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Going Deeper: Cognitive Anthropology's Contributions to Moving Beyond Cultural Competency in Mental Health Practices

Abstract:

Modern mental health counseling aims to highlight a number of values, including multiculturalism and social justice. Such values are very important when dealing with counseling in many areas, but in this article, they are applied to counseling in the area of "trauma." Cognitive anthropology provides a set of tools for understanding a client's expectations and constructs of meaning, which are rooted in their lived experiences and cultural worldview. This paper will also introduce two areas of application where a cognitive anthropological approach can be applied to multicultural counseling in the areas of communication and treatment, which can help further improve the values of multiculturalism and social justice within the counseling profession.

Keywords: mental health counseling, multicultural, cognitive anthropology, trauma, worldview

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Introduction

The field of mental health counseling is rooted within the psychoanalytic theories and approaches that neurologist Sigmund Freud began developing in 1897, in which he supported the inception of the first force, or paradigm, of psychology that has guided the practice of psychotherapy. This new way of addressing the ailments of clients relied upon the medical model, which focused on identifying biological etiologies for the disorders or diseases– categorized sets of symptomatic experiences– of clients which psychotherapists attempted to treat. Since its beginnings, psychology and counseling has received criticism for its colonial and patriarchal foundations which have utilized European and Euro-American males as the standard for diagnosis, ignored the systemic, social, cultural, and political contexts, and operated under the assumption that clients must conform to their environments. However, many scholars and professionals in the mental health field since Freud have further developed and shaped the discipline to be more effective and inclusive than its historical roots.

Though the field has advanced in its treatment theories and approaches over the last century, this paper recognizes there are still contributions necessary for the continued development of ethics, theories, and techniques of mental health counseling pertaining to effective and meaningful multicultural counseling, which is centered on the needs and values of culturally diverse clients. To properly present its argument, this paper will begin by presenting brief historical highlights focusing on the development of the fourth and fifth paradigms of counseling, which are multiculturalism and social justice. Following this, and after locating itself within the values promoted by multiculturalism and social justice, this paper will offer two examples of published works calling attention to the continued need for understanding the underlying constructs of meaning that are used by culturally diverse clients to interpret their lived experiences within their sociocultural and political realities. A cognitive anthropological approach will be presented to explore the levels of meaning necessary to understand the culturally diverse client's schematic expectations and perceptions relating to an aspect of counseling, such as the experience and treatment of "trauma." Finally, the paper will indicate two areas of application within multicultural counseling, those of communication and treatment, which a cognitive anthropological approach can help improve following the values of multiculturalism and social justice.

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Moving Beyond Cultural Competencies

Before the mental health field's recent concepts of multicultural counseling and competencies were established, the history of the counseling profession revealed the harmful use of western hegemonic theories and practices for historically marginalized clients. In response to the lack of attention and understanding of culturally diverse clients and professionals in the field, beginning with the civil rights era, the field of mental health professional services experienced the start of its fourth force, or paradigm shift, influencing new developments in research and the field: multiculturalism. This paradigm shift followed the earlier shifts of psychodynamism, behaviorism, and humanism, and focused its attention on the culturally specific concepts, needs, and treatments of culturally diverse clients.[1] The fourth force of multiculturalism promoted the attribution of cultural competencies through psychology and counselor education, because it identified that the counseling profession needed to recognize clients as being culturally centered and influenced by contexts and constructs. This shift influenced a number of changes within the field following its inception during the 1950s. For instance, the social and racial injustices found in the political turmoil of the 1960s influenced the development of the Association of Non-White Concerns in Personnel and Guidance in 1969 followed by its journal, *Journal of Non-White Concerns*, three years later in 1972.[2] A year later, the Vail Conference was sponsored by the National Institute of Mental Health, and is famously known for launching the scholar-practitioner training model within counseling and psychology. Additionally it is known for prompting an official dialogue on the culturally competent provision of professional counseling to clients of another cultural group. It is recounted that, "[f]rom this conference came the resolution that providing professional services to culturally diverse individuals is unethical if the counselor is not competent to provide them and that, therefore, graduate training programs should teach appropriate cultural content."[3]

Cultural competencies in counseling are understood as relating to the capacity to understand the client's worldview as a result of attaining "awareness, attitude, knowledge, and skills that allow clinicians to understand, appreciate, and work with culturally diverse individuals" during their treatment, engagement, and completion.[4] Such cultural competence is intended to be only the starting point for mental health professionals and is

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to foster multicultural awareness that is ever-growing within the clinician, leading to greater sensitivities to the identities, lived experiences, and needs of their culturally diverse clients. Some argue that cultural competence includes cultural humility,[5] though some indicate that cultural competence only indicates a minimum requirement of awareness, knowledge, and skill, whereas cultural humility represents a lifelong willingness to "self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships."[6] Other problems with sustaining only minimal competencies in multicultural counseling appear in the voices of mental health professionals of marginalized communities, who argue that moving beyond the minimum requirement of competencies is to embrace cultural humility, responsiveness, and reflexivity. One such example is the attention Carlos P. Hipolito-Delgado gives to the social justice concept and role of allyship stating, "to effectively partner with and support the needs of communities of color, counselors require more advanced skills and dispositions — such as those possessed by allies. Allies to communities of color have a profound understanding and commitment to these communities. They are able to deeply understand and relate to communities of color, while also advocating for social justice for these communities."[7]

