

CULTURAL INFLUENCES ON THE PROCESS OF CONDUCTING PSYCHOTHERAPY: PERSONAL REFLECTIONS OF AN ETHNIC MINORITY PSYCHOLOGIST

ARTHUR M. NEZU

Drexel University

I was asked to reflect how being a member of an ethnically diverse minority group, that is, Japanese American, may have influenced my clinical practice as a psychologist and psychotherapist. I first define the various facets of my “diversity status,” followed by an offering of reflections on how being a member of this group impacted both myself as a therapist and my clients. I conclude with several general recommendations geared to enhance a positive therapeutic alliance and client outcome.

Keywords: cultural diversity psychotherapy process, multicultural psychotherapy

Although I was honored to be asked to write this article regarding the possible impact of my diversity status on the therapeutic relationship and treatment process, I was also somewhat concerned. The majority of my professional writings are about research findings regarding psychological problems (e.g., Nezu, Nezu, & Jain, 2008), clinical interventions (e.g., D’Zurilla & Nezu, 2007), methodological issues (e.g., Nezu & Nezu, 2008), and the process of case formulation (e.g., Nezu, Nezu, & Cos, 2007)—but *not* about me. Writing about “me,” even from a professional perspective, demands that I actually think

about “me.” In that regard, especially being a psychologist, I have to think about a definition of “me,” at least from the point of view of my “diversity status.” This can be somewhat disconcerting, as well as daunting. Who or what is “me?” In what ways am I diverse? Different? Different from whom? After ruminating about this issue, I realized that might be the purpose of this process—that is, to think about *me*, the impact of *me* on *them* (“them” being my clients), and the impact of *them* on *me*, beyond that which generally occurs within one’s professional office (i.e., treatment). Not just to think, but to investigate, contemplate, and reflect. So—if this is the process, what’s the hoped for outcome? It is my hope that you, the reader, engage in a similar process—that is, to contemplate whom *you* are, in what ways are you *diverse/different*, and how does such diversity impact your work as a psychotherapist. If we venture down this path together, the learning might be more enjoyable (and hopefully less threatening).¹

My Diversity Status

The first assigned task is to describe my diversity status. The fact that I will not define my diversity in terms of the size of my ears suggests that such a dimension is unimportant. However, I am not trying to be flippant here—pertinent to this discussion is the notion that if my ears were rather large (or small, or a different color or shape), others might perceive such a characteristic as defining “me,” despite how I might view its significance myself.

Arthur M. Nezu, Departments of Psychology, Medicine, and Community Health & Prevention, Drexel University.

Correspondence regarding this article should be addressed to Arthur M. Nezu, PhD, Department of Psychology, MS 515, Drexel University, 245 North 15th Street, Philadelphia, PA 19102-1192. E-mail: amn23@drexel.edu

¹ I apologize for this rather “folksy” manner of writing this paper. I usually do not write this way, but I thought the journey would be more meaningful if couched in a more pleasant narrative, rather than my usual “cold” scientific/professional style. Please do not allow this method, if you find it distasteful, to detract from my major thesis.

Japanese American

The most physically obvious diversity dimension about me is my ethnic background. I am a “sansei”—a 3rd generation Japanese American. In other words, both my parents were born in the United States, whereas both sets of grandparents were born in Japan. Note that I do not refer to being Japanese American as my “racial” background, but rather as my “ethnic” background. Although there is no universally agreed upon definition of the term race, it frequently invokes a strong biological framework. In other words, differing races emerge, or are caused by, differing underlying genetic structures. However, increased research into the genetics of race indicate that “there is no genetic or phenotypic character that is unique to anything approaching a racial group . . . there is far more variation within groups than there is between them (Johnston, 2004, pp. 4). Being a psychologist, especially one adopting a biopsychosocial world view of human behavior, it is important for me to promulgate terminology that is not only more accurate, but also less emotionally charged.

