means and standard deviations for each question and also demonstrated for each perception item the competency group produced the largest means. Inspection of the standard deviations suggested homogeneous responses for all three questions. Casewise diagnostics and box plots revealed that all scores were within three standard deviations from the mean for each dependent variable. Therefore, no significant outliers were found in the data.

In order to determine whether or not there was a significant difference between the three conditions across the three dependent measures a multivariate analysis of variance (MANOVA) was performed. Due to unequal cell sizes the more conservative Pillai’s Trace MANOVA statistic was used for the omnibus test (Fields, 2000). For the overall model there was a significant difference between the groups and across the dependent measures, $F (6,110)=2.43$, $p<.04$. Further analysis testing the between-subjects effects utilizing ANOVA tests for each of the dependent variables revealed the following re-
TABLE 1

Means and Standard Deviations of Experimental Conditions by Item

Item 1: Realistically, how much change do you believe the client is capable of?

<table>
<thead>
<tr>
<th>Experimental Condition</th>
<th>Mean</th>
<th>SD</th>
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<tr>
<td>Competency (A)</td>
<td>3.26</td>
<td>0.75</td>
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<tr>
<td>Deficit (B)</td>
<td>2.75</td>
<td>0.74</td>
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<tr>
<td>Control (C)</td>
<td>3.25</td>
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<tr>
<td>Total</td>
<td>3.05</td>
<td>0.80</td>
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Item 2: If they receive counseling, do you believe the person would change for the better?

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<th>Mean</th>
<th>SD</th>
</tr>
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<tbody>
<tr>
<td>Competency (A)</td>
<td>3.43</td>
<td>0.66</td>
</tr>
<tr>
<td>Deficit (B)</td>
<td>2.96</td>
<td>0.96</td>
</tr>
<tr>
<td>Control (C)</td>
<td>3.00</td>
<td>0.85</td>
</tr>
<tr>
<td>Total</td>
<td>3.15</td>
<td>0.85</td>
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Item 3: What is the prospects of the client getting better?

<table>
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<th>Experimental Condition</th>
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</thead>
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<tr>
<td>Competency (A)</td>
<td>5.30</td>
<td>1.30</td>
</tr>
<tr>
<td>Deficit (B)</td>
<td>4.21</td>
<td>1.44</td>
</tr>
<tr>
<td>Control (C)</td>
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<td>1.29</td>
</tr>
<tr>
<td>Total</td>
<td>4.85</td>
<td>1.44</td>
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Results: Item 1 (Realistically, how much change do you believe this client is capable of?) approached but did not attain significance F (2, 56) = 3.09, p=.053). Item 2 (If this person received counseling, do you believe they will change for the better?) was non-significant. Item 3 (The prospects of the client getting better) was significant, F (2, 56) = 4.5, p<.02 (See Table 2).

Post-hoc analysis was performed to isolate which groups were significantly different on item 3. Due to unequal cell sizes the more conservative Hochberg’s GT2 statistic was utilized (Field, 2000). Post hoc results revealed a significant difference between competency group and the deficit group (p<.03). The competency group perceived greater potential for positive change in the client than the deficit group. There was no difference between the competency and control group.

Discussion

There were three hypotheses in this study which included; 1) Participants who were primed for competencies would have a more positive view towards client change/prognosis; 2) Participants primed for deficits would have a more negative view of client change/prognosis and 3) There would be no effect on the control group who were primed for neither competencies nor deficits. The results indicated that there was a difference between the deficit and competency group in the direction hypothesized for the third question. There was partial support for hypothesis one and two, but only for perceived potential for positive change. Figure 1 displays a visual representation of the means for the third
TABLE 2

<table>
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<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
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<tr>
<td>Between Groups</td>
<td>16.55</td>
<td>2</td>
<td>8.28</td>
<td>4.50</td>
<td>.015</td>
</tr>
<tr>
<td>Within Groups</td>
<td>103.08</td>
<td>56</td>
<td>1.84</td>
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</tr>
<tr>
<td>Total</td>
<td>119.63</td>
<td>58</td>
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hypothesis. As previously mentioned, hypothesis 1 approached but failed to attain significance in the hypothesized direction. The results showed the priming of the participant to look for competencies or deficits did lead to a significant difference in prognosis. When it comes to prognosis there was no difference between the control group and either competency or deficit group. Apparently, a person’s perception of a client’s potential for change can be affected by a priori priming. The present results would suggest that the ideas that we use to organize our work as counselors do affect how we see our clients. It may be reasonable to assume that one’s prognosis can influence what interventions if any one may use with a client. It is also reasonable to assume that one’s prognosis of a client could impact the therapeutic relationship. If a counselor does not believe that a client is going to improve or has less potential to improve then that could affect the nature of the therapeutic alliance.

The results supported previous research on priming and the primacy effect (Kerr, 1998; Park, 1986). It appears the information presented first to each group affected the participants’ attitudes when viewing the client. Eagly and Chaiken (1993) describe priming as activating a certain category which increases the possibility the attitude will be used in later opinions. The participants in this study were asked to list competencies or deficits, except for the control group, which activated this category. Therefore when they viewed the stimulus the chance they would use the attitude which was primed in making a judgment was increased. This finding supports what Asch (1946) and Luchins (1957) described in reference to the primacy effect. This study also found the participants answered questions in the direction of the information each group was first provided.

In addition this inquiry discovered that searching for a client’s strengths when viewing the client for the first time led to a more positive perception of the client’s prognosis from the beginning. Wong (2006) describes the process of identifying the strengths of a client as the first phase of the strength-centered model he proposes. He calls this the "explicitizing phase" and suggests strategies to help the counselor do this including examples (p. 139). The partici-

![Figure 1](image-url)
pants of the current study were asked to make highlight and make explicit client strengths thereby creating differences in prognostic perception. Similarly, the present results would appear to be congruent with Brown (1970). As stated earlier, Brown (1970) in a study of experienced and inexperienced counselors, found a highly significant correlation between viewing the client positively, from a personal viewpoint, and the potential for a client to change. These counselors were also more pleased with the improvement of these same clients (Brown, 1970). Therefore having a competency based view of a new client could potentially prime the counselor to focus more on strengths, which would in turn make the counselor have a more positive perception of the client.

Several limitations should be noted that are relevant to the present research. The study should be seen as a preliminary research because the participants were not counseling students or professionals, but undergraduate students. More research will need to be conducted utilizing graduate students and counseling professionals to examine to see if the results hold for other groups. Furthermore the severity of client symptoms, along with the race and the gender of client (Rosenthal, Wong, Blalock, & Delambo, 2004), may also moderate the influence of a priori cognitions on clinical judgments. Examination of perceptions and evaluative judgments to a hypothetical situation and not actual perceptions and behaviors to an actual counseling context is another limitation of the study. Nevertheless, it is speculated that these results fit an already growing body of data that requires a rethinking of traditional mental health models.

The current study would seem to support the position of some researchers that are critical of traditional models for treating client symptoms. Seligman and Peterson’s (2003) suggest that the search for empirically validated therapies (EVT’s) and the brief treatment periods mandated by managed care organizations have hurt the counseling field by depriving the client of the most important defense, a focus on strengths. These authors tell us that by neglecting to look for strengths and competencies in order to focus on what is weak, a counselor misses a universe of truths about the client. The disease model is a limited view and problematic for today’s clinical practice. Ivey and Ivey (1998) propose reframing how practitioners view the Diagnostic and Statistical Manual of Mental Disorders (DSM). These authors suggest that one rise above the traditional pathology model by also focusing on a positive developmental model. Positive developmental models do not necessarily conflict with the pathological view but supplement it.

Researchers from other disciplines have recognized the value of competency-based therapeutic models. Social work practitioners pioneered much of the early territory for a strength based counseling model. For example, Weick, Rapp, Sullivan, and Kisthardt (1989) assert that social work has focused less on pathology and more from a strength perspective that provides a different context through which to practice social work. Cowger (1994) stressed the sociopolitical nature of social work and discusses how a strength based perspective can mitigate the unequal power balance and open up new possibility for client change. Smith (2006) states that focusing on strengths of a client can create a more secure relationship with the awareness that the client will not be judged negatively and will be respected.

Strength-based counseling and positive psychology is a rapidly growing movement within many elements of the psychological community. One can see through a review of the literature, there is a significant effort by many to create a competency or strength-based approach as opposed to a deficit-based counseling (Cowger, 1994; Cantor, 2003; Magnusson & Mahoney, 2003; Seligman & Csikszentmihaly, 2000; Seligman & Peterson, 2003). Smith (2006) reiterates how significant a strength-based approach is for counseling psychology because it appears to be a colossal paradigm shift that moves from the medical model which focuses on pathology to the developing model which highlights compe-
The current study is intended to add to the counseling literature supporting a strength or competency-based approach towards counseling. However, more research in this area is needed. Smith (2006) provides twelve propositions as an outline of strength-based counseling and calls upon counseling psychologist to perform empirical studies to investigate the validity of these principals. These principles offer a heuristic structure for future research since the body of empirical evidence on this topic is small and inadequate.

The results of the present study indicate that a strength-based view when one is forming an initial impression of a client can lead to a more optimistic outlook towards the client’s prognosis as opposed to a deficit-based view. Research has shown that a more optimistic perception of a client at the time of the first encounter is related to a more positive view of the outcome of counseling (Brown, 1970). However, this only represents a small finding considering the amount of research that is still needed in the area of counseling from a strength-based perspective.

References


From “Homophobia” to “Homoemasculation:”
A Primer for Counselors on Sexual Language Discourse

Shannon D. Smith, Shannon B. Dermer, Kok Mun Ng, and Korenna K. Barto

The focus of this article is to familiarize the reader with terminology used to identify and label forms of sexual prejudice, discrimination, and oppression. The pros and cons of both historically used language as well as newer terminology will be discussed. Terms of discussion include homophobia, internalized homophobia, homonegativity, heterosexism, sexual prejudice, sexual stigma, sexual orientation victimization, minority stress, and a recently coined term homoemasculation. Having a clear understanding of such language will help describe, assess, and understand the issues related to being part of a sexual minority group, and potentially aid in the advocacy efforts at individual and larger systemic levels, guide research, and advance scientific study and intervention of this population.

Scientific inquiry is often hindered by limitations of the researcher (e.g., knowledge, theory, understanding) as well as the tools at one’s disposal such as the research design (experimental vs. quasi experimental) or even the type of inquiry (quantitative vs. qualitative). Understanding unique and complex phenomena (e.g., interaction effects) is another potential limitation, particularly when there is insufficient language to describe, categorize, or otherwise allow for scientific inquiry and investigation. This has indeed been the case with regard to studying the role of sexual bias, prejudice, discrimination, and the interaction of multiple forms of oppression toward sexual and gender minority groups including lesbian, gay, bisexual, transgendered, and questioning individuals (LGBT-Q). In particular, until recently there has been insufficient language available to the scientific community to capture the unique, albeit oppressive social and psychological features experienced by the non-heterosexual community.

The advent of specific language, such as the term “homophobia” (Weinberg, 1972), to encapsulate society’s prejudice against sexual minorities opened the door to seeing prejudicial and stereotypical views of society as the stigma to be remedied rather than conceptualizing homosexuality as individual pathology. Correctly labeling and naming sexual prejudice allows it to become a societal issue capable of scientific study and intervention (Herek, 2004). The act of naming also gives activists, advocates, and allies the ability to externalize and battle against negative attitudes that may, at first glance, seem nebulous, but result in very real, systematic oppression that begins early in life (Smith, 2004).
A major component of being sensitive and culturally responsive to working with gay and lesbian clients is the ability to be aware of, identify, and correctly name the multifaceted faces of prejudice, discrimination, and oppression. Having specific enough language to describe, assess, and understand the issues related to being part of a sexual minority is important for therapeutic intervention at individual and larger systemic levels, as well as for guiding research and for dissemination of research and ideas.