In 2008, Jeffrey Arnett published an article recognizing that even while much positive growth in a multicultural perspective has occurred since its origins during the civil rights era of the 1950s, much of the counseling profession is still founded upon concepts centered on only 5% of the world's population. This indicates that the mental health field continues to neglect providing culturally appropriate treatment that understands the lived experiences, values, and cultures of clients who are representative of the remaining 95% of the world's population.[8] It is due to this lack of connection with the lived experiences of culturally diverse clients that many mental health professionals and former/present clients of mental health services have supported the development of the fifth force of counseling, social justice. Social Justice Counseling emphasizes that mental health professionals must understand culturally diverse clients, that their

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lived experiences are "connected to larger sociopolitical contexts," reflect marginalization through oppression, such as colonization, racism, sexism, homophobia, transphobia, etc., and require holistic and interdisciplinary

responses to the systemic injustices being experienced by clients. This includes the experience of the professional advocating with or on behalf of their client.[9]

Going Deeper

Keeping in mind the historical emphasis and development of cultural competencies to move beyond simple awareness, knowledge, and skills relating to supporting culturally diverse clients, as well as social justice approaches such as advocacy and allyship, this section suggests a different direction. Not only should mental health professionals consider going beyond competencies towards social justice action that positively affirms and supports their clients, professionals should also consider "going deeper" in understanding the complex layers of meaning embedded within the lived experiences of culturally diverse clients. The section will first highlight a recent social media post– a clarion call to all mental health professionals really– to follow the social justice paradigm of counseling and to support, affirm, ally with, and advocate for systemic change. It will then continue the conversation of "going deeper" by presenting an example from cognitive anthropology, which models how mental health professionals can investigate a concept, like health inequality or trauma, down to its schematic roots.

"Dig Deeper" Mandate

Art therapist and counselor Alyse Ruriani, who is both an illustrator/graphic designer and advocate/activist, recognized that embodied experiences heavily inform our understandings of ourselves, others, and the world around us. Consequently, when introducing herself, she also emphasizes rightly as "a person with lived experience."[10] Building on her recognition of the role of embodied experiences, which are also shaped by culture and systems, Ruriani created an advocacy-oriented illustration posted to social media bearing the mandate that "We need to dig deeper"– a post liked on Instagram more than 21,000 times and shared on Facebook more than 3,300 times![11]

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Figure 1. We Need to Dig Deeper. Graphic Illustration by Alyse Ruriani, May 8, 2020. Instagram. https://www.instagram.com/p/B_7wCaSjRtS.

In the illustration, Ruriani depicts the context of clients' lived experiences being buried under the systemic layers of the western medical model, which seeks to pathologize the manifested symptoms of clients according to diagnoses' criteria constructed through individualized western concepts of health and paired with pharmacological treatment strategies. Ruriani further argues through the illustration that the necessary tool to uncover the pervasive systemic layers that hinder effective attention to ailing mental health is that of intersectional social justice. The mandate that Ruriani has issued to "dig deeper" is detailed in the social media post caption:

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> We cannot just rely on what we have been doing, because so many people are being failed. We need to go beyond the medical model and pathologization to see what is really there. So many people have completely reasonable responses to the things that have or are happening to them, to the harm that is being or has been done, to the ways the system has and continues to fail them.
>
> People are not just a set of symptoms or a list of diagnoses. They are full human beings with an array of experiences in which they react to. Are we pathologizing grief? Are we considering the intersecting identities each person holds? Are we recognizing the mental [effects] of experiencing racism, homophobia, colonialism, ageism, ableism—all of the ways that people are othered?
>
> We can't just slap a diagnosis on someone, give them some meds, and throw them into treatment. We need to look at the big picture. We need to advocate for the resources and the laws and the change that would make life worth living for more folks. We need to dig deeper if we want to truly help, truly see and hear the people we work with, and truly make a difference.[12]

Within the world of mental health, social media has been a tool utilized to increase awareness of issues that cultural humility is able to respond to through the arm of social justice counseling and advocacy. One such issue is the decolonization of mental health practices, which were initially formed from western concepts of health, society, and culture. Ruriani identifies colonization within her graphic illustration as one example of an underlying lived experience that is significantly impacting the lives of clients in ways that manifest what the diagnosis-treatment oriented medical model identifies as symptoms of a disorder. However, to "truly help, truly see and hear… and truly make a difference," clinicians must realize that the impact of colonization cannot be treated as a disorder, and cannot be resolved with treatments that invalidate the lived experiences. Consequently, social justice counseling and advocacy argues that ethical support for clients includes appropriate treatment approaches to address their clients' lived experiences within their intersections of identities and realities. Social justice counseling and advocacy also calls for approaches that are not just focused on treatment, but also promoting awareness, understanding, and positive societal change.

