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Counseling Practices to Ameliorate the Effects of Discrimination and Hate Events:
Toward a Systematic Approach to Assessment and Intervention

Edward Dunbar

University of California at Los Angeles

Correspondence should be directed to Edward Dunbar, Ed.D., Department of Psychology and Center of Inter-Ethnic and Inter-Racial Conflict Resolution, University of California at Los Angeles, California, 90024. The author would like to thank Dr. Megan Sullaway for her comments and recommendations in the preparation of this manuscript.

Abstract

A treatment model for the psychological sequelae of discrimination is illustrated via three treatment cases in which experiences of racism, gender and/or ethnic/religious hostility were a primary focus of intervention. The client's level of psychological functioning, acuity of hate victimization, coping and identity re-formation strategies are addressed in this phase-oriented model of counseling. The five treatment phases are: (a) event containment and safety, (b) assessment of client-event characteristics, (c) addressing diversity in the counseling alliance, (d) acute symptom reduction, and (e) identity recovery and reformation. Counseling tasks with clients of hate victimization include the amelioration of acute post-event symptoms, re-framing of aversive outgroup attitudes, alleviating disturbance of ingroup identity, and the eradication of avoidant intergroup behaviors. It is proposed that the effective treatment of victims of chronic harassment and acute hate incidents requires the integration of behavioral, cognitive, and multicultural counseling modalities.

Counseling Practices to Ameliorate the Effects of Hate Events

And Discrimination: Toward a Systematic Approach to Assessment and Intervention

The past two decades have seen a refinement of theory concerning multicultural counseling and psychotherapy (Comas-Diaz & Jacobsen, 1991; Sue & Sue, 1991, Atkinson, Morten, & Sue, 1993; Sue, 1998). One of the more promising consequences of these efforts has been the articulation of treatment strategies which are exemplars of effective intervention with specific ethno-cultural groups and/or cultural problems (Coleman, 1995). A significant issue for practitioners serving multicultural populations concerns our ability to address our client's experiences of hate victimization in organizational, community, and interpersonal relationships. This very serious societal problem is most frequently encountered by members of "at risk" minority outgroups; persons of color, the disabled, and gay men and lesbians. Additionally hate aggression mitigates against positive intergroup attitudes for not only victimized individuals but also their families and communities.

Social problems of racism, heterosexism, gender, and ethnic bias implicitly have been a topic of concern to multicultural practitioners and theorists. Yet until very recently there has been little effort to explicitly consider this issue in terms of counseling practice. As suggested by community-based research (Carlson & Rosser-Hogan, 1994) the impact of intergroup conflict upon the targeted individual has important implications for psychological practice, particularly for psychologists in multicultural settings (Ryan & Bradford, 1993; Kim-Goh, Suh, Blake, & Hiley-Young, 1995). This paper presents a five-phase intervention model, which integrates cognitive-behavioral and multicultural approaches, to treat clients who have been the victims of harassment and hate crimes. The model is based upon empirical study of hate victimization, consultation with service delivery professionals with hate crime victims, and most importantly treatment with victims

of hate acute aggression and chronic harassment. The contribution of the interventions to the recovery from hate victimization is considered in three treatment case studies.

Legal and Behavioral Characteristics of Hate Victimization

The treatment of victims of intergroup conflict requires that the practitioner consider not only the psychological but also legal implications of the critical event. In the U.S., federal and state legislation have established legal criteria for bias-motivated crimes. Hate crimes are frequently characterized by physical assault, homicide or attempted homicide, anonymous symbolic forms of harassment, and damage to property (Levin & McDevitt, 1993). The victims of hate crimes are protected under criminal and in many states civil law. To be classified as a hate crime, the offense must evidence an animus by the perpetrator for the victim's ingroup. By contrast, forms of non-criminal hate victimization which do not result in damage to property or harm (or threat of harm) to the person are referred to as hate incidents (Los Angeles County Human Relations Commission, 1994). Hate incidents include experiences of interpersonal denigration, occupational discrimination, and more insidious forms of bias (Cervantes, 1995).

Determination of community-wide base rates of hate crimes and hate incidents is of value not only to policy makers but also professionals involved in service delivery to at-risk populations. Klonnoff and Landrine (1995) provide evidence of the frequency of gender-based hate incidents experienced by women. Ninety-nine percent of their 631 subjects reported having experienced gender-based discrimination during their lives, with 97 percent having experienced some form of gender-based discrimination during the past year. For gay men and lesbians, the incidence of verbal harassment in a 1 year period was reported as 62% and 52%, respectively; 18% of the gay men and 13% of the lesbians in this same sample reported being the victims of an anti-gay crime in the prior 5 year period (Herek, Gillis, & Cogan, 1999). In a study with 318 practicing psychologists, 52

percent of the responding practitioners reported that psychotherapy treatment had addressed client experiences of intergroup race/ethnic conflict (Dunbar & Sue, 1996). These studies indicate that hate victimization occurs more frequently than do many of the recognized psycho-social stressors, such as unemployment, identified in the DSM IV (American Psychiatric Association, 1994).

Sequelae of Hate Victimization

Allport (1954) proposed that victims of discrimination employed an ego defense (or what might now be described as an attributional belief) which was either extrapunitive or intrapunitive. Extrapunitive attributions result in the victim blaming the social environment, while intrapunitive attributions result in victim self-recrimination and denigration. Contemporary researchers have noted that victims of chronic discrimination may experience a constellation of psychological symptoms including feelings of helplessness (Root, 1992), numbing, paranoid-like guardedness (Newhill, 1990), medical problems (Kriegler, 1990; Shrier, 1990) dysphoria, poorly mediated affects (Wyatt, 1994), and denigration of one's socio-cultural ingroups (Bell, 1980). In instances of recurring harassment, the victimized individual may become habituated to their victimization, resulting in dis-regulation their harm-avoidance skills. These would include failure to evaluate risk in novel situations or the use of an active coping response to defend against provocation. Root, in her work with victims of chronic racism and ethnic discrimination, has suggested that many clients evidence symptoms characteristic of posttraumatic stress disorder (1994). Other researchers of trauma have proposed a disorder independent from PTSD, which is attributable to chronic psychosocial stressors. Scott and Stradling (1992) have referred to this as the "Prolonged Duress Disorder."

Just as the severity and chronicity of hate victimization may vary, so too differences of individual vulnerability need to be considered in mental health treatment. As I have observed, the

client's level of psychological functioning prior to the hate incident may play a significant role in treatment outcome. Individual difference variables and prior trauma victimization may both heighten vulnerability to subsequent traumatic events (Ullman, 1994). Clinical researchers have noted that clients experiencing problems characteristic of DSM-IV Cluster B personality disorders, such as Borderline (Lonie, 1993) and Narcissistic Personality Disorder (Johnson, 1995), may be particularly prone to evidence trauma-type symptomatology in response to life stressors which are not objectively traumatic in terms of severity of threat to the individual. Furthermore, ingroup identity status may heighten awareness of and response to intergroup conflict. Highly ingroup identified clients marked by ingroup idealization may evidence greater affective disturbance secondary to aversive intergroup hostility (Bell, 1980).

