Beyond Stereotypes: Stigma and Counseling
Mindy Thompson Fullilove, MD

In a society structured by intergroup enmity, every interaction runs the risk of replacing genuine engagement with stereotypical interchange. Stereotyping can be harmful in all human interchanges, but its presence in therapy is particularly destructive. Therapy ought to provide the client with an opportunity to explore and reorder the ways in which the self is experienced. This requires the therapist to get to know and react to the client as an individual, which is impossible to do if stereotyping comes into play. Stereotyping replaces an understanding of the individual with imaginary characteristics of the individual's group. Stereotypes concretize images of groups: they act to prevent exploration of a complex reality and, when applied to a client in therapy, they effectively block the exploration of self. This article presents four observations about the origins and use of stereotypes and how to ensure that they do not damage the therapeutic relationship.

Believing in Stereotypes

First of all, people believe in stereotypes and use them in everyday life. A 1994 survey of people in the United States found that members of all groups endorsed stereotypes about each other. For example, 46 percent of Hispanic Americans and 42 percent of Blacks agreed with the statement that Asians are "unscrupulous, crafty, and devious in business." Among Asian Americans, 68 percent agreed that Hispanics "tend to have bigger families than they are able to support," and 31 percent agreed that Blacks "want to live on welfare." Although the White people polled were somewhat more cautious than others in endorsing stereotypes, a large majority felt that minorities are given the same opportunities as White people to get a good education, a skilled job, and decent housing.

Stereotyping appears to be a universal human activity, practiced from all sides of every marker of social difference—race, class, region, sexual orientation, gender, religion—providing a kind of social shorthand for otherwise complex intergroup differences. It is, admittedly, easier to think of all Asians as having the same slanted eyes than it is to look carefully at the thousands of variations of eye configurations in the world. Stereotypes are the stuff of our jokes ("How many Poles does it take to change a light bulb?"), our rage ("Fuck you, you faggot!"), and our dreams ("This big Black buck of a man was panting after me."). Stereotypes change with the times, taking on the nuances of the moment, emphasizing the "outgroups" of the moment, but never disappearing from our social strategies for intergroup relations.

Malcolm Gladwell, a Jamaican who had lived in the United States and in Toronto, was struck by the differing social constructions of "Jamaican" in those two places. In the United States, people from the West Indies were widely believed to be "model Blacks" and were accorded greater respect and opportunities than other Black people. In Toronto, by contrast, West Indians were tagged with all the stereotypes given to African Americans in the United States: they were shiftless, lazy, prone to live on welfare, deal drugs, and abandon their children. How could one group of people fit such distinctly different social images? Gladwell wondered: "Didn't Torontonians see what was special and different in West Indian culture? But that was a naive question. The West Indians were the first significant brush with Blackness that White,
Editorial: Working with Culture

Robert Marks, Editor

To bridge cultural divides, it is natural to seek to simplify differences, to make them more comprehensible. Unfortunately, the easiest way to navigate such differences is to ignore them, to avoid questioning assumptions about the world. This issue of FOCUS looks at two methods of accomplishing this questionable goal.

The first is to subscribe to stereotypes, one-dimensional descriptors applied to whole populations of “others.” As pre-judgments based on the assumed characteristics of a group, stereotypes are often negative, but not necessarily so, and it is their nature—dependent on the substance—that may be most destructive to human relations. Mindy Thompson Fullilove looks at the dynamic of stereotyping and stigma and extrapolates four observations about the application of stereotypes and their presence in counseling.

The second method is to impose the values of mainstream culture on all individuals regardless of the cultures with which they identify. The result is a kind of cultural totalitarianism from which no one really benefits, but in which most of us are content to participate. Amanda Houston-Hamilton examines this process and proposes that working “downhill” within a client’s culture presents a more effective route toward therapeutic goals than working “uphill” by relying on cultural generalities—even if a client’s beliefs seem to contradict standard “truths” about HIV.

