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CHAPTER 1

Introduction

As a change agent, whether you work in health care, education, the justice system, or other therapeutic settings, you are in a position to influence lives in profound ways. However, if you're not actively addressing the impact of racism, cultural marginalization, and systemic inequities, your efforts may fall short of the transformative change you hope to support. This book invites you to face these realities head-on through an *antiracist multicultural orientation* (AMCO) framework that is both practical and deeply reflective. You'll be challenged to move beyond cultural competence toward cultural humility, beyond neutrality toward creating opportunity, and beyond awareness toward comfort and action. Grounded in evidence and lived experience, this framework is designed to support you in creating meaningful, equitable, and lasting change, regardless of your role or setting. This book is designed to meet you where you are and challenge you to grow. You will find tools here to deepen your practice and expand your impact. You'll be invited to examine how racism and cultural marginalization show up in your own work and worldview, regardless of your own racial and cultural identity. Then, you'll explore ways to align your values with your methods—so that your interventions reflect not just what you know but also whom you stand with. Finally, you'll be equipped with actionable strategies to promote equity and justice in your everyday interactions, systems, and policies. Each chapter blends theory, research, and real-world examples with practical guidance to help you translate concepts into skills and, ultimately, change. We hope that this handbook will be relevant to practitioners of all races and cultures. Our backgrounds reflect multiple identities, as

described in the Preface, and we hope our approach to the individual needs of all Black, Indigenous, and People of Color (BIPOC) clients will be relevant to the array of identities of our practitioner readers.

What Are the Unique Needs of BIPOC Clients?

In client services, recognizing and addressing the unique needs of BIPOC clients is not just about diversity and inclusion; it's a fundamental aspect of providing equitable, practical support. The experiences, challenges, and cultural contexts that shape the lives of BIPOC clients create a distinctive landscape that demands a tailored and empathetic approach. Your empathetic approach should include the following:

1. *Understanding that the unique needs of BIPOC clients begin with acknowledging their cultural and racial identities.* Each BIPOC culture brings with it a distinct set of values, norms, and historical contexts that can affect how individuals perceive and engage with services (Anders et al., 2021). Note that we focus on understanding the individual rather than a race or culture.
2. *Understanding that BIPOC clients often carry the weight of historical traumas and systemic injustices that have shaped their communities.* These experiences can influence mental health, trust in institutions, and overall well-being (Cénat, 2023).
3. *Understanding that language barriers can be a significant hurdle for BIPOC clients.* Clear and effective communication is essential for building trust and ensuring they fully understand their options (Soled, 2020).
4. *Understanding that BIPOC clients value seeing people who look like them and who understand their experiences.* Representation within the service field creates a safe and welcoming space where clients feel they can discuss their needs openly (Schutt & Rogers, 2009).
5. *Addressing racism and stigma.* These are crucial topics that have become the key social determinants of health for BIPOC clients (Yearby et al., 2022).

What Are Racism and Stigma?

Your empathetic approach should definitely include number 5 from the previous list! Why? The long shadows of racism and stigma continue to have a serious and damaging effect on BIPOC clients within the health

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care system. The interwoven threads of historical injustices, systemic bias, and cultural stereotypes have created a complex tapestry. This tapestry often leads to disparities in access to health care, treatment options, and overall health outcomes. As you work toward building a more just and equitable society, it is important to grasp the deep and long-lasting impact of racism and stigma on the health of your BIPOC clients. However, before you can take your first step toward building that society, you must first understand what type of racism you are dealing with and what the elements of stigma are. Then you will begin to understand their powerful relationship as a true social determinant of health.

Racism

Racism, a deeply rooted and pervasive societal issue, has a far-reaching and profound impact on individuals and communities. BIPOC communities, in particular, bear a disproportionate burden of the harmful consequences of racism. From systemic inequities to psychological and emotional distress, the impact of racism on BIPOC individuals and communities is a sophisticated web of challenges that requires a comprehensive understanding and active efforts toward change. To understand the impact of racism, we first have to understand the type of racism we are dealing with. There are three main types of racism: individual/intergroup, structural, and systemic.

Individual Racism

"Individual racism" refers to the beliefs, attitudes, and actions of individuals that perpetuate racial discrimination and prejudice. It involves expressing biased views, stereotypes, and discriminatory behavior toward individuals or groups based on race. Individual racism can manifest in various ways, such as racial slurs, hate crimes, discriminatory hiring practices, or prejudiced attitudes or biases.