Asian American

“Japanese American” does not equal “Asian American.” In fact, there are more than 40 distinct Asian American groups who live in the United States but differ in language, religion, and cultural values (Sandu, 1997). Therefore, another facet of my diversity can be defined by cultural differences that exist among these various 40+ groups. Similar to the differences between Italian Americans and German Americans, between-groups differences within the overall Asian American population can be rather significant (Sue & Sue, 2003). Let me offer a far-reaching example. One current myth about Asian Americans is that they represent the “successful minority,” that is, “we made it!” (Wong & Halgin, 2006). For example, on the Wikipedia webpage regarding Asian Americans, it states that “overall, Asian Americans have the lowest poverty rate and the highest educational attainment levels, median household income, and median personal income of any racial demographic in the nation.”² However, as Sandu (1997) notes, the poverty rate of certain Southeast Asian groups, in fact, is five times *greater* than the general U.S. population and that such individuals are three times *more*

likely to be on welfare. In addition, a closer look at census figures indicate that only 31% of Hmong adults completed high school, and fewer than 6% of Tongans, Cambodians, Laotians, and Hmongs 25 years and older have completed a 4-year college degree (as cited in Sue & Sue, 2003). These latter statistics strongly point to an overgeneralization error by Wikipedia and possibly others.

Taller Than the Average

How else am I different? According to the 2004 Center for Disease Control and Prevention statistics, the average height of males is between 5’7” to 5’8”. I am a fraction less than 6’2”. I am certainly not a giant—so, why is this an important dimension of self-identified diversity? In part, it is my belief that *any* difference, whether one is born with six fingers, is especially tall or short, overweight or underweight, is physically attractive, athletic, a twin, is gay, or has a great singing voice, can potentially serve as an influential psychosocial factor on one’s cognitive, emotional, and behavioral development. Growing up with a wonderful voice is likely to be a positive influence (although not necessarily), but having six fingers will probably lead to various negative encounters. Unfortunately, being tall and of Asian background is viewed as *incongruous*, and therefore, something very “different.” A frequent comment I hear is that I am “very tall for a Japanese.” Because taller is often considered “better” (Egolf & Corder, 1991), this subtly suggests that being Japanese may not be associated with a positive physical stereotype.

Such comments are similar to those made about Barack Obama when he was running for U.S. president—“he speaks well,” the implication being “for a Black man.” Both are examples of what Sue and colleagues refer to as racial micro-aggressions (Sue et al., 2007)—“brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (p. 273). I am not crying

² Although the web-based encyclopedia, Wikipedia, is a not the most scholarly source of information, it is highly accessible to the average web user; hence, it has the ability to reach a wider audience and therefore of importance in this context. Also, note that the term “racial” is used here.

“victim of discrimination” here—but imagine if you were told by a psychiatrist, physician, or other health professional—“you seem to be a good therapist . . . for a psychologist.”

“Interracial” Marriage

Any other differences? This next one, I treasure. I am married to a woman (Christine Maguth Nezu) of European background (part German, part Slovakian, part Roma³), who also happens to be a psychologist (and at the time of this writing President of the American Board of Professional Psychology). This relationship invokes the label of being in an “interracial” marriage (that word “racial” again—see how it’s embedded in our language!). Among Asian Americans, Japanese Americans have a higher rate of marrying non-Japanese during the past few decades. Perhaps one reason is that they also happen to be the largest U.S.-born group among people of Asian backgrounds, thereby making them more acculturated. In any case, my marriage is different than many other Japanese Americans and especially from other Americans from a European background, thus creating another important dimension in my diversity make-up, further underscoring the notion of “diversity among the diverse.”

A particularly significant reason for highlighting this aspect of my diversity is historical in nature. I had never heard of “Loving Day” until years after my wedding. What turned out to be a nondeliberate (due to my own naiveté), but especially wonderful coincidence, is that Chris and I were married on June 12th, which is when Loving Day is celebrated. Essentially, this day celebrates an important Supreme Court decision in 1967 that made it illegal for states (16 at the time of the decision) to enforce laws that prohibited interracial marriages. Richard Loving (White) and Mildred Jeter (Black) were married in Washington DC because their home state, Virginia, in 1958 had a law that restricted their marriage. Their case went through various levels within the judicial system with all such appeals being denied. However, in 1967, the Supreme Court voted unanimously to end those laws that were endorsed by 42 states throughout U.S. history banning marriages between members of “differing races” (for more information, go to www.lovingday.org).