Client-Centered Counseling

Both authors suggest that the ultimate tool for addressing cultural differences in therapy is client-centered counseling. By maintaining the primacy of clients, counselors allow them to define the beliefs and values that are most salient to that particular therapeutic interaction. This is an important insight, one which while it may seem obvious, is most certainly easier said than done.

As Houston-Hamilton states, “Culture is the force that shapes a person’s core, that tells each of us how to be, how to survive.” In a longer version of her article, she also said, “Culture is like your skin; you’re not aware of it until it itches.”

It is this unconscious mingling of culture and identity that may make it so difficult to sustain enough awareness of cultural bias and allow therapists to make assumptions that are invisible even in the midst of the most authentic efforts at client-centered counseling. Ultimately, the most effective counseling may require superhuman efforts to set aside assumptions not only about others but also about ourselves—since a therapist’s world view will undoubtedly influence his or her view of clients. The best we can hope to offer, I think, is consciousness and humility, and both Fullilove and Houston-Hamilton offer perspectives that can lead counselors toward the judicious application of both of these tools.

smug, comfortable Torontonians had ever had. They had no bad blacks to contrast with the newcomers, no African Americans to serve as a safety valve for the prejudices, no way to perform America’s crude racial triage.... In America there is someone else to despise. In Canada, there is not. In the new racism, as in the old, somebody always has to be the nigger.2

Psychoanalysts and others have argued that stereotyping represents the workings of a basic psychological process common to all people.3,4 Some have proposed that stereotypes are the result of the projection of hated parts of the self onto others. The projection of these shadow parts creates the illusion of a wholly “good” self that can be accepted with equanimity. In effect, stereotyping reduces anxiety. At its foundation, stereotyping is useful as a way of reinforcing group boundaries and increasing an individual’s sense of belonging. Human beings strive for membership in human communities. When healthy avenues of cooperation are blocked by social upheaval or other processes, people may turn to shared hatreds as a source of bonding. This leads to Observation Number 1:

Because we all construct stereotypes and then believe in them, we must know which stereotypes we endorse and in what ways they may interfere with helping others. We must also know which stereotypes of our own group we have internalized.

Unconscious Judgments

The second force that nurtures stereotyping is the tendency to make unconscious judgments. People make judgments from within culture-bound value systems but are often blind to this process. Each of us is a product of a particular culture and operates within the rules of that culture. Each culture’s rules are based on principles, that, for the most part, are never enunciated but are assumed to be correct. A corollary to this principle is the assumption that the rules of other cultures are wrong.

References


In order to understand this problem, consider the array of rules from different cultures regarding personal introductions. Should people bow when being introduced? If so, how low should they bow? Who should bow to whom? Perhaps people should shake hands rather than bow? If so, how hard should the hand be held, and in what manner should it be shaken? Raised to perform greetings in a certain manner, we will unquestioningly infer bad manners or disrespect on the part of strangers who fail to act as required by our culture. That they may be acting with perfect propriety as defined by a different set of rules is an interpretation that is unlikely to occur to the average person. Because cultural censure can be severe, a stranger’s “social errors” might lead to estrangement, or even death.

The growing complexity of modern life has made it more likely that we will meet people from disparate parts of world. The historical diasporas of African and Jewish peoples is matched today by people fleeing war, famine, drought, poverty, and oppression, mixing together people from every isolated hamlet on earth. Susan Sontag observed: “Like the effects of depression, mixing together people from every isolated hamlet on earth. Susan Sontag observed: “Like the effects of oppression, mixing together people from every isolated hamlet on earth. Susan Sontag observed: “Like the effects of...”

We will not always know the meaning of words, behaviors, and gestures to which we are reacting. We must, therefore, train ourselves to inquire constantly, “Did that act, word, or gesture mean what I thought it did?”