Coping with Hate Victimization

An issue of significant importance to counseling practice is the client's ability to effectively cope with the experience of hate victimization. The coping research which examines adjustment to normative life tasks is of questionable applicability with clients who have experienced hate victimization. Rather, the individual's ability to effectively engage the perpetrating party, mediate the conflict in situ, or seek institutional redress is of significantly more importance than if the coping response is per se affective or cognitive, for example. In the study of victims of criminal assault, client employment of an active and self-efficacious coping style is related to better recovery (Sales, Baum & Shore, 1984). Additionally, there is evidence that coping with hate victimization varies by race/ethnic and gender groups. Dunbar, Liu, and Horvath (1995) have noted that active coping is more typically employed by members of empowered ingroups, while Liu and Dunbar (1994) reported that for Asian-Pacifics, greater ingroup ethnic identity was related to use of a more active coping response to hate victimization.

Victims of overtly hostile and injurious hate crimes (as in cases of bias-motivated physical assault) often manifest a coping response marked by avoidance of outgroup persons (Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994). As Herek (1999) and his colleagues found, hate crimes against gays and lesbians significantly compromise the level of trust of the larger social environment and yields more chronic psychological impairment than do similar non-hate related forms of criminal victimization.

Counseling Interventions to Ameliorate Hate Event Sequelae: A Phase-Specific Approach

The effective treatment of victims of hate events incorporates a variety of counseling goals which are subsumed by two superordinate tasks. The first counseling task is the alleviation of the psychological sequelae of hate victimization. This includes reduction of trauma symptoms of intrusive ideation, physiological arousal, numbing and avoidance behavior. The second counseling task concerns the client's re-establishing an adaptive ingroup identity, the employment of culturally congruent coping behaviors, and engagement in benign intergroup contact experiences. The phases of the treatment model are described below and summarized in Table 1.

Phase 1: Containment and Safety. As in other crisis intervention models (Parad, 1965; Scott & Stradling, 1992), the initial task of the practitioner concerns client determining safety and capacity for self-care. In this treatment model, practitioner tasks include assessment of client risk for self-injurious/self-defeating behavior, potential for retaliatory aggression, and impairment of basic life functioning (e.g. work dysfunction or school truancy). As my experience has indicated, it is essential that the practitioner determine with the client the risk of further threat from the identified perpetrators. This has been most pronounced in cases of workplace harassment and community-based provocation, where the perpetrating party may continue to have contact with the client. In such instances, physical removal of the client from the environment may be necessary

prior to proceeding with counseling treatment. One of the hallmark features of the hate event experience is its de-humanizing nature. Victims of acute hate events may manifest symptoms typically characteristic of severe psychopathology, even when the client's pre-event level of functioning was highly adaptive. Initial appraisal should therefore explore for the presence of trauma-related symptoms such as intrusive ideation, avoidance of reminders of the event, numbing and dissociation, and physiological arousal. Additionally, in culturally-crossed counseling dyads, the practitioner should discuss the client's options of being in treatment with a person of his/her own race/ethnicity, religion, sexual orientation, or gender group. As discussed below, this issue remains salient throughout the course of treatment.

Phase 2: Assessment of Client-Event Characteristics. The comprehensive appraisal of the hate victim includes analysis of the critical hate incident and measurement of the client's symptomatology and defining psychological resources. Practitioner tasks include determining the frequency of hate-based events, behaviorally defining the critical hate event *as experienced by the client*, and determining what social support is available to assist in the remediation of acute symptoms. In their study of hate incidents Dunbar, Sue, and Liu (1994) identified five factor-derived types of hate victimization. The factor dimensions were described as interpersonal harassment, exclusion from social groups and networks, co-opting of personal achievement, personal invisibility, and restriction of opportunities for personal achievement. Subsequent research identified three factors of affective response to intergroup conflict; these were: anxiety/tension, dysphoria/sadness, and anger/aggression. These affective responses were found to mediate the victim's reported efficacy in coping with the hate event (Liu, 1995). These dimensions of victimization and affect response are used in a clinician rating scale in the proposed model. Client assessment for prior trauma history, as well as determination of the chronicity of discrimination can

assist the practitioner in defining subsequent (phase four and five) counseling intervention goals. It is particularly important to thoroughly explore the client's prior intergroup contact experiences and to determine whether the client was either victim or witness to experiences of violence and abuse. As has been noted, prior history of abuse is prognostically meaningful in terms of less effective help-seeking behavior and recovery from traumatic events (Cascardi, O'Leary, Lawrence, & Schlee, 1995).

In phase two, psychometric assessment includes use of symptom-focused measures and clinician ratings scales which specifically pertain to intergroup conflict and/or trauma history. The following case illustrations employed the MMPI, which, in a recent meta-analysis has been deemed a viable clinical measure with persons of color (Nagayama Hall, Bansal, & Lopez, 1999) than other symptom measures. As such, the selection of symptom measures needs to be considered contingent upon the socio-cultural characteristics of a given client (Sue & Okazaki, 1995). Additionally, ongoing client assessment is one of the most important tasks of the counseling psychologist (Trevino, 1996). Assessment in treatment of hate events is a particularly dynamic process, in which careful monitoring of change in symptomatology, ingroup identity, and intergroup contact is essential in appraising the efficacy of treatment.

Phase 3: Addressing Diversity in the Counseling Alliance. Treatment must explicitly deal with in-the-room issues of diversity as it influences the working alliance. From my experience, the impact of the practitioner's race and ethnicity upon the therapeutic relationship is obviously important. Practitioner-oriented researchers have noted the importance of counselor competence to adequately discuss race with their clients (Brantley, 1983), and to effectively determine the impact of chronic discrimination events upon the client's level of functioning (Shannon, 1973). Accordingly, the role of the counselor's race, sexual orientation, ethnicity, and gender are often

magnified in instances in which discrimination and hate-related crime are the foci of treatment. The failure of White practitioners to comprehend the experiences of discrimination of their client's of color has been noted by Ridley (1984), resulting in the reinforcement of a worldview in which intergroup contact is suspect and ineffectual. Furthermore, as has been made clear by the work of Helms (1989), the impact of both the practitioner's ingroup (i.e. race) membership and ingroup (i.e. racial) identity influence counselor efficacy.

Phase three practitioner tasks include the self-assessment of competence in terms of culture-related information and capacity to implement interventions in a culturally salient manner (Johnson, 1987). Particularly important in this regard is the practitioner's examination of counter-transference experiences in working with victims of severe hate events. As I have found in consultation with victim assistance staff, practitioner reactions of ingroup guilt, political reification of the client and his/her experience, feelings of helplessness, and heightened awareness of personal biases and prejudice are particularly relationship-damaging in working with victims of hate events. Prior research has indicated that counselors more favorably assess victimized individuals, independent of the level of the client's psychopathology (Ofri, Solomon, & Dasberg, 1995), and that practitioners may internalize the trauma symptoms of their clients, particularly in cases of violent hate events (Comas-Diaz & Padilla, 1990; Straker & Mossa, 1994).