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Digging Deeper with Cognitive Anthropology

Similarly to Ruriani's work in illustrating systemic issues being faced by marginalized communities, cognitive anthropologist Victoria Katherine Burbank presented her ethnographic findings in *An Ethnography of Stress*, which provided evidence that the health inequality that manifested as premature morbidity and mortality experienced by an Aboriginal Australian community at Numbulwar was actually an unintended consequence of earlier Anglican mission socialization endeavors (assimilation) of Australia's indigenous peoples.[13] Her approach to uncovering the layers of historical, social, and cultural systems to interpret the meaning behind the health inequality was framed by a social determinence of health perspective. The perspective underlying this model of understanding health is founded in the concept that structures and systems within society can determine the varying degrees of health experienced by people within that society, and also that some groups of people within that society are disadvantaged and consequently experience greater disparities of health compared to other people groups benefiting from those same social structures.[14]

Burbank also identifies the significance of a person or people's culturally defined and systemically shaped experiences by stating, "Experience is what people have, in the sense of what they think and feel as they interact with their environment… [which] is always a culturally apprehended one, understood largely through knowledge and belief acquired from others."[15] These experiences are representative of their lived realities, and the cognitive constructs inherent to their sociocultural shaping guide their interpretation of how they understand the experiences of their lived realities. So, as Burbank investigated Numbulwar's premature morbidity and mortality, she discovered that the underlying stress instigating the health inequality was understood by the Numbulwar community through their sociocultural constructs. Burbank shares one example in which the sociocultural constructs supported by the Australian Aboriginal belief system informed the local community's considerations of death:

> While we are not surprised to hear that the death of kin is stressful for many, unless we have prior knowledge of Australian Aboriginal belief systems, we would neither anticipate nor understand how substantially ideas about black magic contribute to the distress accompanying such deaths. Without knowledge of local acts, events, and consequences and how local Aboriginal people interpret these, we would not understand how ideas

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> about ganja use and "losing culture" are connected to losses occasioned by death. Nor would we understand how thoughts about family and violence, and associated feelings, such as "angry" and "worry," reverberate in this experience.[16]

Burbank's ethnographic work demonstrates the role of colonization in creating "stress" through its processes of socialization and introducing, and at times enforcing, foreign constructs and practices into indigenous communities. From the perspective of social justice counseling and advocacy, which would take into consideration the Australian Aboriginal community's intersections of lived experiences, the medical model which only treats the body and the psychological diagnosis and treatment of the individual is not enough to address the underlying systemic issue of colonization which helped create the health inequality from the beginning. Burbank's ethnographic work dug deeper by seeking to understand not just the cause of the premature morbidity and mortality from a western framework, but also how the community themselves perceived their experiences and the cause of their experiences. Burbank presents in *An Ethnography of Stress* the significant insight that can be provided for addressing systemic injustices, such as colonization and its long-lasting impact, through investigating the schemata that both inform and are informed by the community's culture, and which guide the community's interpretation of their lived experiences.

Cognitive Anthropology & Layers of Meaning

The multiculturalism and social justice paradigms of mental health counseling call for more intentional interaction with the layers of meaning, which are inherent in the concepts held by culturally diverse clients. Cognitive anthropology has historically been defined as "the study of the relation between human society and human thought,"[17] and it often focuses on cognitive processes, affective experiences, cultural taxonomies and schemata, and meaning among many other subjects. In consideration of Ruriani's graphic illustration promoting attention to lived experiences, intersectionality, and social justice as well as Burbank's investigation of the indigenous schemata of stress at Numbulwar, this section intends to discuss especially the layers of meaning located within a term, such as "trauma," that might commonly be used within the mental health field and inform diagnoses and treatment approaches. The layers of meaning surrounding "trauma" and its treatment will be depicted through five layers: 1) the

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engagement of the term as used within counseling, e.g., "trauma"; 2) the diagnostic perception guiding the understanding of trauma etiology and symptoms; 3) the medical model and expected treatment approach; 4) the worldview providing the foundations to the treatment; and 5) the schemata behind the worldview.