The Role of Events in Shaping Psychology

Third, our models of individual psychology have undervalued the importance of trauma and other stressful events in shaping character and mental distress. A part of what distinguishes people is the “event structure” of each individual’s life. Minority people, for example, will experience acts of oppression, as well as life conditions, that result from social structures that define and confine them to the margins of society. A gay man, growing up in a small town, will search in vain for images that affirm his sexuality. In his longing for support, he may eventually accept exile from his birthplace as the price he has to pay to live with some measure of dignity and freedom.

John Preston, in an autobiographical essay titled “Medfield, Massachusetts,” described what it felt like to have to leave home in search of a place for himself: “In some ways I moved into my new life with great joy. There was real excitement in it, certainly there was a great passion... I also experienced rage over what was happening to me. I was being taken from Medfield and everything it stood for. I was the one who should have gotten a law degree and come home to settle into comfortable Charles River Valley politics—perhaps with a seat in the Great and General Court. . . . But I was no longer one of them. I had become too different.”

Events like this shape the life course of a gay man. His efforts to make sense of his experience will define his philosophy and the issues he might bring to therapy. In order for therapy to be meaningful, it must have the tools and the sensibilities to explore the event structure of the client’s life. This leads to Observation Number 3:

If we undervalue events, we might miss the key turnings in a person’s life story. Instead, we must study the great and small happenings in the lives of our clients.

The Fragmented Society

The final force that generates stereotypes arises because society is structured...
Understanding the setting of African American churches is key to understanding the experience of many African American gay men.

Why was it so important to signal that a social boundary had been crossed? Clearly it had nothing to do with understanding how the clinic served its community because both clinic and community were located on the “other” side. It is more likely that the title was directed at the stereotypes of the largely White, middle-class readership of the magazine that would never venture into the South Bronx and thought of it as an awful place. Simon meant to entice them on an exotic journey into “otherness,” a little bit like taking a tour with National Geographic.

If the only way a therapist—or any person—gets information about the “other” is through a lens tinted in this fashion, he or she will remain forever in the dark. Rather, if we are to help, therapists must get to know other settings and the people in them.

For example, it is important to understand that African American gay men who were “raised” in the church are often very religious people for whom the church was a second home. They are also often alienated and confused by the homophobia in the church. For many, the dual feelings—loving the church but hating the denunciation of the clergy—undermine self-esteem and interfere with HIV risk reduction and HIV care.

Whether or not there is damage to self-esteem, the church’s attacks on gay men and lesbians have meant that many people do not know how to apply religious teachings to their own lives. One gay man admitted being baffled by his relationship with the church, which he said spawned in him a “kind of schizophrenic child.”

On the other hand, he said it was difficult for him to accept the church because he recognized the barriers it had created for him.

Understanding the setting of African American churches is key to understanding the experience of many African American gay men. The same can be said of other people and other settings. This leads to Observation Number 4: It is hard to get to know people outside of our own group, but we must expand our horizons and our venues.

Conclusion

Each of these four forces acts both independently and together to keep people ignorant about each other. In turn, each force acts to shape the history and content of the therapeutic relationship. It is possible for these stereotypical interactions to undermine the therapeutic alliance. But it is also possible that genuine engagement will promote individual recovery.

Clearinghouse: Cross-Cultural Work

References


HIV and Culture: Working Downhill
Amanda Houston-Hamilton, DMH and Noel A. Day

Culture is the force that shapes a person's core, that tells each of us how to be, how to survive. It is a group's design for living, which defines the perception and interpretation of the group's experience of being human. A successful culture evolves over time to meet needs specific to particular environments and circumstances, new conditions, or the assimilation of other groups and their precepts. Shared meanings and values develop not only within ethnic groups, but also within affinity groups—based, for example, on social class, gender, and sexual orientation. Behavior is culture made manifest, giving visible form and expression to beliefs, values, and attitudes of both client and counselor.1,2,3

Herb Shepherd, a pioneer in the field of organizational change, used to say he had the choice of "working uphill or downhill" when he was trying to modify an organization: like Sisyphus, he could roll the boulder of institutional beliefs and norms uphill, only to be frustrated as it rolled back downhill, or he could take advantage of the momentum of these same values. To work downhill, he would speed the group toward its goals by analyzing an organization's culture and identifying consistent strategic interventions based on its inherent values.