An additional phase three practitioner task is the articulation of culturally salient themes of the client's ingroup resilience. By this I mean the practitioner actively encourages the client to relate their personal experience of victimization to that of members of their ingroup. This strategy is threefold, in that it serves to: (1) establish a commonality of personal victimization with that of a meaningful social network, (2) draws upon lessons learned from other credible ingroup persons about how to cope with adversity, and (3) reinforce the concept of change and adaptation as being a

desirable means to resolve problems associated with intergroup conflict. These themes of resilience provide the client with a chance to talk aloud how other people like them have dealt with challenge and coped. They may be embedded in folk stories, art, literature, ingroup significant others, music, or culturally proscribed traditions to solve problems.

Phase 4: Acute Symptom Reduction. Subsequent to safety determination, initial evaluation, and cultural analysis, the practitioner needs to systematically resolve the cognitive, affective, and behavioral sequelae of the hate incident. These counseling practices are based upon empirically validated models of treatment with crime and sexual assault victims (Foa, Riggs, & Gershuny, 1995). The cognitive model developed by Resick in the treatment of sexual assault victims hold particular value in this regard (Resick & Schnicke, 1993). These include: (1) de-sensitization to intrusions related to the hate incident, (2) reframing the client's self-negations about victimization, (3) skills training in anger/affect modulation, and (4) use of dialogic and dialectic techniques in vivo for perpetrator confrontation. These steps in the treatment process are sequentially inter-related throughout stage four intervention. The employment of stimulus de-sensitization and imaginal prolonged exposure training is recognized as an effective intervention with trauma victims (Barlow & Cerny, 1988; Fairbank & Brown, 1987), and is viewed as a treatment of choice with sexual assault victims (Davidson & Foa, 1991). Multi-modal interventions employing progressive relaxation, visual imagery, and in vivo de-sensitization are all appropriate for use with clients of hate victimization. It is critical that symptom ratings be recorded routinely by the client and counselor in order to determine intervention efficacy.

In acute symptom reduction, cognitive re-framing (Meichenbaum, 1977) and contingency-based problem solving (Linehan, 1993) are employed to diminish intrusive ideational material, victim self-denigration, and generalized aversive association to members of the perpetrator's

ingroup. I have observed, however, that the efficacy of these cognitive techniques is significantly mediated by the client's exposure to benign intergroup contact subsequent to the critical event. Training to develop client anger management skills is often required. This provides the client with tools to manage poorly modulated affects, particularly diffused hostility (Williams & Williams, 1993). Self-monitoring activities should be linked to targeted desensitization activities to alleviate anger response (Suinn, 1977). Alternately, the practitioner should also consider the appropriateness of referral for pharmacotherapy if acute post-incident ideation remains prominent.

As I have observed, when (phase one) safety needs have been established, the client often attempts to comprehend the motives of their assailant and frequently evidences a desire to express their feelings about if not towards the perpetrator. Counseling should employ what Linehan (1993) calls dialogic techniques in this regard. This may include dialectic and role playing techniques to allow the victim to safely address feelings about the perpetrator. Journal writing and art therapy (Liebmann, 1996) techniques may be employed as well. Dialectic approaches, as defined by scientist-practitioners such as Greenberg and Safran (1989) provide a safe method of articulating, confronting, asserting, and externalizing the client's feelings and beliefs. The cultural appropriateness of this treatment modality must be particularly considered. Imaginal and dialectical forms of in vivo confrontation is not meant to be a prelude to an in situ encounter with the perpetrator. The few programs, which advocate victim-perpetrator interaction, have failed to demonstrate treatment effectiveness with either victims or perpetrators (Fred Persely, personal communication, March 19, 1996). In the absence of convincing evidence to the contrary, such "re-staging experiences" are best seen as counseling-damaging acts and are to be generally avoided.

Phase 5: Identity Recovery and Reformation. Intervention tasks of this stage of treatment include measuring and reinforcing symptom reduction and change, reframing distorted outgroup

attitudes, promoting benign intergroup contact experiences, and shaping an adaptive ingroup identity. These tasks are initiated once acute symptoms are in remission. One of the more significant issues in intervention with clients who have experienced hate events concerns the impact of the critical event(s) upon the individual's ingroup identity. One such method of assessment has already been demonstrated in Helms' research concerning racial identity. This ego-status model of racial ingroup identity has direct application for assessment and counseling with hate event victims.

Conceptually, hate events pose a critical challenge to the client's self-construal of their relations with outgroup persons. In my clinical experience, post-event intergroup attitudes are significantly mediated by the history of pre-event intergroup contact and the individual's ingroup identity. Identity recovery solutions sought by the client may yield a regressive shift towards greater outgroup denigration and avoidance of intergroup contact. This would serve to avoid re-experiencing the event and to minimize the likelihood of recurrence of victimization. Concomitant to this is a striving for greater engagement with ingroup members and (depending upon other pre-event factors) an idealization of ingroup values, behaviors, and beliefs. This significantly characterizes the Immersion/Emersion racial identity status as described by Helms. Conversely, clients who experience chronic insidious forms of discrimination may arrive at a very different identity solution. Under these conditions, ingroup denigration or denial is predicated upon the assumption that ingroup memberships are undesirable or ineffective in enhancing the quality of the individual's life. For these persons, an effort to minimize ingroup identity and/or awareness of between-group differences may occur. This identity solution is most characteristic of an Conformity-type racial identity status. Clinically, I have observed that, while more acute and injurious forms of intergroup conflict may result in idealized or exaggerated ingroup identity, more

insidious and recurring discrimination may discourage if not punish ingroup identity development. In clinical practice, these identity solutions are manifested by a marked splitting of ingroup-outgroup associations. Client attributions concerning between-group differences are fueled by affective polarization and the adoption of an outgroup-avoidant lifestyle. Treatment of ingroup-outgroup splitting constitute a critical task in client recovery.