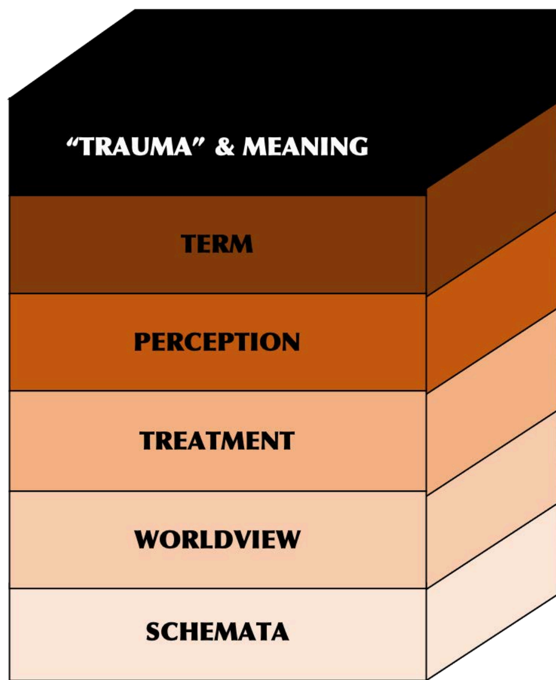

Figure 2. Layers of Meaning in Trauma & Treatment

Layer One: Engaging the Term

This paper posits that in order to begin the exploration of a term's layered meanings, one must begin with the term itself. In the present example, the term "trauma" is being explored. As one considers language and the role of a single word, the gravity of significance becomes apparent when it is realized that a single word can hold multiple meanings within one context and many more potential meanings as other contexts are considered. Looking at the term "trauma," this term holds a basic definition of "wound" and "injury," though further meanings are pulled

out when considering the contexts of treatment. Medical treatment, which focuses on the physical body, would define "trauma" within the scope of physical wounds endured by the body. However, this definition changes when exploring the context of psychology and the existence, origin, and impact of trauma to one's cognitive and affective experiences. Having in mind the different perspectives and paradigms which shaped the field of mental health, one may guess that there are different ideas about trauma held within this context as well. Following the multicultural and social justice paradigms, one such definition of trauma could be understood psychosocially:

> Trauma is socially produced. To speak of psychosocial trauma is to emphasize that trauma is produced socially and, therefore, that understanding and resolving it require not only treating the problems of individuals but also its social roots, in other words, the traumatogenic structures or social conditions.[18]

From this exercise, the context in which a term is used greatly impacts the definition utilized to connect meaning to the communicated message. When multiple contexts intersect, the meaning of a term can become even more difficult to elucidate, especially if the term is altogether foreign to some or all of the contexts experienced by an individual. As such, at times, a term may not be found appropriate if the intended meaning cannot be acquired by the recipient of the message, and another term which closely relates should be contemplated. Furthermore, some contexts contain terms and ideas that other contexts do not as a result of some human experiences not being shared beyond a particular sociocultural group. This too then needs to be weighed when communicating interculturally within the context of multicultural counseling. What one may consider as "trauma" within western society, another may not consider as such.

Layer Two: Engaging the Perception

Below the layer of the term itself and any superficial connotations connected to it according to the context it is used in, the second layer in which to dig deeper is the underlying perception one holds about the term. The perception of "trauma" is one which was only recently formed in the 1980s and prompted the inclusion of it as a disorder– post traumatic stress disorder (PTSD)– within the *Diagnostic and Statistical Manual of Mental*

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Disorders (*DSM*).[19] This manual, which contains the listings of symptoms which manifest according to identified disorders and diseases, presents the following definition of PTSD in its most recent itineration as,

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
>
> 1. Directly experiencing the traumatic event(s).
> 2. Witnessing, in person, the event(s) as it occurred to others.
> 3. Learning that the traumatic event(s) occurred to a close family member or close friend.
> In cases of actual or threatened death of a family member or friend, the event(s) must
> have been violent or accidental.
> 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)
> (e.g., first responders collecting human remains; police officers repeatedly exposed to child abuse).[20]

This definition promotes a perception of "trauma" which involves trauma being treated and medicated through the medical model. However, this perception is one which is criticized as being inherently flawed due to its emphasis upon the individual and their experience without taking into consideration the collective experiences of a community, particularly as a result of overwhelming systemic pressures and dangers upon these communities.

However, what are the alternatives to the perception and definition of "trauma" that offer a more helpful position from which "trauma" can be understood and addressed in culturally appropriate ways that are particularly meaningful to marginalized communities which have been harmed by the medical model-oriented perceptions? One such perception is understanding "trauma" through the lens of general affliction, which locates the issue requiring correction outside of the person and identifies assets within the person or their community that can assist in addressing this external source of affliction. Robert Lemelson and Annie Tucker identify that psychological anthropology offers a number of ways through which mental illness could be viewed beyond the western medical model and indicate that through the use of these alternative perceptions, more effective approaches to address mental health in culturally diverse communities is possible:

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> There have been many anthropological works, both ethnographic and theoretical, devoted to defining culture's influence on factors crucial to mental health or disturbance such as developmental processes, family emotional environments, explanatory models and idioms of distress, and the treatment and interpretation of illness and distress. The traditional interests of the field such as kinship, subsistence patterns, cosmology, and ritual life also contribute to a broader understanding of the multiple contexts of health and illness.[21]

By exploring these alternative perceptions, one may also experience greater awareness that the standard treatment approach for "trauma" is not the expectation globally, and in fact other treatment approaches are perceived as being more effective and appropriate within sociocultural contexts beyond that of western society.