The success of HIV counseling can depend on the capacity of counselors to use, rather than to mitigate, the power of culture. This article explores the idea of working downhill with cultural issues, enabling counselors to uncover the meaning each client gives to HIV-related issues and to work in concert with these meanings.

The Cultural Context of HIV Counseling
The most influential behavior change models in the HIV counseling arena reflect Anglocentric, pedagogical notions, and the idea of changing cultural attitudes—a central HIV education method—is the epitome of working uphill. Anglocentric principles value individual responsibility and control, assume that the medical system is trustworthy, and propose that client-based issues like low self-efficacy or denial are the primary obstacles to behavior change. They suggest that single interventions are appropriate and that information—the more the better—should be presented in a didactic form with knowledge passing in one direction, from presenter to audience.

Any of these assumptions may contradict a client's world view. Working downhill means working within the context of a client's perspective and taking time to define meanings within this world view that will suggest authentic motivations for risk reduction. But, HIV education typically negates alternative theories and alienates a significant part of its intended audience. For example, as a legacy of the Tuskegee Institute’s syphilis experiments, in which Black subjects went untreated for 40 years, many African Americans distrust the medical system, question the role of HIV as the cause of AIDS, and view the epidemic and even standard prevention measures such as condom use as part of a larger genocidal plot against African Americans.4 Counselors can chose either to dismiss such responses as dysfunctional or to explore the meaning of such beliefs, acknowledging the credibility of such

References


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Amanda Houston-Hamilton, DMH, 1988

See also references cited in articles in this issue.
suspicions and joining with clients to discover what each sees as the HIV prevention implications of such a history.

The Counselor’s Challenge

In the scant qualitative work published, ethnic minorities have been considered inherently “hard to reach,” a term that serves simply to distance populations with whom professionals are unfamiliar. Appropriate interventions to many groups have been hindered more by this marginalization than by the cultural attributes that researchers ascribe to them.

Many clinicians avoid interventions with clients whose cultures seem at face value different from their own and, in this way, avoid interactions that might risk failure. But one of the best models for working downhill with cultural values lies in the fundamental premise of client-focused work: the client is at the center of the interaction, and the therapist, as facilitator of change, collaborates with the client, listening for the meanings and metaphors that can establish and promote the intervention plan the therapist and client have developed together.

Interventions that work downhill with individuals from any historically oppressed group should begin by assessing both real and learned powerlessness, the sources of many cultural adaptations, and survival mechanisms that seem to oppose HIV prevention strategies. This assessment also should acknowledge the distinct effects of class, generation, and other elements that bestow privilege or diminish social status.

Interventions are dependent not only on appropriate and precise language, but also on rules of courtesy, sequencing, familiarity, assertiveness and candor, phrasing, grammar, and medium. Each aspect involves an exchange of expectations determined by a combination of personal experience and cultural messages. Clear communication of these expectations and the correct interpretation of cultural meanings in turn develops the rapport necessary for uncovering and harnessing the attitudinal norms that are central to behavior. Communication also instills trust, a prerequisite to accepting and incorporating protective health measures into everyday life.

To work downhill and remain client-focused, consider four steps:

- Find ways to acknowledge regularly to oneself and to clients that each human being comes with both cultural and personal histories, which are integral to a sense of self and a shared world view.

- Incorporate a full range of sensory information and expressive resources to uncover the style and medium that makes prevention approaches most accessible, understandable, and acceptable to the client.

- Don’t be afraid to modify prevention messages, modes, and materials as new information emerges that may make culturally biased concepts clearer to clients with different world views.

- Explore not only the client’s barriers to change but also what power, sex, drugs, and other HIV-related issues mean to the counselor.