Intergroup Racism

"Intergroup racism" refers to racial discrimination and prejudice that occur between different racial and ethnic groups. It involves negative attitudes, stereotypes, and actions directed at individuals or groups based on their racial or ethnic background, often motivated by a sense of superiority or a desire to assert dominance. Individual and intergroup racism have been grouped as one type of racism because they are two interconnected forms of prejudice and discrimination based on race that

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significantly affect society. These manifestations of racism are deeply rooted in historical, social, and cultural contexts, shaping individuals' experiences and interactions.

They are connected through their impact on the larger societal framework of racial discrimination and inequality. Individual racism can contribute to intergroup racism when biased beliefs, stereotypes, or discriminatory behaviors are directed toward members of other racial or ethnic groups. These individual acts of racism can fuel tensions, reinforce negative stereotypes, and maintain inequalities between groups. Intergroup racism, on the other hand, can reinforce and perpetuate individual racism. When different racial or ethnic groups are pitted against each other, it can foster a climate of hostility and mistrust. This environment may further entrench individuals' prejudices and biases, leading to discriminatory behaviors that perpetuate harmful stereotypes.

Systemic Racism

"Systemic racism" refers to the oppression of a racial group to the advantage of another as perpetuated by inequity within interconnected systems (such as political, economic, and social systems). It functions through a web of institutional practices and cultural norms that collectively produce and sustain racial disparities, often without the need for overtly racist intent. For example, when predominantly Black neighborhoods receive less funding for schools, face higher rates of policing, and have limited access to quality health care, these outcomes are not isolated; they are the result of systems working in tandem to marginalize a specific group. Systemic racism is deeply rooted in history, yet it continues to evolve, adapting to new contexts while preserving old hierarchies. Its power lies in its ability to appear neutral (i.e., "just the way things are"), making it all the more urgent to name, challenge, and dismantle it at every level of society.

Structural Racism

Structural racism is one of the most significant and problematic types of racism to try to eradicate. This type of racism explicitly emphasizes the role of laws, policies, and entrenched norms that form the framework or scaffolding of these systems. It is the architecture that upholds racial disparities by embedding inequality into the rules and routines of everyday life, often without explicit mention of race. For example, voting-zone laws, zoning laws that segregate neighborhoods, school funding models tied to property taxes, and sentencing guidelines that disproportionately affect BIPOC communities all reflect structural racism in action. These

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mechanisms are not accidental; they are the result of historical decisions and deliberate design, sustained over time through inertia and resistance to change. Unlike overt bigotry, structural racism operates subtly, making it harder to detect and dismantle, yet its impact is profound, shaping life outcomes across generations.

Impact of Racism

Over the past few decades, researchers and practitioners have identified racism as a pervasive population health crisis and a root cause of disease in the United States and globally (Wakeel & Njoku, 2021). In the world of health care, a fundamental (slow) shift is occurring. There is a shift toward recognizing the crucial role that acknowledging racism plays in the treatment of BIPOC clients. Racism has profound and pervasive effects on BIPOC individuals and communities across various aspects of their lives. These effects can be physical, emotional, psychological, social, economic, and systemic. It's important to recognize that racism is not only about individual acts of discrimination or prejudice but also includes systemic and structural inequalities that disproportionately affect BIPOC individuals. Table 1.1 (pp. 6–7) presents some of the ways racism affects BIPOC individuals (Jean et al., 2023).

Stigma

"Stigma" refers to a collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced against, and discriminate against people with mental disorders (Gary, 2005). Stigma is a barrier. Fear of stigma and the resulting discrimination discourage individuals and their families from getting the help they need. But to truly understand stigma, you must examine its elements—namely, labeling, stereotyping, prejudice, and discrimination (see Table 1.2, p. 8).

Stigma and racism are deeply intertwined as social determinants of health, compounding the barriers BIPOC individuals face in accessing equitable care. Racism fuels stigma by reinforcing negative stereotypes, dehumanizing narratives, and fostering systemic exclusion, which in turn shape public attitudes, institutional policies, and clinical practices. These forces contribute to mistrust in health care systems, underdiagnosis, and inadequate treatment while also exacerbating stress, anxiety, and chronic illness. When stigma and racism intersect, they create a cycle of marginalization that undermines mental and physical health, making culturally responsive and antiracist care not just ethical but essential.