Counselors should have a precise and accurate vocabulary in order to be able to name and externalize both covert and overt expressions of sexual intolerance and prejudice in addition to having knowledge about sexual development and the coming-out process. It is important for counselors to be capable of identifying and understanding prejudice, discrimination, and oppression in order to help intervene with clients and advocate for sexual minorities within the counseling profession, social institutions (e.g., education), and the broader realm of society (Smith & Chen-Hayes, 2003). This imperative and rationale is certainly in line with the theoretical underpinnings of the Multicultural Competencies and Standards (Sue, Arrendondo, & McDavis, 1992), the Competencies for Counseling Lesbian, Gay, Bisexual and Transgendered (GLBT) Clients (ALGBTIC, n.d.), and the counseling Advocacy Competencies (Lewis, Arnold, House, & Toporek, n.d.). In this article several concepts frequently used to identify and label sexual prejudice, discrimination, and oppression are discussed with the hope that counseling professionals will gain a clearer understanding of their nuances and usage.

**Homophobia**

The first popularized term used to externalize discrimination toward gay men and lesbians was homophobia (Weingberg, 1972). The definition included the dread of being in close quarters with gay men and lesbian women, and an irrational fear, hatred, and intolerance by heterosexuals. This construct echoed ideas such as Churchill’s (1967) concept of “homoerotophobia” describing the fear embedded in society of erotic or sexual contact with members of the same sex. Churchill's view of homoerotophobia focused on the societal/cultural prohibitions against homoeroticism, while Weinberg utilized the term “homophobia” to refer to individual discomfort and fear of homosexuality.

The construct of homophobia was created in the midst of strong political uprisings during the 1960s and 1970s against the medicalization and pathologizing of homosexuality. The medicalization of homosexuality began during the 18th century when human sexuality was seen as a medical concern and medical concepts were used to buttress religious values (Morin, 1977). The major view that the medical and psychiatric fields offered of homosexuality was as an illness. The medicalization of homosexuality necessitated professionals to endeavor to “cure” people of homosexuality through psychological, medical, and/or spiritual means (Wilkerson, 1994). Rather than being free of ideological influence, the medical field constructed knowledge in a way that transmitted and legitimized political and religious values often at the expense of oppressed groups (Morin, 1977; O’Donohue & Caselles, 1993; Szaz, 1970; Wilkerson, 1994). The idea of homophobia helped turn the pathologizing focus from gay men and lesbian women to those who had negative attitudes and reactions toward homosexuality (Hudson & Ricketts, 1980; O’Donohue & Caselles, 1993).

Although the word homophobia called into question the oppressive effect of medical, religious, and political discourses about homosexuality, the term itself was critiqued in later years for certain limitations (Herek, 1998, 2000, 2004; Hudson & Ricketts, 1980, Lehne, 1976; Morin & Garfinkle, 1978; O’Donohue & Caselles, 1993; Shields & Harriman, 1984). Many conceptual frameworks for the term homophobia have been proposed (Hudson & Ricketts, 1980, Lehne, 1976; Levit & Klassen, 1974; Morin & Garfinkle, 1978), but over time the viability of
utilizing one concept to explain the complex phenomenon of attitudes toward homosexuality has been questioned due to limitations and restrictions of adequate meaning.

Homophobia became a global term used to describe any pejorative attitude and behavior at all ecological levels. It was used to describe personal (individual) and cultural homophobia that included all negative myths, negative language, and any belief system that did not equally value homosexuality and heterosexuality (Morin & Garfinkle, 1978). As well as creating conceptual and definitional problems, having one construct to conceptualize values, attitudes, and behaviors related to perceptions of homosexuality threatens the psychometric adequacy of instruments purported to measure homophobia (c.f., O’Donohue & Caselles, 1993).

In addition, the meaning of the root word “phobia” was questioned. Most antigay prejudice does not rise to the level of a true phobia. The central emotion involved in phobias is typically fear, whereas the central emotion in most prejudice is anger (Herek, 2004; Shields & Harriman, 1984). Negative attitudes toward homosexuality do not necessarily equate with phobic-like fear and aversion (Fyfe, 1983; Herek, 1984, 1988; Hudson & Rickets, 1980; MacDonald, 1976; Robinson, Gaither, & Heinert, 2006). In fact, O’Donohue and Caselles (1993) argue that the incorrect labeling of all people who disagree with homosexuality as “phobic” is, ironically, as ambiguous and pejorative as some of the language gay activists seek to eradicate.

Homophobia was originally created to highlight negative affect of individuals. Although words like cultural or societal homophobia have been added to the lexicon, homophobia is a term that tends to highlight individual, micro-level prejudices rather than focusing on prejudice, discrimination, and oppression at the macro-level. Homophobia started as a term to refer to the extreme reaction of an individual, but has expanded over time to include any negative psychological and social reactions to various sexualities (Blumenfeld, 1992; Haaga, 1991; Fyfe, 1983; Lingiardi, Flanga, & D’Augelli, 2005; Stein, 2004). Rather than conceptualizing negative attitudes toward sexual minorities as an individual phenomenon, they are currently viewed as influenced by social, political, and interpersonal factors (Blumenfeld, 1992; Stein, 2004). Societal prejudice is identified as the root of homophobia (Hegarty & Massey, 2007), and yet the word homophobia connotes an individual origin. If homophobia is conceptualized as a type of fear, discomfort, or anxiety then it conveys the notion that something is merely wrong with an individual rather than the person being a conduit for societal prejudice. Societal (cultural) homophobia shapes individuals’ attitudes (Fyfe, 1983; Hegarty & Massey, 2007; Morin & Garfinkle, 1978).

Has the meaning of homophobia been stretched too far when it is used to explicate attitudes, behaviors, and values at the micro-, meso-, and macro-level? While the term homophobia has been powerful in influencing people and calling them to action, we believe that this single term is not precise enough at this current point in time to encapsulate the multifaceted attitudes toward homosexuality and the etiology of those views (O’Donohue & Caselles, 1993; Herek, 2004; Szaz, 1970). The following statement illuminates this point:

Interest in homophobia seems to emanate from a broader interest in general reactions to homosexuals and homosexuality. Thus, an increase in conceptual clarity would be gained by clearly delineating the domain of reactions to homosexuals and homosexuality, how elements of this domain may constitute higher-order constructs, and the interrelationships between subsets of this domain (O’Donohue & Caselles, 1993, p. 192).

Indeed the scientific community will be forever indebted to Weingberg’s (1972) construction of the term homophobia; the term has served a distinct purpose as noted above, and reflects perhaps the first major developmental stage of social and scientific understanding of prejudice.
toward homosexuals and homosexuality in general. However, at this juncture in time new language (terminology) is required to further define the nuances and idiosyncrasies of the various types of bias, prejudice, stigma, and multiple forms of oppression directed toward sexual minorities. Below we review and discuss various terms that have appeared in the literature recently that tend to further our understanding of the sexual minority experience.

**Internalized Homophobia**

Although homophobia was previously described as a process external to sexual minorities it simultaneously reflects an internal manifestation of a similar psychological process within the individual and collective group. Weinberg (1972) hypothesized that the same irrational fear and hatred that can be felt by heterosexuals can also be internalized by homosexuals, resulting in a type of self-hatred. Simply put, internalized homophobia is negative feelings about one’s own sexual minority status resulting from stigmatization. It involves negative self-attribution about one’s sexual orientation based on societal values that heterosexuality and opposite-sex relationships are more healthy, intimate, committed, and “normal” than other types of sexual orientations or relationships. Overall, internal homophobia entails accepting the dominant society’s prejudice against sexual minorities and turning those values and attitudes inward. Internalizing societal attitudes and beliefs may manifest itself within sexual minorities as a threat to self-acceptance or even as self-hate. Those who have not disclosed their sexual minority status are more likely to experience internalized homophobia (Herek, 2004). However, even those who are ostensibly gay-affirmative and self-accepting may have lingering societal messages of inferiority. The term covert internalized homophobia has been used to label the enduring effects of internalized homophobia in those who have struggled against societal stereotypes (Gonsiorek, 1988; Meyer & Dean, 1998).

Again, the term homophobia may not be technically correct in that phobia connotes fear of self rather than highlighting the feelings of shame, guilt or anger. Others differentiate between homonegativity and homophobia. Homonegativity is seen as multidimensional construct that includes anti-gay attitudes, beliefs, and judgments (Bell, 1991; Herek, 2004) and could be used concomitantly to denote external and internal components of societal attitudes. The terms “internalized homonegativity” and “covert internalized homonegativity” are more accurate descriptions of this process than “homophobia.” However, the term homophobia is so ingrained in the literature and society that it may make such a transition difficult.

**Sexual Orientation Victimization**

Internalized homonegativity may contribute to developmental opportunity loss, self-doubt, constriction of affect, social vigilance, turning away of social opportunities, and inauthentic heterosexual role-playing/relationships, resulting in the notion of sexual orientation victimization (c.f., D’Augelli, 1998; D’Augelli, Pilkington, & Hershberger, 2002; Hershberger, & D’Augelli, 1995). Typically, as children and adolescents develop they become aware of sexual attraction and experiment with this attraction through various forms of dating behavior. Due to internalized homonegativity, youth and young adults who have same-sex attractions may shy away from dating opportunities or engage in opposite-sex dating in order to fit in with societal expectations (Smith, Dermer, & Astromovich, 2005). In addition, GLBT-Q individuals may restrict their expression of affect and hyper vigilantly monitor their own behaviors so as not to transgress gender or sexual norms (i.e., heterosexual biased norms). Social vigilance involves monitoring one’s own behavior (based on the apparent perceptions of others) to make sure one conforms to gender and sexual orientation norms, that is heterosexual norms. Sexual minorities often develop acuity at assessing others’ awareness of one’s sexual orientation. These
types of victimization directly related to sexual orientation are perhaps best conceived as forms of sexual orientation victimization, and not conceived of as simply responses to homophobia. This type of characterization is also in line with state (e.g., police) and government (e.g., federal agencies) reporting agencies on crime and victimization due to sexual orientation such as is found in the Uniform Crimes Report (UCR). For example, in the 2000 annual UCR published by The Federal Bureau of Investigation (FBI, 2000), a hate crime is defined in the following manner: “A hate crime, also known as a bias crime, is a criminal offense committed against a person, property, or society which is motivated, in whole or in part, by the offender’s bias against a race, religion, disability, sexual orientation, or ethnicity/national origin” (pg. 59). Of the 8,152 hate crime incidents reported to the FBI in 2000, 16.0% were motivated by sexual-orientation bias (FBI, 2000).

D’Augelli (1998) believes these restricted or inauthentic experiences are all forms of sexual orientation victimization (SOV). SOV results in both the internal effects of not feeling comfortable in “one’s own skin” and the inability to forthrightly express sexual attraction and affection without fear of stigmatization or retribution. There appear to be four manifestations of victimization: developmental opportunity loss, self-doubt induced by cultural heterosexism, institutional victimization, and direct attacks by those who know, suspect or assume the victim is a sexual minority. Direct attacks may take the form of verbal abuse (e.g., threats, harassment), physical attacks (e.g., chased, kicked, hit, beaten, murder), property attacks (e.g., vandalism, arson), rape, sexual assault, or incest as a result of revealed or suspected membership as a sexual minority. These direct attacks may emanate from family members, friends, peers, or strangers. Institutional victimization ranges from an invisibility in societal institutions (e.g., school, legal, governmental, religious) to an outright criminalization of homoerotic behaviors. Sexual orientation victimization ranges from seemingly innocuous jokes, to hostile verbal comments, to physical/sexual attacks. This results in a normative victimization that posits heterosexuality as normal and attraction to members of the same sex (homoeroticism) as abnormal and deviant. Normative victimization has also been referred to as heterosexism.