How Does My Diversity Status Affect Me as a Therapist?

Does any aspect of the manner in which I define myself as noted above impact the way I do therapy—my choice of orientation, my case formulation, or the nature of the therapeutic relationship I have with clients? My best judgment call—I’m sure that it does. But how so?

Theoretical Orientation

It is highly possible that my ethnic background initially led me to an affinity for a scientific approach to understanding human behavior, which subsequently influenced my embracing a broad-based cognitive and behavioral orientation. I went to a magnet-type public high school in New York City, Brooklyn Tech, which at the time only admitted males (which was bad for my social life, but good for my academic training), but was specifically geared to provide a strong college preparatory education for individuals seeking careers in various engineering and math professions. This is highly praiseworthy within East Asian American cultures. Being reinforced for good grades in such academic areas likely led me to believe at an early stage that such a career path was for me. Having little to do with the topic at hand, however, I did decide by my junior year in high school to pursue psychology in general and clinical psychology in particular by the time I was a sophomore in college.

On the other hand, growing up in a neighborhood in Queens, New York, where my family was the only one of Asian descent, I had minimal contact with a community-based Asian or Japanese culture. As such, any sociocultural influence regarding a more “Eastern Asian” world view (e.g., Buddhist philosophy, collectivist vs. individualistic orientation, predominance of family over self) was absent. Typical of many sansei in the United States, my parents and grandparents were greatly affected by World War II—my dad was awarded a Purple Heart during his service in the special U.S. Army unit, the 442nd (the special Army unit comprised of Japanese Americans), and my mom spent a few developmentally formidable years in the “internment” camps, as did both their families. Although to this day I do not

³ Roma is the proper term for the group of individuals in Europe often referred to as “gypsies.”

know for certain, it is my assumption that their reaction to these experiences led to an avoidance of anything Japanese and an eagerness to acculturate. However, because higher education, a better life, and the “pursuit of the American dream” were also core beliefs among Asian families during this time, more subtle cultural influences did occur. Thus, that facet of being a Japanese American in the baby-boomer generation that valued education, professionalism, and “the American way,” probably influenced me to adopt a more scientific approach to psychotherapy. However, being the only Asian family in a neighborhood that was White with a sizable Black minority population (we actually lived on the proverbial “dividing line” street between these two groups), I also grew up in somewhat of a cultural vacuum.

Case Formulation

My diversity status has also likely influenced the world view that I have adopted in understanding how “people tick” and how to go about helping them to change. As noted above, I define myself as a cognitive and behaviorally oriented clinical psychologist who advocates idiographically applying nomothetically derived evidenced-based approaches using a theoretically grounded case formulation model. In other words, I tailor scientifically sound therapeutic interventions to the unique features of a given clinical case using a predetermined set of algorithms (e.g., Nezu, Nezu, & Lombardo, 2004). This suggests that until the appropriate types of culturally sensitive clinical trials are conducted that provide for data-based information (Eap & Hall, 2008), rather than blindly applying a given intervention, I attempt first to determine the likelihood that it would be effective for a given client. One guidepost I use in gauging this probability is the degree to which he or she is *divergent* from the sample with which the scientific investigations were based. For example, if the vast majority of participants in the randomized clinical trials demonstrating the efficacy of a given intervention were White heterosexual males, even though the data suggests that the principles upon which the therapy approach were scientifically sound, if working with a Black, lesbian female, the likelihood that I would need to invoke my clinical “tailoring tools” increases greatly.

How does my own diversity affect this process? I would posit that many therapists use sim-

ilar clinical decision-making road maps as above. But, it is my further belief that because of my own differences from the “mainstream,” this alarm gets triggered much earlier and faster. Whether it is because I am more sensitive, thoughtful, insightful, or more responsive to conditioning paradigms regarding diversity, I am not certain. But an awareness of the existence of differences is omnipresent. Being a member of the majority rarely requires someone to question the world view of the majority and frequently reinforces the notion that their worldview is the *correct* worldview. Being a member of the minority group always reminds one that he or she is one of the “others” (Nezu, 2005). Being of a diverse background, I am continuously aware of the potential importance that such differences might play with regard to the manner in which a given client’s clinical story was authored.