Layer Three: Engaging the Treatment

As mentioned previously, the mental health field has historically been rooted in the medical model, which seeks through diagnostic methods to understand why a patient is ill, unhealthy, or experiencing disease or disorder and then treat the patient according to the treatment viewed as standard for that diagnosis. This model assumed that much of a patient's disorder stemmed from biophysiological causes and that the standard of human health could be best exemplified in males of European descent.[22] This model was conceived on ethnocentric and sexist ideologies which were then perpetuated through colonization and patriarchy as well as unethical lobbying of pharmaceuticals for specific treatments according to the diagnosis based on the American Psychiatric Association's *DSM*.[23] Despite advancements in the field, the reliance upon the medical model has significantly impaired mental health professionals' ability to meet the therapeutic needs of their culturally diverse clients whose worldview supports their expectation of a different treatment model than that which gives a diagnosis and directions for corresponding medication, or a referral for medical treatment by another specialist.

When treating trauma, the most common approach parallels these aspects of the medical model which will treat trauma with medication management and therapy based in cognitive behavioral therapy. Clinical psychologist and professor at the University of Liverpool, Peter Kinderman expresses that the mental health field should depend upon a model of

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treatment that seeks to support understanding the client's underlying needs and providing appropriate care that decreases their distress in lieu of the medical model, which pathologizes the distress, creates stigma, and fosters distance between the client and necessary social support.[24] This understanding allows for the inclusion of culturally appropriate models of treatment which may include folk healing approaches (e.g., Shamanism, Curanderismo, Espiritismo, Ho'oponopono, Santeria, etc.) that focus upon holistic understandings of the issue afflicting the person and seeks balance, harmony, healing, and resolution that is congruent with the person's sociocultural worldview.[25]

Layer Four: Engaging the Worldview

Worldview lies below the surface of the former three layers and directly influences their construction and operation within society and interpersonal interactions. A person's worldview influences their perception and expectations involving an experience, such as "trauma" or "affliction" and its corresponding treatment or resolution. Lillian Comas-Diaz clarifies that worldview "refers to the personal attitudes, beliefs, and behaviors that may unconsciously or consciously influence interactions with individuals of any cultural background," and additionally warns that misunderstanding, misdiagnosis, and failed or discontinued treatment may occur when a mental health professional is unaware of the role of therapist and client worldviews.[26] Koltko-Rivera describes worldview similarly, though he depicts more practically the overarching power that a worldview holds:

> [It is a] way of describing the universe and life within it, both in terms of what is and what ought to be. A given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle), what objects or experiences are good or bad, and what objectives, behaviors, and relationships are desirable or undesirable. A worldview defines what can be known or done in the world, and how it can be known or done. In addition to defining what goals can be sought in life, a worldview defines what goals should be pursued. Worldviews include assumptions that may be unproven, and even unprovable, but these assumptions are superordinate, in that they provide the epistemic and ontological foundations for other beliefs within a belief system.[27]

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To further demonstrate the impact of contrasting worldviews clashing within the counseling context, Comas-Diaz provides the common worldview assumptions that clash between a therapist and their culturally diverse client:

Western Therapist	Culturally Diverse Client
- Everyone is responsible for his or her actions. - Everyone has a choice in every situation. -Everyone is autonomous. -Everyone has his or her own identity. -Many clinicians assume that they are free of cultural bias. -Individualism is presumed to be more appropriate than collectivism. -Community support systems are not normally considered relevant in the clinical formulation of individuals' health. -Ethnocultural ancestry and historical roots of individuals' backgrounds have minimal relevance in clinical treatment. -Geopolitical issues bear no influence in clinical treatment.	- Culture is complex and dynamic. - Reality is constructed and embedded in context. -Every encounter is multicultural. - Clinicians' cultural competence is relevant to all clients. - Clinicians' understanding of nonverbal communication and behaviors is crucial to healing. - A western worldview has dominated mainstream psychotherapy. - Clinicians engage in cultural self-assessment. - Healing is holistic and involves multiple perspectives. - Healing entails empowering individuals and groups.

Figure 3. Contrasting Worldviews in Counseling Context as shown in Lillian Comas-Díaz, Multicultural Care: A Clinician's Guide to Cultural Competence, 1st ed, Psychologists in Independent Practice (Washington, D.C: American Psychological Association, 2012), 25-26.

Figure 3 is particularly insightful to understanding the culture clash which may arise within the counseling process due to conflicting worldviews. One aspect of worldview is the perception one has of "self in relation to other" and the roles of *self* and *other* in decision-making, individual autonomy, communal responsibilities and expectations, etc. As a mental health professional considers "trauma," they need to not only seek the deeper meaning of the term within the context of counseling and the clients' sociocultural context, the related perceptions, and the expected treatment

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approaches, but they must also dig digger to the underlying meaning that culturally diverse clients attribute to an experience, such as trauma, from their worldview.