In counseling treatment with gay and lesbian clients, the pre-event status of identity development is correspondingly critical to post-event recovery. In the study of gay and lesbian identity formation, Cass (1979) and Troiden (1993) have viewed sexual orientation development as a succession of self-referenced status points, which ultimately result in a more coherent and stable identity. For Cass, gay and lesbian identity development identity includes progression through self-reference of one's sexual orientation from sensitization, to identity confusion, to identity assumption, and finally resulting in identity commitment. For Troiden, the evolution of a gay or lesbian identity is marked by the employment of various strategies, such as denial, repair, avoidance, redefinition, and acceptance. Only this latter strategy yields a fully-integrated and healthy self-image as a gay male or lesbian. Both of these identity models share with the racial identity model of Helms (1989) recognition of the salience of intergroup contact experiences in identity formation. For clients at an Identity Diffusion stage of sexual identity (i.e. in which ingroup identity membership is ambivalent), as described by the Cass (1979) and Troiden (1993) models of gay/lesbian identity development, hate experiences may prove particularly destabilizing. A regressive identity solution for such a client would typically evidence internalized self-blame, with hate victimization being a consequence of an unhealthy lifestyle, resulting in the integration of societal stigmatization into his/her sexual identity. In contrast, for clients at a fully integrated stage of gay/lesbian identity (in the Cass model this is referred to as Identity Commitment) help seeking

and recovery could be expected to be significantly more efficacious. For persons with effective social supports and healthy self-regard, the discriminatory event may facilitate a more adaptive ingroup identity than had existed prior to the incident. These clients would more readily utilize mental health services and perceive an identified ingroup as a support mechanism. As such, even when the more acute symptoms of the hate event have been effectively ameliorated, further psychological intervention may be required to allow for a full recovery of selfhood and ingroup identity status as found prior to the critical event. Once more it should be stressed that the client's pre-event level of functioning plays a crucial role in treatment outcome.

Case Illustrations of Assessment and Treatment

Procedure and Assessment Methodology

Three counseling cases are presented of clients who voluntarily initiated treatment at a private psychology group in the greater Los Angeles area. The psychology group where the clients were treated serves a heterogeneous socio-demographic client population. Some of the client demographic information was modified to preserve client confidentiality. Each client was initially seen for an individual assessment interview. Demographic information (e.g. client educational level, medical/developmental history, race/ethnicity, etc.) was recorded and DSM IV diagnoses were assigned. Counseling assessment included: (1) defining the presenting problems which precipitated treatment, (2) determination of DSM-IV diagnoses via administration of a modified version of the structured clinical interview for the DSM (First et. al., 1995) at treatment initiation, (3) reported (pre-event) intergroup contact experiences, and (4) psychometric assessment of symptoms and functional impairment. This information has been summarized in Table 2.

Method of Analysis

The proposed model of assessment and treatment is considered via a series of case illustrations in which treatment explicitly focused upon client problems related to discrimination and hate-based events. As suggested by Kazdin and Kagan (1994), case-based research can contribute to the study of under-investigated client problems, employing a non-experimental methodology. This idiographic approach can lead to refinement of theory which may be (subsequently) revisited via conventional empirical study. These case analyses follow the recommendations for psychotherapy research as outlined by Kazdin (1992). This included the employment of psychometric assessment methods, ideographic (e.g. client-specific) material, and pre- and post-treatment counselor ratings across multiple cases. These case illustrations integrate behavioral rating and psychometric data in the assessment phase of treatment. These cases also sought to define behavioral features of the hate activity. Assessment included serial measurement of the trauma symptoms manifested subsequent to hate crime events and insidious prolonged discrimination. These cases provide an illustration of differences in the nature of the (hate-based) critical event and subsequent psychological sequelae and are typical if not prototypical of the practice issues which counselors face in working with multicultural populations. They also serve to guide discussion of how counseling interventions can ameliorate client problems, as well as underscore the palliative role of positive ingroup identity and help seeking behavior.

Measures

Social Group Conflict Scale. The Social Group Conflict Scale (SGCS; Dunbar, Sue, & Liu, 1994) examines the phenomenological characteristics of a specific intergroup conflict event. The SGCS includes 27 ratings of intergroup conflict events (e.g. "I was excluded from a group activity."). Responses are scored to reflect five factor-based conflict dimensions of: (1)

interpersonal provocation/harassment, (2) restriction of information and resources ("Gate Keeping"), (3) personal isolation/minimization, (4) control/co-opting of personal achievement, and (5) social group exclusion. From the original sample, the conflict dimension scale mean scores were 14.04 (SD= 9.80), 9.30 (SD= 7.92), 9.82 (SD= 5.57), 5.63 (SD= 4.56), and 5.60 (SD= 4.88), respectively. Higher scores indicate greater intensity of the experience. Three principal components varimax rotated factor-based dimensions of subjective affective response (Liu, 1995) are also derived from 21 affect ratings, yielding dimensions of: (1) anxiety/tension, (2) dysphoria/sadness, and (3) anger/aggression. The mean scores for these dimensions with the standardization sample were 15.73 (SD= 6.11), 19.51 (SD= 7.02), and 14.57 (SD= 3.73), respectively.

Impact of Event Scale. The Impact of Event Scale (IES) is a widely employed measure of trauma symptoms (Horowitz, Wilner, & Alvarez, 1979). This measure has been used to describe features of post-trauma response for clinical samples and trauma victims. The IES consists of two dimensions of post-trauma symptoms, avoidance and intrusion. In the source article the intrusion scale score for a population of psychotherapy outpatients, who were in treatment secondary to the death of a next of kin or a parent, was 21.2 (SD= 7.90) and the avoidance the scale score was 20.8 (SD= 10.2). In a study of intergroup conflict and discrimination experiences of university students, the mean IES scale scores were 9.66 (SD= 5.41) for avoidance and 12.21 (SD= 6.92) for intrusion symptoms (Dunbar & Liu, 1996).

Minnesota Multiphasic Personality Inventory. The Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1983) is one of the most widely used measures of psychological symptoms and personality traits, having been employed in numerous studies addressing psychological problems and subjective well being. The three validity scales and the ten

clinical scales were employed in the current study. The clinical scales of the original form of the MMPI are reported to be significantly correlated with the corresponding clinical scales of the MMPI-2 (Butcher, Graham, & Ben-Porath, 1995).

Case Summaries

Case One: Workplace discrimination of an African-American Female.

This client (referred to as Karen) initiated treatment via referral by her organization's Employee Assistance Program. She was a mid-career masters-prepared engineering professional who was a project manager for a high-technology firm. She initially sought treatment due to complaints of job stress, anxiety, and career concerns. Karen had been married for a decade. She described her marriage as "only adequate," with her husband having not been regularly employed for more than 2 years. Karen also acknowledged a history of sexual abuse by a neighbor. She denied prior psychological treatment. She did not report problems in her relationships with co-workers or issues of racism as being of concern in her referral from her EAP counselor, who was also an African-American woman. Initial assessment included an intake interview and administration of the MMPI. Based upon the interview with Karen, a diagnosis of Anxiety Disorder with Panic Attacks was assigned; the initial GAF score was 48, indicating serious psychological symptoms. Her MMPI profile yielded an elevated 8-4 profile (Scale 8/Sc T-Score = 77; Scale 4/Pd T-Score = 71); the Welsh code for the profile was 84'037-9216/5#LF-K. Treatment with Karen initially focused upon reduction of her anxiety symptoms via relaxation training and cognitive problem-focused interventions. Cognitive intrusions of molestation events (experienced by her as a child) which became prominent in the course of relaxation training necessitated the incorporation of desensitization training, employing autogenic techniques to reduce arousal secondary to the intrusive childhood trauma material.