Therapeutic Relationship

A behavioral perspective would suggest that the therapist, him- or herself, functions as a “stimulus.” Various characteristics of therapists, such as their age, gender, height, weight, clothing, office space, diplomas on the walls, accent, hairstyle, and so forth, all serve as pieces of information that can be interpreted correctly or incorrectly by a client. Being behavioral in orientation, I believe in this notion strongly; being of a diverse background, however, sensitizes me even further to search for possible reactions on the part of my clients. Again, this is likely to be a common action on the part of most therapists; however, how I interpret, for example, in-session anxiety behaviors, such as wringing of the hands or sweating, might be slightly different. Of course, many would hypothesize that such actions can be “caused” by a variety of factors—the reason the client came to therapy in the first place, concerns about being diagnosed as “crazy,” social awkwardness due to an unfamiliar situation, and so forth. However, one hypothesis that is *always* on my list of potential variables is the client’s reactions to me personally (i.e., to my stimulus characteristics), particularly as research has documented the negative impact that skin color and facial features have on perceptions (e.g., Ahnallen, Syemoto, & Carter, 2006; Sherman & Clore, 2009). Therefore, my own diversity has strongly influenced me to be highly attentive to this aspect of the therapeutic process, both in

terms of how it can facilitate therapy progress, and how it might hinder it.

Psychotherapy Technique

Valuing education and knowledge, whether it is because of my background (i.e., the Asian American community values education), I give significant credence to the idea that a substantial role characterizing what I do as a therapist should be as an “educator.” In other words, it is important for me to explain to clients why I believe they are experiencing the problems that they are, what factors influence their maintenance and exacerbation, what can and should be done to affect their problems, and why such strategies are supposed to work. For example, research has demonstrated that Asian Americans, because of their unfamiliarity with the concept of counseling in general, have difficulty understanding the counseling process and as a consequence, tend to rate the credibility of counselors and the therapeutic alliance as low (Wong, Beutler, & Zane, 2007). Therefore, it becomes particularly important to “educate” them about counseling or therapy from the very beginning.

How Does My Diversity Status Affect My Clients?

As noted above, I believe that I as a therapist represent a variety of stimulus characteristics, some of which are more likely to be salient and relevant within the context of therapy. However, to know me is to recognize that I am not White; that is, it is difficult to ignore my Asian facial features. How this impacts a potential client when he or she first meets me (assuming they do not know my ethnic background beforehand) can vary considerably.

Theoretical Orientation and Case Formulation

Whereas consumer knowledge about differences among theoretical orientations is likely becoming more sophisticated as a function of the Internet, I continue to find that when asked, most individuals seeking therapy do not know the difference between a psychiatrist and a psychologist or among a Freudian analyst, a Skinnerian behavior analyst, or a Beckian cognitive therapist. However, given my facial characteristics, I have been told (after therapy has successfully ended

and I elicit program evaluation information), that I am someone who is exceptionally (this adjective is my clients’ perceptions and not my ego talking) “calm and collected,” that I am wise and highly educated, and that I am a good teacher. Rather than believing that I am a phenomenal therapist (remember that Asians are also supposed to be somewhat self-effacing), it is possible that such accolades are partially a function of positive stereotypes about Asians that people bring to therapy.

As a cognitive–behavioral therapy-type psychologist, I frequently teach clients behavioral stress management techniques, such as relaxation training, deep breathing, and visualization. Such procedures are often infused with a “mindfulness” philosophy (i.e., a focus on the “here and now”), which has been scientifically found to be effective (Kristellar, 2007). However, a mindfulness approach also is similar in philosophical territory to more East Asian religions, such as Taoism, Buddhism, and Shinto. Do I (non)consciously foster the perception that I am particularly “mystical” and that I have a more deeper understanding of such strategies, or is this a perception on the part of certain clients?