Layer Five: Engaging the Schemata

Ronald Casson identifies schemata (plural form of "schema") as "knowledge structures" which are the basis of cognitions.[28] David E. Rumelhart similarly calls schemata "the building blocks of cognition."[29] With such descriptions attributed to this nomenclature, one would recognize that this paper argues that when exploring the levels of meaning to be found within a term such as "trauma," the base layer of meaning would be the very knowledge structures, the building blocks, which are necessary to build this concept as well as other concepts. When digging deeper, the mental health professional who desires to demonstrate more than simple multicultural competence, must engage the underlying schemata. Casson explains that human behavior itself is informed by higher and lower forms of schemata as they "serve as the basis for all human information processing, e.g., perception and comprehension, categorization and planning, recognition and recall, and problem-solving and decision-making," and thus can be used to guide the person throughout the lived experiences of their lives.[30] These schemata do not acts as rules, such as what may be found within a person's worldview, but instead are "autonomous and automatic– once set in motion they proceed to their conclusion– and they are generally unconscious, nonpurposive, and irreflexive."[31]

Schemata are often understood as structures or "images" which represent knowledge (acquired data) concerning generic concepts and then are utilized automatically to guide the person is understanding the data being received in their lived experiences. For instance, Freud considered the creation of a "God-image" which is established upon the schemata formed by a person in relation to their father, whereas Ana-Maria Rizzuto explores the meanings that a person may hold pertaining to "God" as a concept and entity which are formed from numerous sources formed by relational schemata.[32] In consideration of these constructive "images," or categories of bound data, which are used to guide a person in understanding themselves and their experiences in the world around them, how might this relate to a mental health professional understanding the "building blocks" concepts that a culturally diverse client may hold? Understanding the importance of schemata and their role in guiding the construction of a person's concepts

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about their own experiences, a mental health professional may seek to understand these schemata through various techniques common to Object Relations, Attachment Theory and experiential Gestalt theory as they seek to uncover the foundational concepts guiding a person. From a cognitive anthropology approach, the explanatory model of a distress approach could be utilized which allows the culturally diverse client to share their perceptions of their experiences through a narrative, while also being able to refer to important sociocultural values, concepts, and wisdom intimately connected to their worldview. Through this method in cooperation with the mental health professional's respectful interviewing, the culturally diverse client's schemata which construct their understandings of their experiences (which may or may not be categorized as "trauma") may be determined. Furthermore, should these schemata be determined, the mental health professional can continue their investigation focused on how those identified schemata guide the client in understanding what is culturally and socially expected in addressing or resolving their distressing experiences.

Application to the Mental Health Field

Thus far, this paper has accentuated the significance of the mental health field moving beyond therapists acquiring multicultural competencies to therapists practicing cultural humility and seeking to utilize culturally appropriate treatment approaches. These approaches can be discerned as culturally appropriate when one considers the schemata upon which the approaches are founded, and if the schemata originate within Western sociocultural constructs or within the indigenous sociocultural constructs of the client. To further promote the practice of cultural humility within multicultural counseling, the therapist should consider the application of the above cognitive anthropological insights to understanding the functioning of communication and treatment approaches in the therapeutic context.

Communication

Within any form of communication, a term, sound, image, or idea may be shared without much contemplation of its communicated meaning, because oftentimes when the communication is held between familiar individuals, the communicator assumes that the recipient understands them. It is only when the communicator or recipient recognizes the presence of a misunderstanding that further meaning is elucidated. When

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dialogue is held between people who are unfamiliar with each other, there is a greater probability for a misunderstanding, though there may also be increased awareness for the need to ensure the intended message has been received. Communication in the context of multicultural counseling must be intentionally utilized– crafted even– to increase therapeutic growth and to decrease harm to the client.

As a therapist and client engage each other in a multicultural counseling context, misunderstandings can be a natural accompaniment to their encounter because of meanings not being transmitted or interpreted properly. The interpretation of meaning is complex, and there are a number of reasons that would prevent any person from correctly interpreting the intended meaning. William B. Gudykunst highlights that misunderstandings can result from a number of reasons that are common particularly within intercultural dialogue:

> (a) The messages may be transmitted in a way that they cannot be understood by others (e.g., pronunciation or accents may hinder understanding), (b) the communication rules of the cultures from which the communicators come may differ and influence how messages are interpreted (e.g., one person is being indirect and the other person is interpreting the messages using direct rules for communication), (c) one of the communicators may not be able to adequately speak the other's language (e.g., one person is just learning the other's language and is not fluent), (d) one person may not understand how to accomplish a certain task or interpret a specific utterance within a social context (e.g., a person who does not speak English well may try to complain to an English speaker and actually apologize), (e) one person may make errors in attributions because of his or her group identity or intergroup expectations (e.g., a North American expects a Japanese to be indirect and does not recognize a direct answer to a question when it is given), [or] (f) the communicators may not be familiar with the topic being discussed.[33]

Each of the above reasons stem from people being unaware of some important component relating to communication, whether it be relating to cultural norms, language, rules of communication, or pronunciation. These communication barriers, which sometimes cannot be avoided, can prevent dialogue partners from being able to closely match the interpreted meaning from the transmitted meaning and can effectively impede the therapeutic progress experienced by a client. Within the context of therapy, Lillian

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Comas-Diaz points out that culturally diverse clients must be able to explain their needs within their own language and ways of communicating, which often connects to a cognitive emotional narrative style of communication that enables them to best construct the meaning they intend to share with the mental health professional.[34] Furthermore, through the mental health professional's utilization of an explanatory model of distress, which is a structured and culturally validating anthropological tool of appraisal, they can understand the expectations and perceptions of the culturally diverse client relating to their illness.[35]

Reflecting on the complex reality of language and lived experiences and that neither of which exist as having analogous meaning between any culture (and even within the same), it would be foolish and culturally ignorant for a therapist to believe that the meaning of "trauma" is held the same outside of their own culture. As much of psychology and therapy was developed according to western constructs, the notion that "trauma" and its related treatment would be understood the same globally is equally foolish. As such, not only should therapists seek to uncover an *emic* understanding of how their client perceives the idea of "trauma" and its connected lived experiences, but so also how these ideas and experiences are communicated between people, and how it should be addressed or resolved in treatment, if there be any treatment identified as necessary.