After nearly three months in (weekly) counseling, Karen described a series of events which led to a change of focus in counseling. Specifically, she noted that she was having problems managing members of a project team that she was leading; she felt that she was not being kept abreast of the progress on the team's activities. Behavioral analysis revealed several issues of concern. She noted that she had not been linked into a company e-mail list, which tracked the activities of project team members. When she met with the other team members and complained about this, one member of the group, a tall White male said, "You don't need to know the technical information, just manage it." Karen felt that this man was frequently provoking and challenging her. At the same time, she indicated that her Director, a White woman, had stated that the project team members had complained about being asked by Karen to attend meetings which they felt that Karen herself should have attended. Karen was angry and upset that her decision making in delegating tasks was being questioned. She was also upset that her Director felt that it was acceptable to have project team members bypass Karen with their criticisms. Karen described her relationship with her Director as being superficially cordial, but felt disengaged and unable to solicit her guidance in managing her group. In terms of phase one tasks, the identified event was evidently recurring but posed neither an imminent threat to physical safety nor to her ability to carry out a variety of routine tasks.

From the period when these incidents were first discussed, a gradual worsening of relations with both the team and her Director occurred. Karen felt increasingly isolated from day-to-day operational issues, provoked by the same White male team member, and unsupported by her Director. Further discussion in counseling revealed Karen's history of both positive and ambivalent inter-race relationships. She noted positive contact experiences at her multi-racial church and prior experiences of having successfully worked with and managed White employees. Karen's initial

work in therapy had made the subsequent discussion about racial harassment viable, even in a racially crossed dyad. Karen also ascribed greater credibility to the practitioner due to the referring EAP counselor at the company who indicated she provided specialized work with multicultural issues. At this point in treatment, assessment (e.g. phase two) included the SGCS and the IES. Her IES scores (Avoidance scale score of 16 and an Intrusion scale score of 8) were lower than those reported for traumatic symptomatology in the Horowitz et al. (1979) standardization sample. As compared to a non-clinical sample of persons who experienced discriminatory events, her scores were in the mid-range (Dunbar & Liu, 1996). The SGCS scales indicated affective arousal as reflected in the elevated dysphoria (score of 30) and anxiety (score of 22) scales (both of which were more than one standard deviation above scale baseline). SGCS conflict ratings characteristic of provocation, gate keeping, and social isolation were in the mid-range vis-à-vis the baseline values.

Karen's help-seeking behavior included the solicitation of the involvement of a human resources manager in her division, who was also an African-American woman. After an initial meeting, however, Karen noted that the manager appeared reluctant to become involved in the dispute with the project team members or Karen's Director. Karen's ability to respond to the problems at work were compromised by her anxiety and panic; she acknowledged that she likely "came across" as scattered and noted being alternately despondent and angered at being left out of both the formal and informal information networks of her organization. Of note is that the IES scores on serial testing became notably elevated as the workplace discrimination worsened. Subsequent (i.e. three month) IES re-testing revealed a substantial rise in both the avoidance (score = 23) and intrusion (score = 14) symptoms.

At this point, counseling interventions emphasized taking behavioral "time-outs" after workplace conflicts (e.g., taking walks during her lunch hour, initiating brief conversations with friends who were outside of her department, and initiating more positive social activities). Treatment also incorporated an in vivo dialogic approach to assist Karen to process her feelings after difficult encounters with other staff. This led Karen to outline ahead of time the content and process of her one-to-one meetings with her Director. Her efficacy in managing these meetings was then examined by her in terms of principles used in assertion and communication training (Bower & Bower, 1980). This provided her with specific behaviors to employ in responding to workplace provocation. These interventions occurred over a 2-week period. Significant consequences of counseling were twofold. Karen responded in a more modulated manner to provocation by her co-workers and project team members. In addition, Karen was able to see that even with improvement in her behavior in the workplace, the attitudes and actions of some individuals did not significantly change. This helped her to redefine what aspects of the problem were rooted in the organizational environment. The progress in her behavioral self-management led to initiation of a workplace intervention, in which Karen secured the involvement of a company-sponsored non-binding dispute resolution program. This was facilitated by the treating psychologist and the organization's internal EAP manager. Through this program, Karen was guaranteed the participation of a senior executive of the organization, who served as her advisor and coach in initiating a review of her complaint. The dispute resolution process included interviews with Karen, her Director, and the project team members. This process occurred over a six-week period. The outcome produced an agreement satisfactory to both Karen and her Director. Although the organization did not formally concede that there had been a violation of its EEO policies, it did find that there had been a failure of her Director to effectively support her and provide assistance in addressing employee complaints.

The solution to Karen's situation is consistent with that found in many organizations today. She was offered a choice of positions in other areas of her company. This included a corporate position which she saw as being highly desirable in terms of her career aspirations and which provided her with significant visibility to senior management. Karen accepted this new position; she was also included in an employee mentoring program and was funded by her company to enroll in an executive MBA program. At the same time, no formal action was taken against her Director or co-workers. While Karen benefited from pursuing an organizational remedy to her race-related work problem, it would be inaccurate to suggest that she evidenced substantial therapeutic gain in terms of her anxiety. Post-conflict events suggested to the contrary. Furthermore, the impact of the workplace dispute was evidenced in her marital relationship, in which her husband proved to be dismissive and unsympathetic to her situation both during and subsequent to her participation in the dispute resolution program. This, interestingly, led her to form stronger relationships with her friends who were mostly Black and Asian. The (phase five) treatment tasks of ingroup identity reformation and engagement in benign outgroup contact were attained in substantial part to her having maintained positive relationships with non-Blacks throughout her occupational crisis.

Case Two: Ethnic and religious-based workplace harassment of a White Jewish male.

Jason was a computer repair technician employed with a large manufacturing company. He was referred by a member of his organization's Employee Assistance Program. Initial complaints were explicitly linked to workplace experiences of being harassed by co-workers because he was Jewish. At the initiation of counseling, prominent complaints included sleep disturbance, dysphoria, guardedness, and irritability. He also complained that he had been drinking more than he liked. Specifically, he denied a history of alcohol abuse, noting he had been active in track and field sports for several years. He denied a history of trauma or abuse, and reported having had a

good childhood. Jason reported a good marriage, positive family relations, and a satisfactory friendship network. He indicated a long-standing involvement with his Jewish faith and reported that he had met his wife through his neighborhood synagogue.