Another related Asian “stereotype” not infrequently voiced by my clients is a surprise that I am not practicing more “complementary and alternative” types of strategies (a large proportion of my clients are medical patients suffering from a variety of chronic illnesses) because I am of Asian background. One client even told me that I should wear a silk robe, grow a long beard, and adopt a slight accent—that way I could make a lot more money.⁴

Therapeutic Relationship

The above reactions represent more positive influences related to my diversity background—what about negatives? Decades ago, when I was a naïve intern, I was the psychology representative on a substance abuse unit that was part of a large state psychiatric hospital located in a remote rural area in Connecticut (imagine what it was like to be the “lone” Asian once again). One

⁴ On occasion, I have to admit, I have fantasized that such an approach would help get me on “Oprah,” especially when a royalty check for one of my academic books only allows me to treat my wife to a nice bottle of wine (not even a whole dinner!).

of my responsibilities was to conduct individual psychotherapy with members of the inpatient population. One rainy, warm afternoon, I heard a knock on my office door indicating that a new client I was waiting for was arriving on time. When I answered the door, I was faced with a White male, about 32 years old, who was taller than me (remember that I am close to 6' 2"), solidly built (at the time I was rather thin), and short-cropped hair. I quickly remembered reviewing his file, but only then realizing the significance of his look of anger and horror when I answered the door. This individual had been a captain in the Green Berets and had served two tours of duty in Vietnam. On a warm rainy afternoon, my facial features took on a heightened significance to this client and quickly escalated to a negative first impression. Needless to say, if I was White, we would not have had to work on the therapeutic relationship as much as we did. However, in addition to the personal satisfaction I ultimately felt in helping him overcome substance abuse and posttraumatic stress disorder, I also learned a valuable personal lesson. I *am* a stimulus—whether I have Asian facial features, wear a tie, have pictures of my family on my desk, or have a picture of a sunset of the beach as my screensaver—I *am* a stimulus!

What happens if a client is also of a diverse background? As would be suggested by the above—sometimes the effect is positive and sometimes it is negative. With individuals of diverse ethnic backgrounds, but not Asian Americans, I sometimes get the feedback that I am viewed as someone who is more sensitive than other professionals because I am an ethnic minority. On the other hand, I sometimes come to find out that an initial impression is that I remind them of certain people they met. Before I open my mouth, they think I would engage in a similar communication style as that “Chinese grocer in my neighborhood that I can’t understand” or the “Korean dry cleaner who always overcharges me!” On the other hand, certain individuals have (mis)interpreted my “calm” style as “emotional coldness.”

If the client is of an Asian background, similar scenarios have also occurred. On the more positive side, certain individuals perceive that I am better able to understand and empathize with their situations because of the congruence in ethnicity. On the other hand, there have been times when I have lost Asian American clients after the first session because they felt that my cognitive-behavioral orien-

tation is counter to a more traditional Asian belief system with regard to medical and spiritual explanations of psychopathology and wellness. Once again—“diversity among the diverse!”

General Guidelines

Based on the above, here are some general guidelines that I have followed that are relevant to both therapists with and without a diverse background who have clients who are either congruent or noncongruent with their diversity (or lack of).

1. *Remember that diversity does not equal biological determinism.* As noted earlier, genetic make-up cannot serve as guideposts to classify individuals according to racial orthogonal divarications involving psychosocial variables, such as intelligence and personality. In recognizing the influence of biological factors on human functioning, remember that “between-subjects” variability exists largely due to sociocultural variables, rather than biology.

2. *Respect subcultural diversity.* Not all apples look or taste the same. This simple (and rather obvious) statement should also be applied to people of similar cultures. Gay men do not equal lesbian women, Japanese Americans do not equal Hmong immigrants, and Mexican Americans do not equal Guatemalan Americans. The best way that I have found to learn about a particular client is to ask questions about their background and the meaning such factors have to them. I have developed an intake form that specifically includes such questions.