Heterosexism

The term heterosexism was created as a parallel to language that externalized other “isms” such as racism and sexism and describes a belief system that posits the superiority of heterosexuality over homosexuality (Morin, 1977; Alden & Parker, 2005). Heterosexism denotes the idea that the “natural” sex orientation is and must be heterosexual (c.f., Alden & Parker, 2005). Whereas homophobia has been defined as an individual’s negative, fearful emotional response to homosexuality, heterosexism has been defined in ecological terms. That is, as a systematic process of privilege toward heterosexuality relative to homosexuality, based upon the notion that heterosexuality is normal and ideal (Palma & Stanley, 2002; Pharr, 1998). The insidious nature of heterosexism in our cultural institutions means it is all around, while simultaneously rendered invisible. The group that holds a privileged status in a particular society goes unquestioned, unnoticed, and is the assumed group membership for all individuals unless there is evidence to the contrary (Smith, 2004).

Heterosexism is also referred to as cultural heterosexuality due to the presumption that individuals are heterosexual unless there is evidence to the contrary. The intended or unintended result of viewing heterosexuality as the social, cultural, and behavioral norm (as opposed to merely the statistical norm) is that this stance implies that all other sexual orientations and related practices are abnormal or deviant (Braun, 2000). The implication of heterosexism is that non-heterosexuality automatically becomes open to question and subsequently the object of various forms of prejudice and discrimination. Violence toward GLB people
could be seen as an exaggeration of heterosexism embedded in the dominant society (cultural heterosexism) (Alden & Parker, 2005).

While homophobia refers to individual beliefs and behaviors emanating from personal ideology, heterosexism refers to the cultural ideology that maintains societal prejudice against sexual minorities (Herek, 2004). The term heteronormativity has also been suggested to represent a similar idea. This term was initially coined by literary critic and social theorist Michael Warner (1991) to signify sexual minorities marginalized, ignored or persecuted by social practices, beliefs or policies. It has been used to define the normalization process of heterosexual practices and lifestyles as fundamental and “natural” within society, and to juxtapose non-heterosexuals as deviant, aberrant, and non-natural. It underscores the presupposition in society that heterosexism is the normal or right way (i.e., predisposed or predetermined sex orientation) of being, and anything non-heterosexual is abnormal, and therefore, morally wrong and non-natural. The advantage of utilizing concepts such as heterosexism and heteronormativity, as opposed to homophobia, is that they acknowledge the collusion in anti-gay attitudes at all societal levels. These terms underscore the exclusion or invisibility of sexual minorities; the disadvantage is they fail to reflect adequately the vehemence of overtly intolerant attitudes and behaviors.

Sexual Prejudice

Herek (2004) has suggested that the term sexual prejudice be used to represent negative attitudes based on sexual orientation. It is similar to Reiter’s (1991) term “homosexual prejudice,” except that sexual prejudice is a more inclusive term. Herek posits that using the term sexual prejudice will enhance study of anti-gay attitudes because it does not fall prey to some of the disadvantages of using the term homophobia, and links hostility based on sexual orientation to research on other forms of prejudice. Prejudice can be defined as an attitude based on judgment or evaluation directed at a specific social group and/or its members, and involving negativity, hostility, and/or dislike. Furthermore, the term sexual prejudice does not involve the implied irrationality or fear encompassed in “homophobia.”

Herek (2004) posits that sexual prejudice should replace the use of the terms homophobia and heterosexism. He asserts that homophobia is “best understood as an irrational fear and that...[it]... represent[s] a form of individual psychopathology rather than a socially reinforced prejudice” (p.19). While heterosexism, versus homophobia, refocuses our attention at the societal level, its intense focus on the macro-level does not satisfactorily include individual attitudes. Unlike the previously discussed terms, sexual prejudice is able to integrate macro-, meso-, and micro-level attitudes.

“Sexual prejudice” compensates for some of the shortcomings previous attempts to conceptualize this issue fell prey to. Nevertheless, it is not an all-encompassing term. Herek (2004) points out that prejudice only refers to anti-gay attitudes or homonegative attitudes, but not necessarily the effects of prejudice.

Sexual Stigma

Stigma is the societal shame associated with a person based on an identity or characteristic that the dominant group devalues or finds unacceptable. Herek (2004) suggests that “Sexual stigma refers to the shared knowledge of society’s negative regard for any nonheterosexual behavior, identity, relationship, or community” (p. 15). He further purports that once a group is stigmatized, the stigmatized portion of a person’s identity “trumps all other traits and qualities ... others respond to the individual mainly in terms of it” (p. 15). Stigma is seen as something within a person rather than a socially constructed label that others affix to that person or group (Link, 2000).

Sexual stigma devalues non-heterosexuals and may lead to hostility (from either the dominant or marginalized group), restricted identity, exclusion, discrimination, and less access to
power and resources (Herek, 2004). In addition, when brought up in a society that stigmatizes membership in a particular group, the shame, rejection, and associated group stereotypes may be internalized by the minority. Sexual stigma is perpetuated through heterosexism: the rejection of lesbian, gay, bisexual, transgendered, and queer (LGBTQ) people, same-sex relationships, and the LGBTQ community. Sexual minorities adopting these negative, dominant beliefs have been labeled “internalized homophobia.”

**Minority Stress**

Coping with the constant bombardment of negative attitudes from society can be overwhelming and draining. Minority stress stems from the prejudice, discrimination, and oppression associated with being a marginalized group in society (DiPlacido, 1998; Meyer, 1995; Meyer, 2003). Such stress may emanate from both external and internal sources. Sexual minority stress is the type of stress experienced due to being a non-heterosexual.

The antidote to internalized homonegativity and sexual minority stress is not a realignment or alteration of sexual orientation toward the dominant society’s view of normal sexuality, rather the antidote lies in advocating for cultural change while assisting clients toward a resocialization that leads to self-acceptance. Meyer and Dean (1998) argue that sexual minorities must shake off the ill-effects of a “heterosexist opportunity structure: norms and institutions that promote opposite-sex relationships and devalue and discourage same-sex intimate relationships” (p. 165). Individuals must create space in their hearts and minds for a new structure that defines sexual minorities as normal, valued, and accepted. Only in creating and integrating such a structure can sexual prejudice be adequately critiqued from an empowered position (Meyer & Dean, 1998), counselors must adopt such a structure as means toward social advocacy and justice, and as a way to fight against the deleterious effects on LGBTQ individuals, same-sex relationships, and the family members/organizations that love and support them (Smith & Chen-Hayes, 2003). Contesting the insidious effects of sexual prejudice without adopting a new value-structure opens the door to covert internalized homonegativity.

**Homoemasculation**

One final term for inclusion in this discussion; as coined by the first author; is *homoemasculation*. The term emasculate means to castrate (to deprive of virility or procreative power) or deprive of strength or vigor (to weaken) according to the Mirriam-Webster dictionary (Mish, F. C., et al., 2003). Popular usage of the term connotes de-masculination or stripping of one’s masculinity as to humiliate. The first author defines *homoemasculation* as the systematic (social and psychological) process of castrating (denying and stripping) non-heterosexuals of certain basic rights, privileges, and benefits offered in society while simultaneously affording such to heterosexuals. The social castration includes limiting or preventing non-heterosexuals from receiving or obtaining distinct benefits typically afforded to heterosexuals in society such as marriage, child adoption, health care, legal terms and rights, survivor rights and benefits, access, etc. The end result is that non-heterosexuals are deprived of social rights and privileges (i.e., a weakened state), and left feeling vulnerable and humiliated. In this vulnerable state of humiliation, they are susceptible to host of oppressive antics, particularly the internalization of *homoemasculation*. Internalized *homoemasculation* occurs when non-heterosexuals adopt such notions that certain rights and benefits do not belong to themselves, and view them as the right and benefit of the heterosexual; this is a form self-castration. In the larger social context, *homoemasculation* is the process whereby anything non-heterosexual is emasculated for the primary benefit of heterosexuals, and for the sole purpose of maintaining heterosexist dominance (i.e., power and privilege) in society. Although the term *emasculations* was historically associated with men only (gender specific), in forming this
new term, *Homoemasculation*, the application to women is appropriate because the type of emasculation it is defining includes both genders as reflected the various forms noted above (gender non-specific).

*Homoemasculation* is a useful term for helping non-heterosexuals recognize their social deprivation of rights and benefits as compared to their heterosexual counterparts, as well as increasing understanding and providing the ability to empirically measure the systematic processes involved in this social emasculation – particularly when examining the interaction effect of various heterosexist dominated institutions such as politics, religion, education, law, business, and so forth. It may be, for example, George W. Bush’s religious right to believe in the sanctity of marriage as a “holy” union, however, the constant veto of gay marriage as civil or some other type of union results in maintaining the *homoemasculation* of non-heterosexuals right and privilege to being united in marriage – which should be a basic civil right to all people regardless of race, religion, creed, sex orientation, etc.

**Conclusion**

Counseling professionals are urged to respond to the need for intervention at the social level to reduce antigay attitudes and prejudice and at the individual and relational level to help GLBT-Q clients develop healthy sexual identities (Meyer & Dean, 1998; Smith & Chen-Hayes, 2003). Having the proper language to describe, understand, and research sexual oppression and prejudice is one step in helping practitioners, researchers, the GLBT-Q community and society-at-large create an opportunity structure that not only accepts, but normalizes same-sex attraction and relationships.

We have reviewed and critiqued within this article nine concepts relating to prejudice, discrimination, and oppression based on a non-heterosexual orientation. Understanding terminology and its fit for describing the experience and effects of being a marginalized group is important in order to be able to: (a) be more accurate in the use of terminology in literature, (b) be more clearly describe, understand, and empathize with the experience of clients who are members of a sexual minority, (c) do a more accurate assessment of the effects of prejudice, discrimination, and oppression with individual clients and with sexual minorities as a group, and (d) clarify issues so that their effects can be more readily researched. Overall, there is still a need for researchers and theorists to: (a) further clarify terminologies, concepts, and constructs that are still murky, and (b) develop linguistic vehicles that accurately capture intrapsychic and social phenomena related to sexual prejudice, discrimination, and oppression.

**References**


Working with Spanish-Speaking Clients: 
Interpreter Use or Bilingual Counselors

Clarrice Rapisarda

The growing Spanish-speaking population’s mental health needs are undertreated, partly due to the language barrier (Guzman, 2001; National Institute of Mental Health, 1999; Ramirez & Smith, 2007). This presents challenges for counselors in forming the client-counselor relationship and in accurately assessing, diagnosing, and counseling clients. Two solutions to meet this challenge, the counselor’s use of an interpreter, and the use of a bilingual counselor, are explored. Important considerations for counseling clients when a language barrier is present are discussed.

The growing Spanish-speaking population's mental health needs are undertreated, partly due to the language barrier (Guzman, 2001; National Institute of Mental Health, 1999; Ramirez & Smith, 2007). This presents challenges for counselors in forming the client-counselor relationship and in accurately assessing, diagnosing, and counseling clients. Two solutions to meet this challenge, the counselor’s use of an interpreter, and the use of a bilingual counselor, are explored. Important considerations for counseling clients when a language barrier is present are discussed.

Because of the potential for misinterpretation of the emotional communication from the client, Altarriba and Bauer (1998) recommended counselors restructure the initial evaluation by first asking clients about their worldviews. With Hispanic clients, this approach would encompass the main areas of time, nature, activity, and social relations. The counselor can begin to assess the level of acculturation of the client with this information. Rivera and Altarriba (2002) cautioned counselors to use care when assessing the nonverbal communication of clients. What might appear as psychopathology may be originating from cultural differences.

Marcos (1976) recommended that counsel-
ors be aware that the language barrier can significantly distort the perceptions of counselors as they work to diagnose their clients during the assessment phase. Diagnostic criteria might not be an appropriate match with the cultural background of the client and communication difficulties may complicate an accurate assessment process (Cofresi & Gorman, 2004; Hunt & de Voogd, 2007; Karliner, Perez-Stable, & Gildenborin, 2004). Marcos (1976) found that a group of Hispanic schizophrenic patients showed more pathology when interviewed in their secondary language of English instead of their primary language of Spanish. Brown, Kim, and Barrio (2003) found similar results related to the diagnosis of depression in non-English speaking clients. Brown et al. described depression as occurring in a broader context for Hispanic clients. In addition to traditional depressive symptoms Brown et al. said depression was culturally defined and related to the cultural identity of the client. They urged counselors to view depression in the context of family relationships and gender role of the Hispanic client, in addition to considering traditional symptoms of depression. Brown et al. argued that a diagnosis would not be accurate until after this was done.