According to Barbara Solomon, a non-racist counselor has “the ability to perceive in any behavior—other’s or one’s own—alternative ways to explain that behavior, particularly those [behaviors] which the self might most strongly reject as false.” Counselors establish cross-cultural credentials with clients not by showing off bits of knowledge about the traditional behaviors or beliefs of a group, but by regularly demonstrating an openness to learning about the forces that affect clients and influence their HIV-related risk or protective behaviors.

Authors

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Until his death in 1995, Noel A. Day was Chief Executive Officer of the USRA Group and President of Polaris Research and Development, a policy and applied social science research group in San Francisco and Washington, DC. Mr. Day had been a consultant and university instructor for more than 25 years in education, mental health, and organizational development.

New AHP Book Published

The AIDS Health Project announces the publication of a new anthology on HIV-related counseling: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. The product of 13 years of experience in the epidemic, the book discusses the most complex and difficult issues facing providers working with HIV. Published by Jossey-Bass Publishers, the book retails for $34.95 but is available to FOCUS subscribers for $27.95—a 20 percent discount—plus shipping and handling ($4.00) and tax for California purchasers (8.5%). For multiple, rush, or international orders, call 415-502-4930, or send payment and address to UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Recent Reports

Cultural Competence and Counseling
Sue S. In search of cultural competence in psychotherapy and counseling. *American Psychologist.* 1998; 53(4): 440-448. (University of California, Davis.)

Ethnic match and cognitive match between therapist and client, and the degree of ethnic-specific counseling services are three factors that may relate to treatment outcomes, according to a review article on cultural competence.

There are three basic characteristics of cultural competence. “Scientific mindedness” is the ability to form and test hypotheses about culturally different clients rather than making premature conclusions. This can help avoid mistakes that may occur by applying theories appropriate to one culture to members of a different culture. “Dynamic sizing” is the ability to judge when to generalize and when to individualize. This allows a therapist to avoid stereotyping a client at the same time recognizing the general significance of culture. “Culture-specific expertise” is the knowledge and understanding of the therapist's own culture, of the cultural groups with which he or she works, and of sociopolitical influences as well as the specific skills needed to work with culturally diverse groups.

A key finding in the literature is that matching clients with therapists of the same ethnicity often results in a greater number of sessions attended. A Los Angeles study found that Asian Americans with little assimilation into U.S. culture had more favorable treatment outcomes, lower dropout rates, and more counseling sessions when matched with therapists in terms of ethnicity and language or both than did clients those who were unmatched with therapists. Other studies of Mexican Americans found similar results, although the effects were less substantial. For African-American and White clients, ethnic matches resulted in increased therapy attendance, but ethnic match had no bearing on the treatment outcomes for these two groups. The importance of ethnic matching may depend on acculturation level or the specific ethnicity of the client.

In terms of ethnic-specific services, researchers have found that clients who attend programs that respond to their specific cultural needs have lower dropout rates and stay in programs longer than those who use mainstream services. Treatment outcomes, however, were indistinguishable between the two groups. Research also indicates that matching clients with therapists based on cognitive similarities in terms of treatment goals, coping mechanisms, and problem solving produces better treatment outcomes. In no case did cognitive mismatches or dissimilarities lead to more effective treatment.

Considering the Cultural Barrier Hypothesis

A study of community college students in California found that Mexican American subjects who adhered strongly to traditional cultural values and behaviors perceived higher levels of counselor credibility than subjects who did not relate to these values. This was true regardless of the counselor's model of helping. In general, Mexican American subjects attributed greater credibility to counselors than did European American subjects.

Researchers interviewed 109 Mexican American (38 men, 71 women) and 90 European American (39 men, 51 women) subjects enrolled in sociology, psychology, or Chicano studies courses in community colleges. Both groups reported a mean age of 23 years. The majority of Mexican-Americans reported incomes under $20,000 (39 under $10,000 and 30 under $20,000); while 40 European Americans reported incomes of less than $20,000, 25 had incomes greater than $50,000. Mexican American subjects had various levels of acculturation into U.S. society.