Culturally Appropriate Treatment

As one considers the challenges to effective intercultural communication within multicultural counseling, one should also consider how the client's worldview and underlying schemata informs their understanding of what comprises appropriate treatment. A western therapist who depends upon practices and treatment approaches that align with western constructs are imposing concepts of disorder and healing which may be counterproductive and harmful to their non-western client. In this way, among other ways, the work of colonization to socialize non-western peoples continues through therapy, which directly opposes the ethic of counseling to "do no harm." Anthony J. Marsella writes, "If the counselor fails to consider her or his role and function as sources of power, she or he can harm a counselee by imposing certain ill-considered methods and content rooted with cultural and historical contexts that sustain the abuses of power."[36] Therefore, as a counselor considers the complexities to understanding the layers of meaning that reside within a term such as

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"trauma" and comprehends the far-reaching impact of imposing outsider views of "trauma" and its treatment upon the lived experiences of others, the work of the counselor becomes clear as including that of decolonizing therapy by practicing cultural humility and responsiveness that informs the use of culturally appropriate concepts and practices.

In an example of a Balinese woman receiving the diagnosis of Tourette's Syndrome (TS) presented in *Afflictions*, Robert Lemelson and Annie Tucker indicate the appropriateness of treatment is very well established in the worldview of the client. In this example, the woman received not only the diagnosis but also underwent the standard care for TS though her condition only worsened. As her symptoms increased in severity, so too did the distress she experienced from stigma and misunderstanding from her family. After the treatment suggested from the western medical model did not satisfy the woman or her family, the woman pursued an approach of addressing her affliction in a more culturally meaningful way: traditional healing involving ritual offerings paired with the explanatory model that integrated and utilized her indigenous structures of meaning and belief system.[37] This example demonstrates the efficacy of traditional healing approaches over the western medical model, which promotes the understanding of treatment and healing needing to target afflicting experiences through cultural-oriented methods that address culture-bound afflictions, ailments, or disconnection from sociocultural values.[38] With such therapeutic success already being achieved by moving beyond the western model of diagnosing and treating mental illness to include traditional healing perspectives, approaches, and techniques, mental health professionals need to consider what they can learn from these non-western traditional approaches to further understanding what it means to be human, and how to address afflictions in more culturally meaningful ways. In so doing, mental health professionals are balancing the power dynamic that is present and not perpetuating structures based in colonization, patriarchy, and other forms of systemic injustice.

Conclusion

As demonstrated by the many contributions of mental health scholars and professionals since the civil rights era of the 1950s, there must be more than *adequate* or *competent* awareness, knowledge, and skill relating to theories and techniques of providing counseling support to culturally diverse clients. The fourth and fifth forces of counseling,

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Multiculturalism and Social Justice, have revealed the significance of sociocultural contexts as well as systemic structures to shaping the lived experiences of marginalized clients who represent intersections of life other than cis-gendered, heteronormative, middle-class white Protestant European/Euro-American males. Particularly, these movements indicate the vitality of mental health professionals exhibiting cultural humility, responsiveness, and reflexivity that is paired with skilled advocacy and allyship with their clients who are experiencing the pressures of systemic oppression.

In this paper, we have traced some historically significant steps within the mental health field towards our present paradigms that encourage professionals to move beyond cultural competencies in counseling. Following the brief recognition of these events, the paper highlighted examples from both fields of mental health and cognitive anthropology in which the directive to "dig deeper" was understood as a necessary task in clarifying underlying systemic issues which manifest symptoms and create health inequalities. The paper continues by elucidating the layers of meaning required to explore when considering the area of "trauma" and its treatment within multicultural counseling and then provided some considerations for practice.

End Notes

[1]Manivong J. Ratts and Paul Pedersen, *Counseling for Multiculturalism and Social Justice: Integration, Theory, and Application*, Fourth edition (Alexandria, VA: American Counseling Association, 2014), 24-25.

[2] This organization later renamed itself to broaden its attention to the needs of other marginalized racial and ethnic people groups, so from 1985 to the present the organization has been known as the Association for Multicultural Counseling and Development. The Association's journal also underwent a name change. Manivong J. Ratts and Paul Pedersen, *Counseling for Multiculturalism and Social Justice: Integration, Theory, and Application*, Fourth edition (Alexandria, VA: American Counseling Association, 2014), 9.