The counselor must consider how best to meet the needs of clients whose primary language is not English in the assessment and counseling process. Chung and Bemak (2002) suggested the counselor utilize cultural empathy during this process and throughout the providing of counseling services for the clients. They believed basic empathy skills learned in the Western culture might not be enough when dealing with clients from different cultures. Chung and Bemak further recommended adding the view of the client in relation to their family and community as well as incorporating the client’s values into what the counselor calls empathic skills. With cultural empathy, the counselor can explore how best to cross the language barriers. Two options for navigating these barriers that will be explored include the use of an interpreter during the assessment and counseling process and the use of the counselor who is bilingual.

### Use of an Interpreter

When the counselor is not able to speak the native language of a client and the client does not speak English or is not comfortable attempting to speak English, an interpreter can be utilized. Benefits and barriers to the use of an interpreter in counseling sessions are examined.

#### Benefits to the Use of an Interpreter

The use of an interpreter in a counseling session immediately helps the client to see that the counselor is aware of potential issues and is working to create a safe counseling environment (Rosenberg, Seller, & Leanza, 2008). Lopez (2000) reported that the use of an interpreter offers clients a choice in which language they communicate. The interpreter facilitates this communication by accurately relaying information between the client and counselor; additionally, the interpreter may negotiate appropriate cultural communication (Rosenberg et al., 2008). The counselor will need different strategies during a counseling session to successfully navigate these levels of communication with the interpreter and the client.

Before the initial assessment, the counselor first has the task of finding an appropriate interpreter. Bourquin (1996) suggested only using interpreters who were certified or who had at least gone through training of how to be an interpreter. He cautioned that knowledge of another language did not mean proficiency with interpretation. By selecting a trained interpreter, the counselor would have more confidence that errors in meaning during the interpretation process would be reduced. Research has shown that clients will often rely on a family member to provide interpretation (Bischoff & Loutan, 2004; Gerrish, Chau, Sobowale, & Birks, 2004) if a trained interpreter is not present. This may be concerning because of the risk for the family member to introduce bias into the interpretation process (Lee, Sullivan, & Lansbury, 2006);
however with the use of a trained interpreter, the family member is relieved from this responsibility. Lopez (2000) added that an interpreter could also help circumvent potential problems during the course of the session. It is recommended that one meet with the interpreter prior to the initial assessment to discuss confidentiality, the process and how it will function with the interpreter as a third party, and any content specific knowledge the interpreter would need to understand. Lopez reported that the counselor could also use this meeting as time to clarify the structure of the session and how the interpreter could be of most help.

Once an interpreter has been chosen, the counselor must then adapt the communication style of the sessions. Lopez (2000) suggested first asking the client to share any thoughts about working with an interpreter. To facilitate communication and accuracy of interpretation, Lopez recommended using short sentences during the session. Although this might appear to take longer, it gives the interpreter a chance to accurately convey everything that is being said. Lopez also recommended frequently checking with the client for meaning or clarity. It is also helpful to encourage the client to address any information that is not being communicated or not being accurately communicated.

**Barriers to the Use of an Interpreter**

Despite the counselor’s best efforts at restructuring the session to accommodate the inclusion of an interpreter, Plata (1993) reported that errors could still occur. Common errors of the interpreter Plata described included misunderstanding the meaning of the client and/or the counselor, translating wrong words, or allowing personal opinion to color the interpretation process. Davidson (2000) reported that interpreters he studied would edit or delete entire parts of the conversation from both sides without telling either side what they had done. Interpreters blamed time constraints for abridging responses and reported they felt pressure to speed up the process of interpretation.

Frequent checks with the client for accuracy of the interpretation are necessary to attempt to control for this practice. Frequent checks with the client also can help the counselor maintain control of the session. Davidson (2000) described sessions between doctors and patients in which the interpreter was in control. The interpreter would initiate questions to the client and then filter through the responses, weighing the information for level of importance. Only the important information would then be relayed to the doctor. This procedure could be potentially disturbing as the interpreter is not a doctor and has not had training as such. Davidson reported cases in which the interpreter attempted to influence the diagnosis process as well through the insertion of personal opinions about the client to the doctor without clarification of the origins of the statements.

Practical barriers involving issues of time and the formation of a therapeutic relationship are also present in working with an interpreter. Lopez (2000) discussed issues of time in that the counselor might be limited or restricted to setting appointments based on the schedule of the interpreter. This factor could significantly delay the assessment process. Furthermore, work with an interpreter is extremely time intensive and may be more difficult for the counselor (Lopez, 2000; Rosenberg, Lanza, & Seller, 2007). There is the time involved in meeting with the interpreter prior to the initial assessment and the time needed to process the interpretation with the client. Additionally, the counselor will need to take time after the session to clarify any questions the interpreter had about material during the session.

While the therapeutic relationship between the counselor and the client is seen as the foundation for counseling, it can be confounded when an interpreter is used. The presence of an interpreter as a third party in the counseling session complicates and may detract from the formation of the therapeutic relationship (Raval & Smith, 2003). Research results from Raval and Smith found that counselors had difficulty in establishing a working relationship with the in-
terpreter. This lack of connection in turn negatively impacted the formation of the relationship between the counselor and the client. Forming a positive working relationship with the interpreter, therefore, needs to be a focus along with other tasks during the pre-meeting planning (Lopez, 2000) prior to working with the client.

**Use of a Bilingual Counselor**

When a client does not speak English as the primary language, an alternative to the use of an interpreter is pairing the client with a bilingual counselor, who is able to speak the client’s primary language. The use of the bilingual counselor during counseling sessions affords the client the option of choosing to speak in either English or the client’s primary language. Benefits and barriers associated with the use of a bilingual counselor are explored.

**Benefits to the use of a Bilingual Counselor**

Guttfreund (1990) regarded a bilingual counselor with a client who had limited knowledge of English as the ideal combination. Choice, always an important element in the counseling process, is now available to the client. The client can choose in which language to communicate. Depending on the client’s level of comfort, the client may switch between the dominant and secondary language (Rogers, 2005). This language switching could occur multiple times within the course of one session.

Marcos (1976) discussed how the counselor could utilize the language switching as a therapeutic technique in that the client might switch to the secondary language as a defense against emotional issues. The bilingual counselor would need to be aware of this possibility and be prepared to address it with the client. Marcos also suggested that the counselor could initiate language switching during a session. Changing the communication from the primary to the more distant secondary language of the client could help the client start initial exploration into a difficult issue.

**Barriers to the Use of a Bilingual Counselor**

Marcos and Urcuyo (1979) agreed that the use of a bilingual counselor with a client was beneficial. However, they also offered some cautionary advice for bilingual counselors. They reminded bilingual counselors to not assume complete understanding of what the client says. The client might use words when speaking in the primary language that are from a specific dialect. Common words might also have a unique meaning to that client’s cultural background (Cofresi & Gorman, 2004; Marcos & Urcuyo, 1979).

Bilingual counselors will need to clarify meanings of English words intermixed in the primary language of the client (Marcos & Urcuyo, 1979). Bilingual counselors should pay particular attention to client usage of English terms related to mental health conditions (e.g. ADHD, depression). The client might be using the term without a clear understanding of the clinical meaning of the term. In addition to misunderstanding words, Marcos and Urcuyo discussed the possibility of bilingual counselors missing information from the client. The bilingual counselor may lose nonverbal or subtler forms of communication due to the intensity of effort needed to maintain communication in a secondary language. Frequent checks with the client can help the bilingual counselor find out any missed information.

Kiselica and Robinson (2001) discussed possible frustration for a bilingual counselor who only wants the role of counselor. Because of a bilingual counselor’s skills, a client might come asking for more than just counseling. The counselor may be asked to play the additional role of advocate. It is possible that the bilingual counselor may have to advocate for and with the client at school, or in the community to help the client meet basic needs. Additionally, the bilingual counselor may find him or herself acting as interpreter for colleagues with that client and others (O’Leary, Federico, & Ham-
pers, 2003). Kiselica and Robinson urged the bilingual counselor to maintain a multi-systems perspective in working with the client. The bilingual counselor might be the only representative voice the client has within the community. The client might be more receptive to working with the bilingual counselor on therapeutic issues knowing that the other issues are also being addressed.

**Important Counseling Considerations When a Language Barrier is Present**

When working with a client whose primary language is other than English, it is important for the counselor, whether working with an interpreter or bilingual, to keep some basic points in mind. Counselors need to remember that their ultimate goal when working with non-English speaking clients is to help them achieve a cultural balance in their new lives which can facilitate optimal mental health (Miranda & Umhoefer, 1998). Miranda and Umhoefer found that clients had increased reports of depression when they had low cultural balance. The process of helping clients achieve a cultural balance will require continued cultural awareness and sensitivity from the counselor. Additionally, the counselor will need a high degree of flexibility as well as adequate self-care.

**Counselor Flexibility**

Altarriba and Bauer (1998) encouraged counselors to develop flexibility and to allow it to show in all areas of the counseling process, including counselor roles, counseling strategies, and time management. When working with a client whose primary language is not English, it is important for counselors to remember that they may have to be flexible and work in a variety of roles in addition to the role of counselor. The counselor may take on the role of advocate for the client (Kiselica and Robinson, 2001) when helping the client negotiate services in the community or school system. The counselor who is bilingual may also take on the role of interpreter for colleagues (O’Leary, Federico, & Hampers, 2003).

Kiselica and Robinson (2001) suggested counselors might need to be flexible with counseling strategies including the counseling theories or techniques used during counseling. Fuertes (2004) discussed the need for culturally focused techniques such as exploring the client’s adjustment to a new culture, environmental stressors due to that adjustment, and language issues. There may also be a need to simplify techniques particularly when working with an interpreter (Raval & Smith, 2003). This simplification may facilitate the communication and comprehension process. Altarriba and Bauer (1998) supported this flexibility with the counseling process and discussed possible changes the client might initiate in the counseling process due to cultural differences or comfort level. Altarriba and Bauer specifically discussed the inclusion of family or specific relatives in the counseling process because of the cultural meaning associated with them. For example, Hispanic clients view family as a source of support, strength, and comfort. A Hispanic client might feel an increased sense of security from the presence of family in the counseling session. Altarriba and Bauer suggested that counselors may also have to work with traditional healers from the client’s culture, i.e. a Hispanic client might ask a curandero to be consulted during the counseling process.

Flexibility is imperative in helping the counselor with time management. The counselor will need to be flexible in scheduling appointments knowing that each session may last longer than average and that if an interpreter is utilized, the interpreter’s schedule has to be considered in addition to the schedules of the client and counselor (Lopez, 2000). Additional time is required if utilizing an interpreter for the meetings before and after counseling sessions (Lopez, 2000). Paperwork may also require extended time, particularly if counseling forms are not available to the client in Spanish, or if the counselor is required to translate information from Spanish to English before completing the
forms. Because forming a relationship with the client may be more difficult, particularly when a relationship must also be formed with an interpreter (Raval & Smith, 2003), client progress toward goals may be delayed.

Counselor Self-care

Regardless of whether the counselor is working with an interpreter or is bilingual, there are increased demands placed on the counselor by the presence of a language barrier. Marcos and Urcuyo (1979) urged counselors working with non-English speaking clients to take care of themselves. They reminded counselors that through self-care, they increase their ability to provide clients with the choice of how to best communicate and work in the counseling process. Without that choice, Marcos and Urcuyo reported clients experiencing decreased emotional affect and self-esteem and a feeling of being less intelligent. Marcos and Urcuyo recommended that counselors ask for additional supervision or find other supports to help them process these demands and to enable them to continue to provide clients with choice.