The researchers developed four counseling transcripts containing excerpts from two fictional counseling sessions with two different clients. In each version of the transcript, the counselor responses varied according to the helping model being portrayed. Participants received copies of the transcripts and filled out questionnaires to evaluate the credibility of the counselors. The questionnaires were available in both English and Spanish. Researchers also assessed among Mexican American respondents levels of acculturation and "enculturation," that is, adherence to traditional cultural values and behaviors.

The results of this study contradict the cultural barrier hypothesis and explain...
why minority populations underutilize mainstream mental health services. According to this hypothesis, the higher the level of a person's connection to his or her ethnic culture, the more reluctant he or she is to seek counseling. Because of the inverse relationship between acculturation to mainstream society and perception of counselor credibility among Mexican American participants, it is likely that factors other than cultural values and customs may limit access to mental health services. Some of these may include language barriers, lack of transportation, and lack of financial resources.

The Evolution of Cultural Theory

According to a historical review article, multicultural theory has emerged as a powerful force not merely for understanding ethnic minorities or people of foreign nationalities but also as a general and overarching psychological theory of human behavior. Multicultural theory is a "fourth force" that complements the other three psychological forces of psychodynamic, behavioral, and humanistic perspectives.

As a result of recent trends in cultural theories, culture has become central to understanding humans and the way they interact with the world. Because people are multi-dimensional and interact with many groups and communities, stereotyping people into one category or description is not realistic. According to multicultural theory, a person's identity is based on many different cultural influences because people often belong to several groups simultaneously. Various influences, including ethnographic, demographic, educational, and economic factors, can affect the way a client perceives and interacts with his or her environment.

Multicultural awareness can help prevent counselors and other providers from misunderstanding the behaviors of their clients. Counselors who increase their attention to cultural contexts can also increase assessment accuracy, meaningful comprehension, and appropriate interventions. An accurate assessment requires an understanding of behavior in the sociocultural context in which it occurs without generalizing based on that context. To gain meaningful comprehension, counselors must understand information from the client's perspective. Appropriate intervention needs to focus on the expectations and values behind the behavior rather than on interpretations of the behavior out of context.

A potentially useful tool to help counselors merge social and personal variables is the "cultural grid," a system that helps match social factors with individual variables to describe and understand a person's behavior in a cultural context. There are two types of cultural grids: the Intrapersonal Cultural Grid and the Interpersonal Cultural Grid. Filling in the blank quadrants of the Intrapersonal Cultural Grid can help identify how a specific behavior is the expression of specific expectations, how expectations develop from values, and how values are learned from particular social-system variables.

The Interpersonal Cultural Grid attempts to describe the relationship between people or groups of people by separating expectations from behaviors. Each of its four quadrants describes one part of a relationship between two people or groups. The two axes represent behavior and expectations, each of which can be the same or different. Depending on the combination of these variables, a given relationship will fall into one of four quadrants: shared positive expectations, cultural conflict, personal conflict, or war. By identifying the stage, or quadrant, of a relationship, an appropriate prevention strategy can work with the parties involved to build on shared common ground.

Next Month

Next month, *FOCUS* publishes its annual book review issue, including discussions of several volumes published recently.

Among these books are *HIV and Community Mental Healthcare*, reviewed by James Dotson, MD; *Practitioner's Guide to the Neuropsychiatry of HIV/AIDS*, reviewed by Jillian Daly, MD; *HIV and Social Work*, reviewed by Marshall Feldman, LCSW; *Psychotherapy and AIDS: The Human Dimension*, reviewed by Gary Grossman, PhD; *HIV and Social Interactions*, reviewed by George Harrison, MD; *Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior*, reviewed by Francisco Gonzalez, MD; and *Lessons from the Damned: Queers, Whores and Junkies Respond to AIDS*, reviewed by Patricia Sullivan, MFCC.
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