3. *Be sensitive to all differences.* Be aware that any difference, especially one that existed during one’s development, is potentially important, be it large ears, sexual orientation, or ethnic diversity. However, certain differences are more culturally bound, steeped in an historical context, and more pervasively influential. I have found Hays’ (2001) acronym, “ADDRESSING,” to be an effective way of reminding me to inquire about all the salient diversity characteristics (*A* = Age and generational influences; *D/D* = Developmental or acquired Disabilities; *R* = Religion and spiritual orientation; *E* = Ethnicity; *S* = Socioeconomic status; *S* = Sexual orientation; *I* = Indigenous heritage; *N* = National origin; *G* = Gender). Such information can provide for a more rich, comprehensive, and accurate picture of one’s clients.

4. *Inquire about a variety of diversity characteristics.* By using the above acronym, not only would you be able to identify important client characteristics, but also how they influence each other. Remember (and apply) the phrase—“diversity among the diverse!”

5. *Inquire about the meaning of diversity for a given client.* It was only as a young adult did I become more familiar with what it meant to be Japanese American. My youth, from a cultural perspective, was likely to be much different than a sansei growing up in “Japantown” in San Francisco.⁵ I would suggest that you respect how clients view their own diversity status. Clients being concerned with how they are viewed by the therapist does not translate to an “oversensitivity or paranoia.” It simply reflects how they have been treated by the “majority” in the past.

6. *Understand the politics of a client’s diversity status.* Not only can a given diversity status be steeped in a heritage of cultural differences, but is also likely to be associated with discrimination, prejudice, and minimal political clout. Given that the therapeutic relationship has political overtones as well (e.g., imbalance in “power” between the therapist and client), acknowledge and be sensitive to the exacerbation of this imbalance as a function of differences in key characteristics between you and your clients (e.g., older White male therapist seeing a younger Black, female client in a college counseling center). I have always found it helpful to *ask the client directly* how he or she feels about me as a possible therapist.

7. *Become more “involved.”* There is an old Chinese saying (also attributed to Ben Franklin)—“tell me and I forget, teach me and I remember, involve me and I learn.” I suggest that you, the reader, download the most recent set of guidelines espoused by the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAEMI, 2009) and “become involved” by taking some of the included self-tests about minorities. I believe that by doing so, you can “learn” to become more culturally competent and even more asseverative about diversity (Nezu, 2005).

Caveat

There is an important caveat to mention here that is relevant to much of this article. Whether it involves attitudes or beliefs about race, ethnicity,

gender, or other personal characteristics, it is entirely possible that clients (and even young clinicians) do not have “ready access” to such cognitions. In other words, there may be a difference between one’s implicit and explicit attitudes. The Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998), used to assess the validity regarding a wide range of attitudes in predicting behavior, continuously demonstrates that implicit associations are a better predictor of actual behavior as compared to explicit attitudes (Greenwald, Poehlman, Uhlmann, & Banaji, 2009). Substantial research further indicates that “even those who sincerely possess tolerant or antiracist views can nevertheless harbor implicit biases (often to their own surprise and chagrin)” (Kelly & Roeddert, 2008; pp. 525–626). As such, to paraphrase a reviewer of an earlier draft of this article—“how does one take such biases into account if he or she is not aware of them?” I believe that reading these types of articles are a start; following the guidelines presented are a second major step. I would also encourage readers who have not taken the IAT to do so at www.implicit.harvard.edu. You may learn something about yourself—I took test and was surprised myself!

⁵ I joke with my wife that she likely is a reincarnated, older Italian male who loves wine, olives, and sitting in the sun talking with friends. As you might guess, despite her own ethnic background (previously described), she grew up in a predominantly Italian-American neighborhood in New Jersey.