Fuertes (2004) discussed what components should be present in supervision for counselors who are bilingual or are working with an interpreter to assist the counselor with self-care. It is important for the supervisor to be able to understand the unique elements present when counseling a client whose primary language is not English. Ideally, the supervisor should be able to understand all languages spoken in the sessions the counselor presents. The supervisor will then be able to assist the counselor in assessing the sessions for accuracy of content, language usage, and potential issues related to miscommunication. The supervisor should also be aware of any cultural issues present in the counseling session and also in supervision with the counselor. It is also helpful for the supervisor to understand the various issues related to time that face the counselor (Lopez, 2000) and how balancing time demands may impact other aspects of the job.

Summary

The growing Spanish-speaking population’s mental health needs are undertreated, partly due to the language barrier (Guzman, 2001; National Institute of Mental Health, 1999; Ramirez & Smith, 2007). It is the counselor’s responsibility to afford clients the choice of language usage to facilitate the counseling process (Marcos & Urcuyo, 1979). Whether a client chooses to work with an interpreter and the counselor or the counselor is bilingual, the counselor faces challenges in forming the client-counselor relationship and in accurately assessing, diagnosing, and counseling the client. While working with clients whose primary language is not English, it is important for the counselor to remain flexible in counseling roles, strategies, and time management (Altarriba & Bauer, 1998; Fuertes, 2004; Kiselica & Robinson, 2001; Raval & Smith, 2003) and maintain appropriate self-care through supervision and additional supports (Fuertes, 2004; Marcos & Urcuyo, 1979).

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Graduate Student Perspectives

This section of the journal is devoted to works created by graduate students through their academic studies. Traditionally, these writings are shared only within a class but often provide valuable insights and reviews of the literature that could benefit all counselors. These articles go through the same review process as other articles but are given more flexibility in terms of subject and format. The review process is open to any graduate student in counseling.
Utilizing Stoic Philosophy to Improve Cognitive Behavioral Therapy

Sarah A. Moore Brookshire

This article explores the link between philosophical concepts and the cognitive behavioral therapies and will consider the practical applications for counselors. Several Stoic philosophers including Zeno of Citium, Chrysippus and Epictetus and the theories of Albert Ellis and Aaron Beck will be looked at in detail. The article will demonstrate that the cognitive behavioral therapies have much in common with stoicism and that cognitive behavioral counselors can learn and apply a great deal of stoicism in clinical practice. Multicultural awareness and appreciation will also be considered and it will be noted that stoicism was ahead of its time in terms of equality and an awareness of the similarities among all people.

The Greek Stoic philosopher, Epictetus, stated that “people are disturbed not by things but by the view which they take of them, when, therefore, we are hindered, or disturbed, or grieved, let us never blame anyone but ourselves; that is, our own judgments” (Epictetus, 1948, p.19). Zeno, the founder of Stoicism, taught that “happiness lay in conforming the will to the divine reason, which governs the universe” (Encyclopædia Britannica, 2006). Ariston of Chios, who studied under Zeno, said “there is only one true virtue of life- an intelligent, healthy state of mind” (Encyclopædia Britannica, 2006). The main tenet of Stoicism is that individuals should focus on what is within their power: their thoughts and actions.

This article will explore Stoic philosophy including philosophers such as Zeno of Citium, the founder of the Stoic school of philosophy; Ariston of Chios, who studied under Zeno and Chrysippus and Epictetus with contemporary theorists Albert Ellis (1973) and Aaron Beck (1976). In the early 1950s, Cognitive behavioral therapies were introduced by Ellis through something he termed Rational Emotive Therapy (RET), later renamed to Rational Emotive Behavioral Therapy (REBT). Ellis acknowledged that his theoretical approach was similar in many ways to the thoughts of several ancient Eastern and Western philosophers. Beck in the 1960s, developed the cognitive therapy model and also gave credit to the stoic philosophers for some of the underlying concepts.

Reiss (2003) argued that REBT originated in the Hedonistic philosophy of Epicurus and further suggested that Epicurus was history’s first influential rational-emotive theorist. Parallels have been drawn between various components of REBT and stoic philosophy. Some of the parallels presented by Herbert (2004) are:

1. the introduction by Thales of Miletus of the idea of criticism as an epistemological tool as compared to cognitive therapists’ questioning their patients’ interpretations of events.
2. the relativistic empiricism of the Sophists, such as Protagoras, who held that one’s reality is a function of one’s unique construal of the world while Ellis suggested that we create our reality through our thoughts and feelings. (p.53)

Still and Dryden (1999) also noted parallels between REBT and stoicism. Within these parallels, rationality is a crucial ingredient in living happily through the cultivation of healthy or appropriate emotions. Below are significant parallels between Ellis’ REBT and Stoic philosophy.
Ellis and Chrysippus both seemed to believe that conflict is between right and wrong (or rational and irrational beliefs) rather than between reason and emotion. Thinking and emotion are essentially interdependent. The notion of sexual asceticism and permissiveness. The notion of hedonism, self preservation and Oikeiosis. Acceptance and fatalism.

In addition, the notion of cognitive impression, “appearance” or phantasia parallels with Cognitive-Behavioral Therapy. For the Stoics, phantasia provides a theory of psychopathology and a basis for understanding value and ethics. Matheson (1916) noted that Epictetus believed that “the whole activity of the person may be summed up in the faculty of handling impressions rightly” (p.xxiv). Therefore, if a person is not able to handle impressions rightly, they would be demonstrating in cognitive-behavioral terms, psychopathology. It is how one utilizes cognitive impressions that make them wise or ignorant according the Stoics.

Ellis believed that human beings are ‘born with a potential for both rational, and straight thinking and irrational, or crooked thinking” (Corey, 1996, p.320). REBT was created and utilized to help clients accept that they will continue to make mistakes but that they can be more at peace with themselves in spite of the mistakes. For many people, there is relief in knowing that you are not expected to be perfect; however, you are responsible for your state of mind. Regardless of what situations or issues are presented to you, you have the ability and responsibility to take the information and use it to move towards self-actualization and away from self-defeating behaviors.

The Stoics had a similar view of human nature. They believed that human beings are rational. Matheson (1916) said that from a stoic perspective, the characteristic feature of human nature is reason which is identified with the whole spirit of the person and is referred to as the governing or ruling principle. The Stoics saw reason and rational thought as a natural aspect of humans. The stoics suggested that we are endowed by nature and by God to be reasonable and when we are in accord with nature we are being reasonable. Epictetus (1944) said that everyone “necessarily treats each particular thing according to the notion he forms about it” (I; III, p.11) and “demand not that events should happen as you wish; but wish them to happen, and your life will be serene” (M8, p.334).

Ellis’ (1993) basic principles within REBT are that our thoughts control our emotions which determine our actions. If a person can change his or her thoughts or self-statements, then behaviors related to those thoughts will change as well. Corey (1996) utilizes the following diagram to talk about the components of REBT (Figure 1).

The premise of REBT is that our beliefs about certain events determine how we respond to the event. If we are able to change our belief about the event, then we will be able to create new feelings in response to the event.

For example, if a client loses his job and his belief about losing his job is that he is a failure and that no one will ever hire him again, he may...
respond by becoming depressed and lethargic. If however, we are able to talk with the client about the irrational beliefs that he holds and he is able to change those beliefs, he may be able to change his emotional response to the event to a more positive, realistic and productive response. Still and Dryden (1999) said that “just as in REBT an emotional and behavioral consequence is always (or nearly always) a product of belief, which may be rational or irrational; so in classical Stoicism choice is always controlled by reason, which may be right or wrong reason” (p.152).

REBT is often criticized as focusing too much on cognitive and not enough on emotional problems. The A-B-C Theory of Personality was used by Ellis to emphasize emotions, beliefs and behaviors. In Raabe (2001), Philosopher Elliott Cohen used a similar explanation of the interaction between cognition and emotion to defend philosophical counseling from the same criticism. The Stoic and cognitive behavioral underpinnings do not suggest that we should be detached from calamities that happen to or around us. It is appropriate at times for the client to respond to a bad situation. However, in general, it is recommended that the client focus on his or her perception of the situation rather than what he or she might do to change the situation. The idea of ‘indifference’ has implications for the Stoic view of happiness. To be indifferent means to show no care or concern for or interest in somebody or something. If happiness is about feeling satisfied that something is right, then, then it would seem difficult to engage in both.

View of Emotional Disturbance

Neither Albert Ellis nor the Stoics spent a lot of time considering the cause of a dysfunctional belief. Ellis (1977) stressed that “the mere understanding of a problem or a knowledge of its underlying causes do not provide [the client] with sufficient material for actually solving [the] problem” (p.270). Although some understanding of why you respond in a particular way may be helpful, neither Ellis nor the Stoics, particularly the later Stoics, recommended that a lot of time be spent analyzing the past.

Epictetus’ philosophy focused on the pain that people experience and ways to cope with that pain. He focused on learning to control emotions and easing the pain that people experience. Montgomery (1993) said that Epictetus believed that the suffering was due to preconceptions and thought that analysis was all that was necessary to minimize or eliminate the difficulties in living. As viewed from a cognitive behavioral perspective, emotional disturbance stems directly from “magical, empirically unvalidatable thinking” (Bankart, 1997, p.272). To go a step farther, blame is given credit for most emotional disturbances with clients. Ellis would encourage clients to stop themselves when they were feeling upset and to think about what is happening. As a client, if you were able to stop the emotion and rationally consider the implications of the situation, you will presumably be able to move pass the blame associated with the situation and make progress.

The Therapeutic Process

The Stoics understood their role to involve a therapeutic treatment of the passions, which they saw as the major obstacles to good personal and public life. Understanding emotions such as fear, grief, anger, envy, jealousy, and erotic love as external, the Stoics concluded emotions unimportant to the internal life of the mind. The Stoics created elaborate exercises to help students internalize the change in perceptions. Many of the exercises have been lost but a few were recorded by Musonius Rufus (Lefkowitz & Fant, 1992).

Rufus separated the exercises into those of the soul and those of the body and soul. The exercises of the soul pushed Stoics to develop a different outlook on life through rote learning of their doctrines. The exercises for the body and soul were instituted in order for the body to become insensitive to pain which in turn, fortified it, allowed it to become courageous, disci-
plined and ready for action. Examples of exercises used as a means to enrich the body and soul included experiencing cold, heat, hunger, frugal food, an uncomfortable bed, etc. In addition to the outward demonstration put forth by the Stoics, the exercises also included writing and mental meditation. The importance of meditation was that it required one to be conscious of each thought, action or sensation. Through this attentiveness, there was room for examining thoughts and changing those that were considered irrational or dysfunctional.

Although Ellis (1989) did not require clients to sacrifice in the ways the Stoics did, he certainly agreed that clients must be attentive to their thoughts, actions and sensations and that through that attentiveness, clients can change how they feel about situations in their lives. Ellis worked with clients to reduce the blame they felt for things that went wrong in their lives. He helped clients create a more realistic and workable philosophy of life. He did not try to remove symptoms but to change the values that were keeping clients in a disturbed state. Ellis helped clients see where they had incorporated irrational thoughts. From this point clients could then begin to develop skills that would allow them to separate rational and irrational beliefs.

Just as with the Stoic philosophers, Ellis believed that his role was to challenge the irrational thoughts. He encouraged, persuaded and directed clients to engage in activities that would counter the irrational thinking. As clients became more aware that they were responding irrationally, they would begin to see the need to modify their thinking and stop the irrational thoughts. Finally, the therapist would work with the client to create a rational philosophy of life that could help them avoid irrational thinking and negative self-talk. Some of the exercises used by REBT therapists include role playing, assertion training, desensitization, humor, operant conditioning, suggestion, and support (Ellis, 1989).

Beck and Ellis held similar beliefs about many aspects of the therapeutic process. While Ellis had a focus on teaching clients, Beck (1976) preferred to pose questions to the client with the intent of encouraging reflection and allowing them to come to their own conclusions. Beck’s goal in the therapeutic process was “to change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schemata restructuring” (Corey, 1996, p. 337). Beck’s clinical behaviors mirrored the pondering and philosophizing of the Stoics.