The determination of safety (phase one) from the perpetrating parties indicated both a chronic and physically non-injurious condition. Jason did not indicate that the harassment posed a threat of physical violence. Behavioral analysis (phase two) indicated that Jason routinely encountered experiences of anti-Semitic provocation and harassment. For example, Jason noted his personal possessions were hidden, vandalized or otherwise tampered with in his work area; he indicated that this occurred several times a week for the better part of two years. He also reported that he was frequently the target of pranks and jokes. These included anti-Semitic jokes directed at him as well as anti-Israel literature being left on his desk. One co-worker pointedly explained that he "went hunting" on Rosh Hashana while another employee explained that Jason was a "cheap Jew" because he did not want to participate in the group's football pool. After more than six months of this harassment, he told his supervisor and co-workers that he wanted the harassment to end. Subsequent to this, his co-workers pointedly avoided him. Jason noted that he had become increasingly isolated from the other employees in his work group. His supervisor, who had been very involved in the harassment, had told him that he "Got what he deserved" for complaining about the other employees' anti-Semitic actions. Jason reported that his supervisor also told him that he would be transferred "because he couldn't get along with anyone." Jason said that this hurt "more than the harassment."

Psychometric assessment (phase two) included the IES, SGCS, and MMPI-1. The MMPI-1 yielded a valid profile with a singular clinical elevation indicating mild depression (scale 2/D T-score = 70). His IES scale scores for Intrusions (score of 22) and Avoidance (score of 28) were

comparable to the reported norms for the Horowitz et. al. client sample for trauma symptoms. The SGCS conflict response scores indicated that provocation (score of 11) and group exclusion (score of 6) were critical event characteristics; corroborating his initial complaints of taunting and isolation from co-workers as the situation on-the-job worsened. The SGCS scale depression score of 24 was two standard deviations above the baseline norm as well.

In the initial counseling session, Jason specifically wanted to know whether the counselor "knew anything about" Jewish culture and if there were other Jewish persons who were seen at the psychology group practice who had also described experiences of discrimination. As such, phase three tasks of addressing culture were immediate issues at the initiation of treatment. Counselor credibility was enhanced when Jason was provided information by the practitioner concerning civil rights in the workplace from a Jewish rights organization and via discussion of research concerning coping with discrimination. Practitioner credibility was subsequently reinforced via Jason's referral to a Jewish attorney, who took specific interest in the case, for information on fair labor practices.

Phase four treatment tasks included defining the coping strategies which Jason had employed and sources of support which he had sought. Help seeking was somewhat limited. Jason noted that he had spoken with his wife and other Jewish friends a good deal but was "embarrassed" and concerned about bringing the issue up at work or with other persons whom he knew socially. He noted that he had initially tried to get the support of his supervisor, but realized that this had probably made matters worse. He felt dismissed by his supervisor and co-workers in the work place as being "someone who had a problem with people talking about Jews." A physician referral for evaluation and treatment via anti-depressant medication was initiated; he was started on a low dose of Trazadone to help improve the quality of his sleep. After two months in counseling, Jason decided to leave his company and initiated legal action. Counseling continued during this time and

included both cognitive- and career-oriented interventions, setting behavioral goals which increased his health-promoting activities. Five month serial testing with the IES revealed a modest reduction in intrusion (with a re-test score of 16) and avoidance symptoms (re-test score of 21). In vivo rehearsal of future contact with former co-workers was instituted. In fact, Jason subsequently encountered several of his former co-workers at local professional meetings. He felt capable of engaging in these activities and felt that he had effectively managed to participate without being significantly aroused by their presence. Jason subsequently initiated labor arbitration, settled his case with his former company and elected not to return to his position. His former supervisor was removed from his position, due directly to the charges brought against him by Jason.

Issues of identity re-formation were marked by a heightened awareness of anti-Semitism, as encountered by friends and other family members. Therapeutic interventions after this point (phase five) included the rehearsal and reinforcement of conflict management responses to anti-Semitic stereotypes. Jason noted that he had become more sensitized to such incidents since having begun counseling. He also developed greater interest in social issues related to anti-Semitism. Resilience themes were identified by Jason for both old testament biblical sources and through discussion at his synagogue. Resilience and coping were grounded in traditional parable of anti-Semitism and proximally by events occurring in Israel concurrent with his treatment. By the conclusion of counseling, his depression had remitted (Foa and others involved in trauma treatment have noted the limited evidence that acute stress and trauma symptoms are alleviated by psychopharmacotherapy) and he had secured regular employment in another firm.

Case Three: Physical assault of an African-American adolescent male.

This case met the criteria of a hate crime for aggravated assault due to the client's race. Initiation of counseling was via referral from the Los Angeles County Human Relations

Commission, a municipal agency responsible for the documentation and monitoring of hate crime activity. The commission had been contacted by the victim's mother when she was told by her HMO that it would be 2 weeks before her son could be seen by a psychotherapist. The critical event was a physical assault by a group of approximately 10 to 12 young White men (aged 17 to early 20's) who were subsequently identified as members of a local hate gang. The victim was one of five African-American youths aged 12 to 15 years of age. The assault took place at a public recreation area on a late weekend afternoon. The event began with the perpetrators calling out racial epithets and cursing at the young Black men. This escalated when the hate gang members chased the youths, one of whom (fictitiously called Robert), a thirteen-year-old, was knocked to the ground, and was repeatedly punched, kicked, and beaten. This continued for several minutes. The information was corroborated by the police report and a witness account. The assault ended when one of the perpetrators stopped the attack, saying that Robert was "too young" and "just a kid." Subsequent to the assault, two of the perpetrators were arrested and convicted. One of the individuals was sentenced to three months incarceration and was placed on summary probation at the time of his release. The second perpetrator was not tried, though no explanation was given by the public prosecutor.

Initial counseling intervention (stage one) focused upon determination of the risk of recurrence of assault from other members of the hate gang. During the first two sessions, Robert's mother was present in the room; at this time the option of referral to a provider of color was discussed, which was declined by the mother. Initial assessment included an individual interview with the mother, who reported that Robert was unable to sleep at night, did not want to go outside, was fearful, and seemed "in a daze." Both she and Robert denied his having a prior history of hate crime-victimization. Robert indicated having school friends who were Anglo, Latino, and Asian-

Pacific. His mother indicated that Robert had been raised in a multi-racial community and had always attended schools that were culturally diverse. Help-seeking behavior initiated in the weeks following the assault was particularly problematic for a variety of reasons. These included the failure of law enforcement personnel who responded to the incident to apprehend more than two of the dozen or more perpetrators at the scene. Equally, the public prosecutor failed to return telephone calls from the mother and treating psychologist in trying to get additional information on the prosecution of the perpetrators. A particularly confusing issue for Robert and his mother was that one of the two responding officers and the public prosecutor were women of color. As such there was confusion concerning the sense of support from persons of color during the acute phase of the case.

Robert completed the IES (avoidance = 24; intrusion = 31) falling in the mid and high ranges respectively for trauma symptoms when compared to the IES sample. The SGCS was administered in an interview format. This revealed elevated affective arousal for anxiety; however, the conflict characteristic scores did not sufficiently portray the nature of the physical assault. The SGCS anxiety scale score was 23; this was one standard deviation above the baseline. Of the five conflict factors, only the personal provocation score was found to be elevated. Early on (phase four) treatment focused upon training in relaxation induction and somatic discrimination techniques. This was subsequently coupled with desensitization and exposure, which was accomplished in vivo via audio recording and play back of the incident as related by Robert. Repeated pre- and post-exposure ratings for subjective unit of distress (SUDS) indicated a gradual reduction in aversive symptoms, arousal, and intrusions. This was accomplished over the first three months of treatment.