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[3] Donald B. Pope-Davis et al., eds., *Handbook of Multicultural Competencies in Counseling & Psychology* (Thousand Oaks, CA: Sage Publications, 2003), 3.

[4] Lillian Comas-Díaz, *Multicultural Care: A Clinician's Guide to Cultural Competence*, 1st ed, Psychologists in Independent Practice (Washington, D.C: American Psychological Association, 2012), 26.

[5] Derald Wing Sue et al., *Counseling the Culturally Diverse: Theory and Practice*, Eighth edition (Hoboken, NJ: John Wiley & Sons, Inc, 2019), 74-75. Perhaps in alignment with Sue et al., Ella Greene-Moton and Meredith Minkler argue the importance of bypassing the debate between cultural competency and cultural humility by proposing a "both/and" position: "also have been profitably used to encourage self-reflection and reflective practice with respect to ability/disability, sexual orientation and gender identity, and numerous other dimensions too often characterized by inequitable power, privilege, and injustice that affect health and well-being. Both concepts increasingly have stressed the need to challenge the institutions and systems in which we live and work that may, wittingly or unwittingly, enable these injustices to remain." Ella Greene-Moton and Meredith Minkler, "Cultural Competence or Cultural Humility? Moving Beyond the Debate," *Health Promotion Practice* 21, no. 1 (January 2020): 142–45, https://doi.org/10.1177/1524839919884912, 145.

[6] Melanie Tervalon and Jann Murray-García, "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," *Journal of Health Care for the Poor and Underserved* 9, no. 2 (1998): 117–25, https://doi.org/10.1353/hpu.2010.0233, 117.

[7] Carlos P. Hipolito-Delgado, "Beyond Cultural Competence," *Counseling Today*, March 27, 2014, https://ct.counseling.org/2014/03/beyond-cultural-competence/.

[8] Jeffrey J. Arnett, "The Neglected 95%: Why American Psychology Needs to Become Less American," *American Psychologist* 63, no. 7 (2008): 602–14, https://doi.org/10.1037/0003-066X.63.7.602, 602.

[9] Ratts and Pedersen, *Counseling for Multiculturalism and Social Justice*, 19, 28-29.

[10] "About Alyse," *Alyse Ruriani Design*, 2020, https://alyseruriani.com/pages/about.

[11] Alyse Ruriani, "'We Need to Dig Deeper' Mental Health Awareness Post," Facebook, May 8, 2020, https://www.facebook.com/alyserurianidesign/photos/a.547408945302503/3001070526602987/.

[12] Alyse Ruriani, *We Need to Dig Deeper*, May 8, 2020, Graphic Illustration, 600 x 600 pixels, May 8, 2020, https://www.instagram.com/p/B_7wCaSjRtS.

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[13] Victoria Katherine Burbank, *An Ethnography of Stress: The Social Determinants of Health in Aboriginal Australia*, 1st ed, Culture, Mind, and Society (New York, NY: Palgrave Macmillan, 2011).

[14] Richard Wilkinson and Michael Marmot, *The Solid Facts: Social Determinants of Health*, 2nd ed (Copenhagen, Denmark: WHO Regional Office for Europe, 2003).

[15] Burbank, *An Ethnography of Stress*, 6.

[16] Ibid., 96.

[17] Roy G. D'Andrade, *The Development of Cognitive Anthropology* (New York, NY: Cambridge University Press, 1995), 1.

[18] Ignacio Martín-Baró, Adrianne Aron, and Shawn Corne, *Writings for a Liberation Psychology*, 2 Ed. (Cambridge, MA and London, UK: Harvard Univ. Pr, 1994), 125.

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[21] Robert Lemelson and Annie Tucker, *Afflictions: Steps toward a Visual Psychological Anthropology*, Culture, Mind and Society (Cham, Switzerland: Palgrave Macmillan, 2017), 74.

[22] Manivong J. Ratts and Paul Pedersen, *Counseling for Multiculturalism and Social Justice*, 20-21.

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[24] Peter Kinderman, "Why We Need to Abandon the Disease-Model of Mental Health Care," *Scientific American*, November 17, 2014, https://blogs.scientificamerican.com/mind-guest-blog/why-we-need-to-abandon-the-disease-model-of-mental-health-care/.

[25] Lillian Comas-Díaz, *Multicultural Care*, 164-172.

[26] Ibid., 20-21.

[27] Mark E. Koltko-Rivera, "The Psychology of Worldviews," Review of General Psychology 8, no. 1 (March 2004): 3–58, https://doi.org/10.1037/1089-2680.8.1.3, 4, quoted in Manivong J. Ratts and Paul Pedersen, *Counseling for Multiculturalism and Social Justice*, 60.

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[34] Lillian Comas-Díaz, *Multicultural Care*, 47.

[35] Ibid., 47.

[36] Rachael D. Goodman and Paul Gorski, "Foreword: Decolonization of Mind and Behavior: A Responsibility of Professional Counselors," viii.

[37] Lemelson and Tucker, *Afflictions*, 73-81.

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