Another way that Beck (1976) incorporated the earlier work of philosophers was through the use of Socratic dialogue with clients. He presented open-ended questions that were used to prompt the client to reflect and come to their own conclusions. Beck also was more subtle in his interpretation of clients’ perceptions and preferred to talk about dysfunctional beliefs rather than irrational beliefs. He did not want to discredit the client’s way of thinking but rather to talk about the negative impact of that way of thinking and suggest more productive and healthy ways of considering the world. Beck went a step farther than both the Stoic philosophers and Ellis by placing more emphasis on the therapeutic relationship and suggesting that more than teacher, the therapist serves “as a catalyst and a guide who helps the clients understand how their beliefs and attitudes influence the way they feel and act” (Corey, 1996, p. 341).

An important notion that the Stoic philosophers and Ellis and Beck were guided by is the need to provide clients with skills that can be applied in future situations. They were intent on teaching coping skills and training clients or students how to manage their cognitions so that they would be able to apply this insight throughout their lives. As Corey (1996) noted, clients learn skills during the therapeutic process that provide them skills they need to identify and dispute irrational beliefs that have been learned and are now maintained by self-imposed belief system.

REBT can be applied in various situations including individual therapy, group therapy, brief therapy, marital/couples therapy and fami-
ily therapy. In marital therapy, REBT therapists typically see couples together (Ellis, Sichel, Yeager, DiMattia, & DiGuiseppe, 1989). In order for the therapy to work, both individuals have to be willing to work on their relationship. The couple is taught the REBT concepts and encouraged to move away from negative emotions such as blame, depression and hostility. The couple must learn how to speak rationally with each other. Rufus, a Stoic philosopher also thought that husband and wife should lead their lives in common, to produce children and have all property in common. He acknowledged that a child can be born without marriage. Therefore, marriage gives more than children; it gives complete companionship and concern for each other (Lefkowitz & Fant, 1992). This concept was atypical for the time period. However, it appears to be a philosophical foundation to consider as we enter into working relationships with couples who are trying to build a stronger relationship.

Multicultural Applications and Limitations

According to Nussbaum (2000) Stoics demonstrate that individuals are not simply stuck with negative characteristics of defective societies such as anger, jealousy, or hatred. Furthermore, the Stoic philosophy suggests that people may eradicate racism and hatred towards groups of people through early education with children. If children are presented with more effective ways to understand, others including emphasizing the similarities rather than the only differences, they will begin to recognize that others are not alien or threatening.

Just as in Cognitive Behavioral therapies, the Stoics believed that the root of making positive changes within individuals was by having them consider and change cognitions. Nussbaum (2000) noted that certain hurtful forms of anger and hatred can be erased by patient reform that follows Stoic conceptions. Stoic philosophy recommends that children consider the group that is different as a resource that they might learn from. In addition, they reminded us that given a change in situation, individuals may be in the situation of those that we are afraid or hateful towards. Rather than responding with anger and hatred to that which is different, people can grow and become better human beings if they are willing to reach out to and learn.

Many people dislike that which is different and that which seems threatening. Using the stoic and cognitive behavioral approaches to consider the issues of racism, discrimination and prejudice seem in some ways idealistic but in others refreshing. Cognitive behavioral therapy can be an effective tool for growth and wellness for clients. It is inspiring to consider that stoic and cognitive behavioral methods impact racism, prejudice and discrimination. As individual counselors, we can continue to impact the communities that we are a part of by working to change the cognitions around prejudice and discrimination.

Two examples that might be positively impacted by philosophical and cognitive behavioral theories are the epidemic of suicide among gay and lesbian teenagers and the impact of sexism on women. In a study by Callahan (1997), it was discovered that teachers who hear antigay slurs against students responded only about 3% of the time. If counselors can reach out to teachers and students using the stoic and cognitive behavioral principles, the hostile environment gay students experience may be reduced, thus positively impacting their environment. The high school years in particular are times of varied forms of group segregation and this could prove to be an opportune time to reinforce these positive concepts in hopes of making the transition to adulthood easier for all marginalized students.

With respect to women’s issues, in many cases the earlier philosophers, oppressed women through their teachings just as women were oppressed within the rest of society during that time in history. However, several of the Stoic philosophers were aware of the oppression of women and advocated for equal treatment of women in society. Lefkowitz and Fant (1992) examined Musonius Rufus’ perspective
on women and found that he was very progressive for A.D. 30-101. He viewed women as, in many ways, equal to men. When asked whether women should study philosophy, he basically said that women were made by the same God and have the same reasoning skills as men and therefore should use those skills. Although he did suggest that women could apply their skills within the traditional roles of women, he nonetheless suggested that women were equal to men in the potentialities they possess.

Rufus even went so far as to say that we would all be better off if women are educated and practice philosophy. He thought that if a man and women should aspire to have the same virtues, then they should also have the same education. Rufus was very logical in laying out the reasons to treat the sexes equally. He acknowledged that men, in general, are stronger than women, and therefore suggested that it makes sense that some work be considered ‘men’s work’ and some be ‘women’s work’. Having said that, he also recognized that there were cases where men should do ‘women’s work’ and women should do ‘men’s work’. He believed that all work is common responsibility for men and women, and nothing is necessarily prescribed for one sex or the other. The underpinnings of Rufus and other stoic philosophers in general, suggest openness to equality of the genders that is not exhibited by philosophers from other periods in history (Lefkowitz & Fant, 1992).

In order to assist students/clients in their transition to a more accepting viewpoint, counselors must also be trained in and support multicultural awareness and be aware of their own biases. This is true for all counselors but is particularly true for cognitive behavioral counselors because we place such an emphasis on changing irrational or dysfunctional thinking. We should not ask anything of our clients that we are not willing to do ourselves.

**Summary**

The links between stoic philosophy and the cognitive behavioral therapies are undeniable. The Stoic criticism as an epistemologic tool and the cognitive therapy’s Socratic questioning of clients’ interpretations are an example of the basic foundational similarities between the two. In addition, it is clear that stoics and Ellis view reality in a similar fashion. Stoics viewed reality as a function of one’s unique construal of the world and Ellis suggested that we create reality through our thoughts and feelings.

Much of the details have been lost of the stoic philosophy, however, the foundation of stoicism is in sync with the foundations of cognitive behavior therapies. Ellis recognized the importance of the stoic concepts and incorporated them into REBT. Other theorists have built on and expanded REBT by varying perspectives and, creating exercises that can be applied to satisfy the goals of cognitive behavioral therapies. As philosophers, all that we can ask is that others take what is good and make it better and more useful. If stoic philosophy is considered carefully by the clinician and the client, it can provide added depth to the therapeutic process.

There is much that we can learn from the philosophers of the past. Although situations and environments are different now than they have been throughout history, many of the underlying concerns that plague people’s lives are the same. It is important that we consider the lessons that have been learned and utilize that information to better serve our clients. Reading more about various philosophers and their philosophies can shed light on many contemporary problems that clients are experiencing.

Having looked more closely at stoic philosophy as compared to cognitive behavioral therapies, a greater appreciation for the impact of philosophy on the therapeutic process develops. As clinicians, we are responsible to our clients and should use all available resources to assist them. The depth that is added to cognitive behavioral therapies by stoical philosophical thoughts will allow clinicians to better meet the needs of their clients. Most importantly, stoicism and cognitive behavioral therapies fo-
cus on not only alleviating immediate problems but in developing skills that will allow for continued growth for the client. In particular, both prepare clients to handle future difficulties independent of the clinician.

Cicero’s interlocutor declares, ‘that unless the soul...is cured, which cannot be done without philosophy, there will be no end to our afflictions. Therefore, since we have begun, let us turn ourselves over to philosophy for treatment; that we may be cured if we want to be’ (Nussbaum, 1994, p.317).

References


A heterosexual’s journey through homosexual experiences is presented from the personal perspective of an individual with an admitted bias and prejudicial disposition. The experiences and interviews of this immersion activity act as an agent of change. The author challenges his deeply rooted bias and prejudice from social and environmental conditioning. The emotional processes encountered by the author demonstrate the difficult and painful progress of challenging one’s belief system. The result of this activity is discussed as the author recognizes his personal growth in the areas of tolerance and acceptance of others who are different than himself.

As I completed my Master's degree in counseling, I played the multicultural game and responded appropriately and professionally while I continued to harbor biased and prejudicial feelings toward others who were different from me. As I became more aware of my feelings this began to affect me personally and professionally in ways that I had not anticipated and I knew that I had to overcome these prejudicial and negative attitudes. African Americans and other minority groups were not a major issue for me as I was able to work with these individuals very well. However, homosexuals proved to be the group that most challenged my core convictions. I questioned myself and internally wondered how could I provide effective counseling services to individuals that I believed were immoral and guilty of engaging in deviant sexual behaviors.

My perspective of homosexuals did not even recognize this group as individuals, only as complete strangers that just happened to be human. However my attitude began to change during a cross-state business trip with a lesbian. I began to notice the similarities of caring, love shared, and difficulties of being accepted and recognized. The experience echoed what Mackey, O’Brien, and Mackey (1997) wrote, “It’s too bad that people, when they talk about homosexuals, just think about the sex act, when it’s really a relationship…it’s the caring, the feeling, the understanding that we have for one another” (p. 157). I had an “aha” experience that shattered everything I had been taught and learned myself. I no longer perceived her primarily as a “lesbian.” We had similarities to be valued and respected as I came to view the unique humanness of this person.

My Christian beliefs were challenged as I tried to reconcile homosexuality with my Christian faith. As I spent time in prayer and critically examined my values and beliefs, I learned that in order for me to be a Christian, I needed to love my neighbors as I love myself and also acknowledge that I had been sitting in judgment of others my entire life. This is not my Christian calling because my faith encourages and challenges me to love unconditionally. This desire to love unconditionally was the primary reason I choose to immerse myself in the homosexual community as I wanted to gain a better understanding of my own biases and this unique group people. My immersion experience consisted of attending a gay and lesbian open Alcoholics Anonymous (AA) meeting, personal interviews and an informal gathering with a gay couple. The insight and understanding I gained through the entire process proved to be highly valuable because I spent quality time with people that I never would have ever associated with

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prior to this immersion experience.

AA Meeting

The gay/lesbian open AA meeting proved to be the most difficult challenge for me which I found ironic, because I initially believed this part of the process would be least threatening. Perhaps, the word “anonymous” provided me with a false sense of security. I attended the meeting alone and although I made the decision to attend a gay-lesbian-bisexual-and-transgendered (GLBT) open AA meeting to supplement my interest in substance abuse issues, on the day of meeting, the closer I came to my destination, the higher my anxiety level increased.

Sitting in the car before entering the building, I began questioning my motives and second-guessing myself. Anticipating the emergence of such intense feelings, I had prepared myself prior to the meeting by taking time to think through and subsequently answer those questions that were most threatening. I am grateful that I took the time to prepare myself because it was this preparation that enabled me to gain enough confidence to confront my anxiety, get out of my car, and walk through the doors of the building. Upon entering the meeting, my anxiety level reached its peak and I had numerous thoughts running through my mind; what happens if I see someone that I know? What if they think I am gay? What will they think of me if I tell them I am not an alcoholic? What will I really learn from these individuals? I am so thankful that my determination prevailed over my self-defeating thoughts because the information that I learned from this meeting dramatically changed my perspective.

During the meeting people were extremely friendly and supportive yet I found myself still quite anxious. Introducing myself to the group and simply stating this was my “first meeting” was as if I was preparing to give a speech to a crowd of thousands of spectators. My palms were sweating, my voice seemed anxious, and I was keenly aware of my surroundings. Once I had introduced myself, I began to relax and some of my anxiety decreased. Throughout the meeting I listened to people share their stories with the group and felt more comfortable than I had anticipated. Even so, the most painful experience of the night was yet to come.