After three months of twice weekly counseling there was a measurable decrement in the trauma symptoms. Serial testing of the IES at this point yielded a significant reduction in the intrusion symptoms (re-test score of 5) and a modest reduction in avoidance symptoms (re-test score of 19). With this (partial) remission of the trauma symptoms, Robert initiated a vigorous physical exercise regime and started attending self-defense classes. At this stage in the treatment there was greater emphasis placed upon anger management and defining behavioral options in responding to racist events. In vivo exposure to the assault continued, as did mental imagery practice. SUDS ratings indicated a significant decrement in arousal to assault-related material. This was furthermore marked by resumption of normal recreational and social activities. With the reduction in acute trauma symptoms, there was a shift towards a more inclusive understanding of the nature of race and racism.

Robert began drawing images of the gang members and of himself; he also became very interested in the music of Bob Marley and Bunny Wailer (reggae recording artists), who emphasized overcoming adversity and “self-resilience” in their music. Robert said the music helped him in “feeling better about” himself. Dialogic interventions were subsequently introduced, this included role playing of verbal confrontation with members of the hate group and journal writing about the incident. Education about community and national groups opposed to hate groups was also provided and became a source of particular interest to Robert, leading him to write and talk about the topic in his middle school classes. However, while Robert's condition notably improved during the course of treatment, that of his mother became progressively problematic. Having initially sought both legal and mental health support, by the termination of counseling (i.e. five months after the assault) Robert's mother had become hostile and dismissive of “the system.” This was principally related to the failure of law enforcement personnel to prosecute other hate

gang members. Robert's mother also stated that his treatment by the police would have been different "if he had been White." She indicated that if her son were victimized in the future, she would "settle it" on her terms and not seek the involvement of law enforcement persons or "deal with Whites." Fortunately, her feelings of disappointment were in contrast to other family members' who took pride in Robert's recovery.

Discussion

These cases illustrate the variety of experiences which practicing psychologists encounter in working with hate event victims. The client problems reported in all three of the cases meet some of the criteria for Acute Stress disorder and/or Post-Traumatic Stress Disorder. In Case Three (Robert), cognitive intrusion, situational anxiety, and physiological arousal secondary to contact with Whites were observed in the weeks following his hate crime victimization. This was apparently developed through classical conditioning secondary to the bias-motivated assault. Case One (Karen) stands in distinction to the other two cases in regards to the pre-event history of trauma related to childhood sexual abuse, which had been the focus of treatment prior to the worsening of her experiences of workplace discrimination. This case exemplifies the role of racism as a situational stressor and the additive role of prior trauma history (e.g. childhood sexual molestation) in coping and adjusting to the event. The contributory roles of favorable pre-event outgroup contact and organizational supports were noteworthy factors in problem management. Equally, it is interesting that in this case the work place harassment symptoms of trauma were not particularly elevated, even in context of the prior childhood trauma intrusions. It should be noted, however, that on-going psychological problems continued to compromise her level of functioning after resolution of the workplace harassment had been achieved.

In Case Two, chronic anti-Semitic harassment created a symptom constellation which included overtly fearful ideation, dysphoria with sleep disturbance, and ineffectual confrontation the perpetrators prior to beginning treatment. This case is noteworthy in terms of the deleterious effects of prolonged harassment. Specifically, avoidance and intrusion symptoms were only slightly improved after several months of treatment. This stands in distinction to Case Three (acute assault), in which significant symptom reduction was achieved in a comparable period of time. In neither case was there a prior history of harassment or trauma. Cases One and Two yielded symptomatology comparable to if not consistent with situationally conditioned psychological disturbance. As is reflected in the IES scores, both intrusion and avoidance symptoms were comparable to the clinical baseline reported by Horowitz et al. (1979).

These three cases reflect distinctly different conditions in which the treatment model was employed. In Case One, intervention occurred over a six-month period, encompassing symptom onset, problem engagement, and problem resolution stages of a workplace discrimination incident. In Case Two, measurement of trauma symptoms occurred two years after recurring acts of anti-Semitic harassment had begun. In Case Three, assessment and treatment were initiated immediately after acute hate crime victimization. In contrast, the IES avoidance symptoms remained quite high. This points to the possibility that victims of hate aggression continue to exhibit an active avoidance response to stimuli associated with the precipitating event and minimize intergroup contact experiences. These cases further raise the question as to the enduring nature of avoidant behaviors employed by victims of hate incidents who do not secure psychological services. Clearly, this issue warrants closer investigation by multicultural researchers and practitioners.

As Sue and Zane (1987) have noted, counselor competence and credibility are particularly significant factors in terms of racially- and ethnically crossed counseling dyads. In the cases

described in this paper, the counselor was a member of the perpetrating group (a White male gentile). This most likely had an impact upon the course of treatment. In the current cases, credibility-enhancing activities included the practitioner being identified by the referring parties as experienced in working with hate crime victims and being a university researcher involved with the topic of prejudice. Furthermore, the referring professional in each instance was a person of color. These factors certainly played a part in the clients' willingness to seek treatment with a White service provider. Credibility-enhancing activities also included active case management with community organizations of the clients' ingroup and serving as a resource in linking the client to hate crime prevention services.

It must be emphasized that the salience of culture in working with victims of acute hate aggression must at all time be recognized. Personally, I have found it critical with hate victims to know when to set aside the prescribed behavioral treatment (phase four) and directly discuss the client's experiences of discrimination. The strict adherence to a pre-ordained counseling model or manual-driven treatment is less salient to the therapeutic relationship than the counselor's being responsive to the client's safety needs and re-formation of his or her ingroup identity. Finally, in terms of the proposed model of treatment, it must be acknowledged that the efficacy of intervention is mediated by larger social and community factors which control help-seeking. Situations in which harassment, provocation, and threat are tolerated will substantially limit the capacity of any mental health intervention to by itself meet the client's needs for safety and autonomy.

The importance of cultural factors, as I have observed, increases as the acuity of disabling symptoms of intrusion, anxiety, and hyper-arousal diminishes. That is, the incorporation of culturally-salient beliefs, resilience themes, and coping behaviors are needed to bridge treatment from phase four symptom reduction to identity re-formation and competency in outgroup contact

experiences. When these culturally-salient issues of treatment are not addressed either the client or practitioner may incorrectly view the counseling relationship as having produced a positive outcome. Rather, the reduction of acute symptoms should serve as a sign for the practitioner to shift treatment towards phase five tasks. Contrary to the notion that cultural factors are usually most important in establishing the working reliance, in work with hate victims, the role of culture is most critical once ingroup identity issues can become a focus of intervention.