References

- AHNALLEN, J. M., SUYEMOTO, K. L., & CARTER, A. S. (2006). Relationship between physical appearance, sense of belonging and exclusion, and racial/ethnic self-identification among multiracial Japanese European Americans. *Cultural Diversity & Ethnic Minority Psychology, 12*, 673–686.
- Council of National Psychological Associations for the Advancement of Ethnic Minority Interests. (2009). *Psychology education and training from culture-specific and multiracial perspectives*. APA Office of Ethnic Minority Affairs. www.apa.org/pi/oema
- D’ZURILLA, T. J., & NEZU, A. M. (2007). *Problem-solving therapy: A positive approach to clinical intervention* (3rd ed.). New York: Springer Publishing.
- EAP, S., & HALL, G. C. N. (2008). Relevance of RCTs to diverse groups. In A. M. Nezu & C. M. Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized clinical trials for psychosocial interventions* (pp. 425–443). New York: Oxford University Press.

- EGOLF, D. B., & CORDER, L. E. (1991). Height differences of low and high status, female and male corporate employees. *Sex Roles, 24*, 365–372.
- GREENWALD, A. G., MCGHEE, D. E., & SCHWARTZ, J. L. K. (1998). Measuring individual differences in implicit cognition: The Implicit Association Test. *Journal of Personality and Social Psychology, 74*, 1464–1480.
- GREENWALD, A. G., POEHLMAN, T. A., UHLMANN, E. L., & BANAJI, M. R. (2009). Understanding and using the Implicit Association Test: III. Meta-analysis of predictive validity. *Journal of Personality and Social Psychology, 97*, 17–41.
- HAYS, P. A. (2001). Addressing cultural complexities in practice: A framework for clinicians and counselors. Washington, DC: American Psychological Association.
- JOHNSTON, F. E. (2004, September). *Race and biology: Changing currents in muddy waters*. Paper presented at the conference entitled “Race and Human Variation: Setting an Agenda for Future Research and Education,” American Anthropological Association, Alexandria, VA.
- KELLY, D., & ROEDDERT, E. (2008). Racial cognition and the ethics of implicit bias. *Philosophy Compass, 3*, 522–540.
- KRISTELLER, J. L. (2007). Mindful meditation. In P. M. Lehrer, R. L. Woolfolk, & W. E. Sime (Eds.), *Principles and practice of stress management* (pp. 393–427). New York: Guilford Press.
- NEZU, A. M. (2005). Beyond cultural competence: Human diversity and the appositeness of asseverative goals. *Clinical Psychology: Science and Practice, 12*, 19–24.
- NEZU, A. M., & NEZU, C. M. (2008). Ensuring treatment integrity. In A. M. Nezu & C. M. Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized clinical trials for psychosocial interventions* (pp. 263–281). New York: Oxford University Press.
- NEZU, A. M., NEZU, C. M., & COS, T. A. (2007). Case formulation for the behavioral and cognitive therapies: A problem-solving perspective. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (2nd ed.; pp. 349–378). New York: Guilford Press.
- NEZU, A. M., NEZU, C. M., & JAIN, D. (2008). Social problem solving as a mediator of the stress-pain relationship among individuals with noncardiac chest pain. *Health Psychology, 27*, 829–832.
- NEZU, A. M., NEZU, C. M., & LOMBARDO, E. R. (2004). *Cognitive-behavioral case formulation and treatment design: A problem-solving approach*. New York: Springer Publishing.
- SANDU, D. S. (1997). Psychocultural profiles of Asian and Pacific Islander Americans: Implications for counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 25*, 7–22.
- SHERMAN, G. D., & CLORE, G. L. The color of sin: White and black are perceptual symbols of moral purity and pollution. *Psychological Science, 20*, 1019–1025.
- SUE, D. W., CAPODILUPO, C. M., TORINO, G. C., BUC-CERI, J. M., HOLDER, A. M. B., NADAL, K. L., & ESQUILLIN, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286.
- SUE, D. W., & SUE, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.
- WONG, E. C., BEUTLER, L. E., & ZANE, N. W. (2007). Using mediators and moderators to test assumptions underlying culturally sensitive therapies: An exploratory example. *Cultural Diversity & Ethnic Minority Psychology, 13*, 169–177.
- WONG, F., & HALGIN, R. (2006). The “Model Minority,” bane or blessing for Asian Americans? *Journal of Multicultural Counseling and Development, 34*, 38–49.