After the meeting, a man came up and introduced himself to me. He asked me questions about my sobriety and I told him that I was not in sobriety. This person asked me if I had any alcohol today and I replied, “No.” He then said, “Congratulations, you’re sober for a day.” Shortly thereafter he began to tell me his story and became emotional. As I listened to him, my heart poured out to this man. I had no concerns about his sexuality, only a sincere humanistic caring about his well being and the emotional pain that he was experiencing. I was also thankful that he trusted me enough to confide in me. While riding home and reviewing the night’s events I felt shame and sadness. This shame resulted from my coming to realize that my long held beliefs were in direct conflict with what I experienced earlier that evening. I was saddened by the fact that I had betrayed this entire group of people without ever having taken the time to know them. Although I did not like the initial feeling of shame and sadness that came over me, I am thankful I did not dismiss them because it allowed it to confront my prejudicial attitudes towards homosexuals and grow interpersonally.

Personal Interviews

I also interviewed some individuals who are homosexual during my immersion experience and my first personal interview went very well. This individual made me feel at home at his residence. I was introduced to his long-term partner and another friend. This individual's story was told to me in an open, honest, and sincere manner. I learned about the difficulties this man experienced to claim his personal identity, and the pain he expressed concerning his coming out process significantly influenced me. His longing to be himself while being subjected to prejudice, both professionally and socially, defines today’s social injustice. As his story un-
folded, once again I found myself not concerned with his sexuality. Instead, I was overwhelmed with genuine compassion. The only concern that I experienced was sincere empathy for the social, emotional, and physical burdens this individual experienced.

As I listened to this person’s story I was reminded of a childhood friend who had similar experiences. I felt shame and humiliation, as I had to confront the manner in which I treated my childhood friend. This person is still isolated from our circle of childhood friends. Now at least I know what I am going to say and how I plan to apologize the next time I see this person. I hope that he will accept my honest attempt to make amends for my previous actions.

The second individual I interviewed probably affected me the most. Similar to the individual in the previous interview, this gentleman spoke of being subjected to prejudice and bias. He lost his position in church due to his sexuality and from my perspective the manner in which he endured this oppression truly defines an important component of manhood. To be able to experience this type of humiliation and not be filled with hatred is an example of forgiveness from which all members of society could benefit. Hearing this person talk about his educational experiences from childhood, once again I felt shame for the ways in which I had treated others who were different than me. Ultimately, what began as an interview experience has led to a friendship that I have now come to cherish.

This individual’s partner of nearly ten years was extremely welcoming to me. Through listening to his story, I became aware of many social issues confronted by the gay community, specifically as it pertains to the gay club life and the emotional pain experienced as individuals oftentimes use that venue as a means to seek acceptance of their identity. This person had to move away from his hometown to a larger city in order to find acceptance. He experienced the nightclub life, which offered him the security to be himself without fear of being judged. I am reminded of the time that I moved away from home to attend college; I had family and social support, yet still experienced one of the most stressful times in my life. This individual received no support once he moved and the emotional pain he experienced was incomprehensible to me.

**Informal Gathering**

The next immersion experience I had consisted of dinner in a public restaurant with a gay couple. I had been out to eat numerous times with heterosexual couples however this was my first social activity with a gay couple. To my surprise, I was not apprehensive about this and the event proved to be no different than any other social event I had attended. The naturalness of this dinner confirmed for me that I was gaining acceptance of others while defeating some of my biased attitudes.

Another interview that opened my eyes to a world in which I was not expecting, introduced me to individuals who were HIV positive. This person’s story was quite different than the others due to his age. He was 50 years old and coming out for him involved sexual experiences with older men. His mother sought therapy to “fix” him. He reported that he was fine with being “gay” but his mother had a more difficult time with his sexuality. This person’s worldview was quite different from any person I had ever met. This was in part due to his unique individual identity as well as his worldwide experiences of different cultures. I was humbled as he spoke and I felt that I was listening to a wise man. His perspectives really enlightened me and I also valued his appreciation of me as I honestly and genuinely explained the purpose of my immersion project along with my racial, homophobic, and prejudicial background.

His partner’s story gave me a clear understanding of the coming out process as he had just recently came out to his parents. The honesty in which he spoke of his anger toward heterosexuals further illuminated the personal injustice that I have delivered throughout my life. The pain I was able to share with this person
allowed me to see the sincere desire of acceptance as well as the pain experienced from not receiving support from a person’s primary caregivers.

As I interacted with this couple, we began to discuss the impact that HIV/AIDS has upon their lives. I was especially interested in the older person’s perspective because I was certain that he had much more insight and experience due to his age and the historical context of HIV/AIDS. He shared his story and I became aware of his HIV positive status. The idea that I had finally met someone who identified his HIV status kept playing in my mind. I learned that part of the reason this couple had moved to this geographical location was in part due to the medical support and resources for persons living with HIV. I learned that his partner was also HIV positive. The most interesting aspect of this couple was that they were living their lives to the fullest extent possible. I was so appreciative of the opportunity to face one of my biggest fears in such a supportive moment. The feeling that I had when I left was not focused on this couple’s sexual lives but on the caring of individuals in the same manner that I care about my closest family and friends.

The experience of interviewing the gay couples proved to be more enlightening. As I learned about different household duties each performed, I was reminded of my own relationship history in which duties and responsibilities were shared, each according to individual strengths and weaknesses. I did not find gay couples to be different from heterosexual couples; though these couples appeared to be more stable and committed than many straight couples I have witnessed in my life. I wonder if it is possible that one of the fears of recognizing gay couples legally is that many will demonstrate more appropriate committed relationships and have lower divorce rates than traditional heterosexual couples.

Insights Gained

Reviewing the literature regarding homosexual individuals and same-sex couples, I discovered that some of the issues I observed in the individuals I interviewed were supported by the literature. For example, the emotional pain experienced by the individuals created increased high-risk behaviors, in social, emotional, and physical aspects. Research has suggested that this is not uncommon for GLBT individuals (Vare & Norton, 2004). In fact, gay-related stress has been found to be associated with higher emotional distress among GLB individuals (Rosario, Schrimshaw, Hunter, & Gwadz, 2002). Through the course of my interaction with the individuals I interviewed this same theme proved to be a significant factor in the lives of the participants.

These painful experiences usually begin during adolescence and continued into adulthood as I discovered during my interviews. The important concerns of the individuals I interviewed were very similar to other heterosexual minority concerns which included identity, romantic relationships, social, and family relationships (Pachankis & Goldfried, 2004). These aspects were clearly evident in my immersion experience. All of the interviews included topics or themes that reflected these concerns. I observed no differences between the same-sex couples and heterosexual couples. This observation supports the literature that contends that same sex and heterosexual couples are similar (Kurdek, 1994). I found the gay couples to function based on factors that were necessary for healthy relationships regardless of sexual orientation. Love, mutual interest, caring, communication, integrity, sensitivity, understanding, and lack of possessiveness were found to be necessary in successful relationships of same sex couples (Tuller, 1988). I observed all of these traits in the couples that I interviewed. Focusing on these conditions allowed me to care more empathetically and genuinely. Finally, a theme that emerged with all of the individuals I interacted with during my immersion experience was their individual and collective social support systems. Through the course of numerous conversations, it became apparent that the
social supports utilized by the participants were very strong. According to Julien, Chartrand, & Begin (1999) same sex couples share a larger portion of their social network than do heterosexuals.

I learned that the mistakes I made are common for heterosexuals. I ignored gay issues prior to beginning my advanced training in counseling. My use of prejudicial language is very humiliating and regrettable. The level of personal discomfort was not a focus for me; I did not own my discomfort as I do now. The manner in which I stereotyped GLB individuals is very dehumanizing to sexual minorities and common mistakes made by heterosexuals in addressing sexual minorities (Conley, Calhoun, Devine, & Evett, 2001). However, it is comforting for me to know that I am working through these mistakes and finding new and more insightful ways to approach people who are different than myself.

Another area that I found to be very meaningful, was that this opportunity truly required that I focus on similarities as suggested by (Valadez, 2006). For my entire life, I have ignorantly focused on differences and what I have found is that they are so much more meaningful experiences of love and respect when similarities are the focus. I thought that I was going to learn some magical difference that would allow me to see past the obvious differences, which would in return, allow me to work through my own bias and prejudices. It was the immersion experience that actually allowed the similarities to speak to my heart. It was in my heart where these feelings were harbored and the only freedom of these biases must be heartfelt in order to be authentic and meaningful. Having had these meaningful experiences with individuals who I now have an honest appreciate for, I am able to give insight and recommendations in this type of activity.

Implications

In dealing with sensitive issues such as racism and prejudices, it needs to be kept in view that people are likely to express openness while harboring prejudices (DeRicco & Sciarra, 2005). This was exactly what I had experienced in my master’s level training program. I verbally expressed my openness but never worked the process internally. I would think that I am not the only graduate student to ever to hide or make light of his or her feelings in order to be politically correct. Another recommendation that DeRicco and Sciarra assert is that professional counselors have an ethical responsibility to continually address their own multicultural competence level. I would further recommend consideration of additional thoughts expounded by DeRicco and Sciarra that includes experiential learning activities that incorporates multiple experiences or events in order to facilitate the development of meaningful relationships. Individuals must also be willing to be open and have the courage to challenge one’s own belief system (DeRicco & Sciarra, 2005).

This immersion experience has allowed me to realize that the acceptance of others has not been the sole objective or reward for me; I need to unconditionally accept others in order to become conscious of my own fears and anxieties and truly love and accept myself. Another benefit to this immersion experience, as reported by at least one of the men I interviewed, was that he was able to heal his emotional wounds by participating in this experience with me. I have come to see that when I work to understand and accept others as they are, I create an environment of unconditional positive regard which improves the lives of everyone involved.

I highly recommend this type of experiential training experience for teaching and training for both master’s level and doctoral students in order to help them begin the process of becoming multiculturally competent. The inclusion of immersion activities, I believe, would provide a richer and meaningful experience for students in regards to their multicultural development. Such experience could also benefit practicing professionals who are seeking to further their professional development and improve their work with clients different from themselves.
I believe further research is needed to address the many questions that remain in regards to experiential activities as it relates to increasing multicultural competence. For example, it would be important to examine the influence individual’s willingness to self-examine their racism and prejudiced beliefs on the outcome of such an experience. What student variables and program design variables serve as factors that contribute to the outcomes of immersion experience? Another area of interest would be topics that are being chosen for immersion experiential learning in a multicultural training class. How should instructors guide their students in their choice of and planning for immersion topic area in order to maximize outcome?

Conclusion

This immersion experience has allowed me to integrate two semesters of multicultural courses into a very meaningful experience. These encounters provided me opportunities to appreciate real life information and issues that I learned in my coursework. Kiselica (1991) spoke of this phenomena as well. He further suggested that these types of encounters allow fears and biases to be confronted; and through value clarification, we are able to experience identity development. This immersion experience was an opportunity for me to challenge my personal prejudices and biases toward the homosexuals. This would not have been possible if my professor had not provided me with an environment that was conducive to developing trust and respect with my peers and professor himself. This sense of safety is essential for individuals to safely express sensitive issues (Kiselica, 1991; Valadez, 2006). Trust develops over time and for me, this started as I began my doctoral program in the Fall of 2006. My cohort members primarily make up the class memberships and have greatly facilitated my trust development. My awareness and knowledge of self and others, so has my skills in relating to sexual minorities increased. This increased competency of knowledge, skill, and awareness coincides with Sue, Arredondo, and Davis’s (2001) tripartite model of multicultural competency. This experience has afforded me the fortitude to become more active in advocating for not only sexual minority concerns but also that of other groups and individuals who experience oppression.

References


For Your Files . . .

is a section devoted to practical applications of counseling techniques. These ideas are submitted by your fellow counselors who have utilized them successfully with their own clients.