Implications for Counseling Research

This article has presented case illustrations of counseling treatment in which hate victimization was an explicit focus of psychological intervention. These cases all dealt with problems related to intentional and overt acts of intergroup aggression and hostility. It should be considered that some of the more enduring assumptions concerning the experience of bias and prejudice unwittingly serve to minimize the incident as being either the product of cultural misunderstanding, on the one hand, or have emphasized the pathological selfhood of persons who have suffered from chronic racism, on the other. As Carter (1995) has noted "... many mental health professionals incorrectly assume that all visible racial/ethnic group members have experienced the destructive influences of racism in society and have been psychologically destroyed by them. Although it is important to identify the social obstacles that obstruct and hamper an individual's potential, it should not be assumed that these obstacles result in only negative outcomes" (pp. 40). We agree with Carter and at the same time perceive a need for counseling research to explicitly study what constitutes effective intervention when racism and prejudice do compromise the client's identity, well being, and prospects for survival.

Determining the efficacy of the treatment of hate victims is compromised by lack of construct clarity and sampling of viable client groups. As suggested by Meehl (1977), idiographic

case methods are of value in enriching clinical understanding of issues under-represented by conventional empirical research. Additionally as mental health research has become more increasingly rigorous, the difficulty of identifying unitary diagnostic subject groups has been noted. The identification of clients who evidence a unitary presenting problem or diagnosis is questionable, given that individuals seeking mental health services frequently manifest multiple symptoms and concerns (Karon, 1995). There is certainly no reason to believe that persons who experience chronic or acute hate events are an exception to this. Any member of the general population may become a hate crime victim. As Berk, Boyd, and Hammer (1992) have noted "[v]ery little is known about risk factors for hate-motivated crimes. Even in the case of race, where skin color and other physical features are relevant, no quantitative estimates exist that separate the impact of race from other related risk factors" (pp 137). Finally, there is reason to question the accuracy of self-report, particularly in terms of hate victimization. Habituation to chronic discrimination may lead to under-reporting by particularly at-risk individuals. Certainly in terms of a topic of this sensitivity, the counseling researcher needs to be wary of drawing conclusions blindly from community samples or simple self-report methods.

Our understanding of the psychological impact of prejudice runs the risk of potentially normalizing (and hence minimizing) the experience of hate as a natural social psychological phenomenon, pathologizing the victim, minimizing other client problems, and/or erroneously subsuming hate victimization as something to be "sensitive to" in terms of practitioner competency. It is hoped that the case material presented here demonstrates that the psychological sequelae may co-occur with other (pre-existing) psychological disorders in such a manner as to be both clinically significant and disabling to the client. The practitioner (and mental health researcher) interested in multicultural issues should therefore be particularly concerned with possible positive counter-

transference and counseling-damaging desires of perceiving their clients as being healthier than they indeed might have been prior to the occurrence of the hate-related event. As such, practitioners may err in the direction of treating all client symptomatology as being causally related to the discriminatory event when it is, in fact, independent and pre-existing.

This treatment model incorporates cognitive, behavioral, and multi-cultural treatment approaches. The proposed interventions do not presume that other methodologies may not prove effective in addressing problems related to hate victimization. Rather, existent mental health practices concerning trauma recovery have most clearly addressed the problems and needs of the victims of hate. Opportunities to study interventions with hate victims exist in terms of case study methods (as employed here) or via institutional settings – such as college counseling offices or community mental health centers. Optimally, victim service programs – where they do exist – may provide the best opportunity to systematically conduct clinical trials. In such a setting, the opportunity to employ dismantling strategies (Maher, 1982) in treatment evaluation could serve to determine which components of the intervention made the greatest contribution to the client outcome.

There is a clear need for counseling researchers to develop a theory-driven approach in working with victims of hate events. This article has attempted to illustrate a variety of client problems related to acute hate events and chronic discrimination. It has been argued that effective intervention with victimized individuals incorporates a variety of cognitive, behavioral, and multicultural counseling strategies. Through the integration of the "best practices" of these approaches, practitioners may effectively intervene in an area of great concern to both their clients and contemporary society.

Table One: Intervention Phases and Practitioner Tasks in Hate Event Amelioration

Phase One - "Event Containment and Safety"

Tasks:

- a. Evaluate and establish client safety from perpetrator(s).
- b. Determine chronicity vs. acuity of hate incident(s).
- c. Assess client's current level of psychological functioning.
- d. Identify and access client supports and resources.

Phase Two - "Assessment of Client-Event Characteristics"

Tasks:

- a. Phenomenological evaluation of event (e.g. behavioral characteristics, affect response, conflict response mode).
- b. Determine client history of traumatic events.
- c. Assess client's ingroup identity attitudes.
- d. Define history of intergroup contact experiences.
- e. Assess pre- and post-event psychological symptomatology.

Phase Three - "Addressing Diversity in the Counseling Alliance"

Tasks:

- a. Practitioner determination of cultural competence.
- b. Establish practitioner credibility.
- c. Address practitioner and client counseling-damaging behaviors.
- d. Assess role of worldviews upon counseling process.
- e. Articulate themes of ingroup resilience and coping.

Phase Four - "Acute Symptom Reduction"

Tasks:

- a. Establish treatment goals and options.
- b. Skills training in stress inoculation.
- c. Prolonged exposure and in vivo de-sensitization to critical event.
- d. Re-frame trauma-induced ideation and attributions.
- e. Skills training in anger/affect management.
- f. Measure and reinforce intrusion and avoidance symptom reduction.
- g. Engage in dialectic and dialogic problem confrontation.
- h. Monitor symptom change and intergroup contact experiences.

Phase Five - "Identity Recovery and Reformation"

Tasks:

- a. Measure and reinforce symptom reduction.
- b. Re-appraise cultural percepts and assumptions.
- c. Promote benign contact experiences.
- d. Assess client ingroup identity attitudes.
- e. Review outgroup attitudes.
- f. Establish after-care maintenance goals.

Table Two: Summary of Client Demographic Information, Socio-Cultural Material, DSM-IV Diagnoses, and MMPI data.

Client Demographic Information	Presenting Focus for Treatment	Post-Event Behavioral Manifestations	Axis I & II Diagnoses	GAF Score	MMPI Scores ^a
1. Adult African-American Female	Workplace Discrimination	a. Anxiety b. Dissociation c. Occupational dysfunction d. Intrusive ideation	Anxiety Disorder with Panic Attacks	48	84'037-9216/5#LF-K
2. Adult Euro-White Jewish Male	Workplace Harassment	a. Dysphoria b. Sleep disturbance c. Occupational dysfunction d. Guardedness	Dysthymia	54	2'061-945738:KF/L:
3. African-American Adolescent Male	Hate Crime Assault	a. Flashbacks b. Sleep disturbance c. Hypervigilance d. Avoidance e. Academic dysfunction	PTSD-Acute	41	n/a

^a In Case One, the MMPI data is from initiation of counseling and prior to the critical event. In Case Two, the MMPI data is from initiation of treatment and after the critical events. The MMPI was not administered to the third client.

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