Keep a Lid on It: The Trashcan of Emotions

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SARCASM = Handle (a bitter kind of sarcasm or caustic)
ANGER = Lid (Sense of Power)

DISAPPOINTED
LONELY SAD
GUilty REJECTED
EMBARRASSED
FEARFUL HURT
ASHAMED INSECURE

Population with whom technique will work best: Any

Ethical Considerations: None

CLIENT: “I haven’t talked to my mom since May of last year and I really don’t care if I ever speak to her again. I just can’t stand her. I hate her…I mean it…I really hate her. I hate the way she acts and how she treats my step-dad and me. She only thinks about herself and it’s been like that since I was a kid. The thing that pisses me off the most is that she doesn’t even care what she’s done, or is still doing, to us. Just thinking about her makes me sick.”

CLIENT: “So when I got into work there was a meeting with the entire staff. It was about the biannual report we have to do. I didn’t get my report done, at least “not in a timely manner,” according to my boss; he called me out in front of everybody. The funny thing was, I wasn’t the only one who didn’t get the report in on time, or at least his time. What an ass! I’m so frustrated; I’m seriously considering quitting.”
Client: “I should have kept my mouth shut and never said anything. I'm an idiot and I'm pissed at myself for ever saying anything. Now everyone is going to know I can't do it. I'm such a dolt for opening my mouth in the first place.”

Comments like the ones above are not uncommon to counselors' ears. In fact, clients often come into a therapy appointment expressing anger about someone or something. Some theorists argue the need to control or at least manage anger (DiGuiseppi & Tarfrate, 2001) while others will state that anger is not necessarily a thing to be managed, but an emotion to be expressed (Lee, 1987; Roffman, 2004). The purpose of this article is not to argue either side of the issue. Instead, the purpose of this article is to introduce a technique to help clients discern whether anger is the emotion that most accurately reflects the situation, circumstance, or experience they are presenting or if anger is being used as a means of protection from other, more vulnerable emotional expressions. The technique to which I am referring is “the trashcan of emotions.”

It may seem strange to use a trashcan as a metaphor to describe a person's emotional experience, but I have found it to be very effective with clients. The trashcan of emotions came about simply through listening to countless stories told to me by my clients. Specifically, the technique evolved from those clients' stories in which anger was the presenting issue, and yet through listening intently to their stories, there seemed to be other feelings underneath that were potentially more painful. In many cases the emotions that were underneath the lid of anger were of such pain that the client was unable or unwilling to attend to them outright. Using the trashcan metaphor enabled a discussion of feelings while maintaining respect for the clients' process. In other words, by drawing a trashcan, similar to the one presented in this article, it allowed clients to literally see how anger is oftentimes the first emotional response when a person experiences what they perceive is an “injustice” (DiGuiseppi & Tarfrate, 2001). Ironically, there may be other feelings that are potentially more powerful, yet leave the clients feeling more vulnerable.

As I listened to their stories and the manner in which they told them, I started to listen with a different “ear.” I was trained early in my career that it is important for a therapist to pay close attention to a client's voice pattern and/or tonal inflections (Jacobs, 1992). It was through listening that I not only heard their anger and frustration, but I also heard other emotions that appeared to be “under the lid” of their anger. Getting to the “other emotions” proved to be more challenging, primarily because anger is considered an emotion that carries an experience of power (Scherer & Wallbott, 1994), and some clients were reluctant to explore other emotions that may have been perceived as leaving them with the experience of being powerless.

In many respects anger is a fairly easy emotion to recognize. For example, in each instance mentioned above, a therapist would readily conclude that the individuals were angry and perhaps justifiably so. Ironically, attempts at “talk-therapy” alone did not offer an opening to address the underlying emotions. Perhaps one reason may be attributable to the power potential that anger tends to elicit and a client's belief that other feelings do not offer the same “power surge.” The trashcan of emotions is a creative way to help clients look beyond their anger and identify other emotions.

Using the metaphor of the trashcan not only helps clients view their presenting problems through a different lens, it also makes the concept more concrete (Jacobs, 1992) and less threatening. It is important to note that the feelings inside the can have no order in their presentation per se; however, depending on the client, I put certain feelings near the bottom of the trashcan. For example, for many clients I place the feelings of fear, insecurity and shame
near the bottom of the can. The reason for this is simply that some individuals, when they see these emotions immediately “under” the lid of anger, may respond negatively, expressing things like, “I am not afraid of her. I just don’t like her!” or “I am not scared of my boss, I just think he’s an ass!” Having the feelings of fear, insecurity or shame near the bottom of the trashcan allows for several things to happen for both, the therapist and the client. First, by seeing feelings near the top that may be regarded by the client as “less potent” (e.g., disappointment and hurt) versus those that may be considered “more intimidating” (e.g., insecurity and shame), the client may be able to delve into the “trashcan” at a pace that may be considered less menacing. Second, it can give the client the opportunity to see how their emotions have “piled up” and have virtually begun to push the lid off the can (e.g., anger outbursts, caustic remarks, etc.). Finally, it is a way for the therapist to illustrate to clients how certain feelings may have been pushed to the bottom of the trashcan, which in literal terms can have an overwhelming stench. Hence, those emotions that have not been addressed and have simply had other emotions heaped on top are probably very old and carry with them a powerful aroma (i.e., childhood feelings/reactions/experiences); it may serve a client to address these feelings in a safe and healthy manner.

In reviewing the excerpts again, can you identify other emotions that may be present? Several things were addressed as a result of using the trashcan metaphor, the first client was able to recognize feelings of disappointment, hurt, sadness, loneliness and rejection. More so, she was able to see how her anger was protecting her from “feeling” the pain of these emotions and thereby not allowing her to grieve what she had always wanted from her mom, that being attention, acceptance and understanding. In the second excerpt, the client’s anger was a protection from embarrassment, humiliation and fear. His anger gave him a sense of power over the situation, but precluded him from experiencing those emotions that could lead toward healing and growth. Finally, in the last piece, the client’s outward debauchery was a means to deal with feelings of shame, insecurity and potential rejection, but in turn prevented her from recognizing and authentically accepting her humanness and her frailties.

Through the use of the “trashcan of emotions” counselors may be able to help clients identify and subsequently deal with those emotions that anger may be blocking. In making that claim, this article is in no way inferring that expressing one’s anger is an unhealthy emotional response. In many cases, it is not only healthy, it is vital for one’s emotional growth (Lee, 1993). Like the emotions “inside the can,” depending on one’s goal for identifying and expressing emotions, anger is an emotion that can move us toward people (e.g., to protect someone) or away from people (e.g., to get revenge, blow off steam) depending on our external response (Tangney, et al., 1996). Nonetheless, it may prove helpful to explore if there are underlying emotions that more accurately reflect a client’s experience. Although taking off the lid of anger and picking through the garbage inside (a.k.a. other feelings) may have the potential to get messy, you may help a client find a treasure that once “cleaned up” can bring great rewards (i.e., emotional freedom). I believe Max Lucado summed it up best when he wrote,

There is a dangerous point at which anger ceases to be an emotion and becomes a driving force. A person bent on revenge moves unknowingly further and further away from being able to forgive, for to be without the anger is to be without a source of energy. Hatred is the rabid dog that turns on its owner. Revenge is the raging fire that consumes the arsonist. Bitterness is the trap that snares the hunter. And mercy is the choice that can set them all free.
References


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Want to contribute to *For Your Files* . . .?

A submission to this section should include: (a) title of the activity; (b) type of client (age, gender, demographics as appropriate) that might respond favorably to the approach, (c) type of problem for which the technique is best suited, (d) any ethical considerations, and (e) full description of the approach. Supporting literature is helpful in understanding the foundation of the technique.
Workplace and college campus violence—Columbine and other school shootings—9/11—Katrina—veterans of the war in Iraq and Afghanistan committing suicide in record numbers—a generation of school children watching the Challenger disaster live on TV—

“We are not in Kansas anymore, Toto” and we see it all on TV, like the 9/11 planes, over and over again.

As counselors we work in many settings and are challenged by handling many different kinds of crisis situations on what has become a too frequent basis. This book can be a major resource for students who are learning about crisis work, new counselors, and veteran counselors who want a review and reminder of the many facets of the work they do. The process, skills, and goals of crisis counseling are not those of traditional individual, group, and family counseling. The authors explain why and present a three phase model (remember, reorganize, restore) as well as the steps in each phase.

Capuzzi and James and Gilliland as well as others have provided us with excellent resources on aspects of different types of crisis. This book provides a background in crisis theory and conceptualization as well a systemic, integrated crisis counseling model.

Other strengths of the books include a discussion of the influence of developmental stages in a person’s reaction to crisis situations, the effects of crisis work on the counselor, and the influence of culture and life history on the way victims react to a crisis. Use of the model is illustrated in its application to three crisis counseling situations. The book presents scholarly theories but a major strength is the authors’ discussion of the theory they propose and its application to crisis work. The book is well written and easy to read.

The authors, Drs. Jackson Rainer and Frieda Brown have extensive experience doing a variety of different kinds of crisis work as well as writing and doing presentations on crisis counseling and therapy.

I strongly recommend this book to students, new counselors, and those of us who have been “at it” for a time. It is a resource you will often refer to.

Disclaimer: Drs. Brown and Rainer were valued colleagues during my time at Gardner-Webb. I taught the crisis course using this text and know how valuable it can be.

Pat Partin
Professor Emeritus
Gardner-Webb University
The North Carolina Counseling Association Journal

The North Carolina Counseling Association Journal is an on-line journal supported by the North Carolina Counseling Association for the purpose of enhancing knowledge and skills of professional counselors in North Carolina. The goals of the journal are threefold: (1) To foster research and scholarly endeavors; (2) To provide a medium for communication among professional counselors in NC; and (3) To enhance continuing education opportunities for counselors throughout the state. The Editors invite counselor educators, supervisors, practitioners, and counseling students to submit manuscripts that address current professional counseling issues.

The Journal is divided into five content areas, with each area addressing an important aspect of the counseling profession.

1. Theory and Research: Manuscripts in this category may include extensive review of the literature on topics pertaining to counseling, an annotated bibliography of key publications, and both qualitative and quantitative original research.
2. Innovative Approaches: Manuscripts in this area may include thorough descriptions of activities, strategies, and techniques that have been developed and implemented by counselors.
3. Current Issues: Manuscripts in this category will feature position papers on timely topics affecting counselors, particularly in North Carolina.
4. Multicultural Issues: Manuscripts in this content area will include research, innovative approaches, and current issues that address multicultural populations that include race, ethnicity, gender, sexual orientation, religion, and social economic status.
5. Graduate Student Works: Graduate student written works that reflect theoretical or empirical investigation that occurs as a part of graduate training will be included in this section.

Publication Guidelines

APA Guidelines (5th edition) should be followed throughout for format and citations. All manuscripts should use 12-point Times New Roman font, be double spaced including references and extensive quotes, allow 1” margins on all sides. Authors are responsible for the accuracy of references, tables, and figures.

Title. A separate first page of the document should include the title, author(s) name, and institutional affiliation of all authors (if not affiliated with an institution, city and state should be listed).

Abstract. A separate second page of the document should include an abstract describing the article in 50-100 words.

Body. All manuscripts begin with the rationale for the manuscript and its significance to the field of counseling. This untitled introduction is followed by a brief review of relevant literature and a statement of how this current article addresses issues the current literature has not resolved.
Research studies will continue with methodology sections and results/discussion sections.

Innovative Approaches will continue with descriptive sections of activity/program followed by a discussion section on practical application, limitations, and implications. Current Issues papers will define the issue and its current impact on the field of counseling in NC.

Multicultural Issues papers will address the impact of multicultural factors on the counseling profession. Graduate Student Works will include a discussion of the implications of this work on the field of counseling.

Submission Guidelines

The submitted work must be original work of the authors that has not been previously published or under review for publication elsewhere. The North Carolina Counseling Association Journal retains copyright of any published manuscripts. Client anonymity must be protected, and authors must avoid using any identifying information in describing participants.

All manuscripts are initially reviewed by the co-editors with acceptable manuscripts sent to additional reviewers of the Editorial Board. Reviewer comments, suggestions, and recommendations will be sent to the authors. Authors and reviewers remain anonymous throughout the review process.

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