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TABLE 1.1. How Racism Affects BIPOC Individuals

Aspects of BIPOC individuals	Impact of racism
Mental and emotional health	*Psychological distress:* Experiencing racism can lead to stress, anxiety, depression, and other mental health issues. The constant threat of discrimination takes a toll on the mental well-being of BIPOC individuals.
	Racial trauma: BIPOC individuals may experience racial trauma, a form of psychological distress resulting from exposure to racial discrimination and systemic racism.
Physical health	*Health disparities:* Racism contributes to health disparities, with BIPOC individuals often experiencing poorer health outcomes, including higher rates of chronic diseases and shorter life expectancies compared with their white counterparts.
	Access to health care: BIPOC individuals may face barriers to accessing quality health care due to economic disparities, discrimination, and a lack of culturally competent care.
Education	*Unequal educational opportunities:* BIPOC students often attend underfunded schools with fewer resources, less experienced teachers, and higher discipline rates. This contributes to educational achievement gaps.
Employment and economic inequality	*Employment discrimination:* Racism can lead to discrimination in hiring, promotions, and wage disparities, limiting economic opportunities for BIPOC individuals.
	Wealth gap: Historical and ongoing systemic racism has led to a significant wealth gap, with BIPOC families generally having lower levels of wealth and assets than white families.
Criminal justice system	*Racial profiling and discrimination:* BIPOC individuals are disproportionately targeted by law enforcement, leading to higher rates of arrests, sentencing disparities, and a higher likelihood of being victims of police violence.
	Mass incarceration: BIPOC communities are disproportionately affected by mass incarceration, which disrupts families and communities.
Housing and neighborhood disparities	*Redlining:* Historical redlining practices have resulted in residential segregation, limiting access to quality housing and educational opportunities for BIPOC communities.
	Environmental injustice: BIPOC neighborhoods are often located near pollution sources and have limited access to green spaces, contributing to environmental health disparities.

(continued)

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TABLE 1.1. *(continued)*

Aspects of BIPOC individuals	Impact of racism
Social and cultural impact	*Stereotyping and prejudice:* Racism perpetuates harmful stereotypes and biases about BIPOC individuals, affecting their interpersonal relationships and sense of belonging.
	Cultural erasure: BIPOC cultures may be marginalized or misrepresented, leading to cultural erasure and loss of cultural identity.
Political and civic engagement	*Voter suppression:* BIPOC communities may face voter-suppression efforts, limiting their political representation and influence.
	Underrepresentation: BIPOC individuals are often underrepresented in positions of power and decision making.

Impact of Intersectionality

BIPOC individuals may also experience intersecting forms of discrimination and disadvantage based on factors such as gender, sexual orientation, religion, disability, and immigration status, which compound the effects of racism and stigma. It's crucial to recognize that these impacts of racism and stigmas are interconnected and often reinforce one another. The lived reality for many is not shaped by a single source of oppression but by overlapping systems that create unique forms of marginalization. For example, a queer immigrant woman of color may experience racism in her workplace, xenophobia in public policy, sexism in health care, and homophobia within her community. Each of these identities compounds the others, not as separate events, but as a constant, interlacing presence that informs how she is seen, treated, and expected to navigate the world.

Intersectionality reveals that the tools we often use to address inequality, whether in social policy, clinical care, or education, frequently fall short because they focus on single-issue lenses. Addressing racism without accounting for BIPOC individuals' other sociocultural identities can leave them feeling unseen and unsupported. Systems and services that treat BIPOC people as one-dimensional often perpetuate exclusion under the guise of neutrality. So to truly support BIPOC clients, practitioners must move beyond universal frameworks and adopt models that recognize how structural disadvantages accumulate and interact. Intersectional harm demands intersectional solutions.

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TABLE 1.2. The Elements of Stigma

Stigma elements	Examples
Labeling	
• When a person, place, or thing is reduced to a single characteristic or label	• *"People just see me as 'the addict' or 'the bipolar one.'"* • *"At work, I'm not Luis anymore; I'm 'the one with anxiety.'"* • *"My family only talks about my mental health diagnosis, never about who I am as a person."*
Stereotyping	
• When negative assumptions are made based on a label or characteristic	• *"People think because I'm on disability, I'm lazy and don't want to work."* • *"They assume because I'm Black and in therapy, I must come from a 'broken home.'"* • *"Everyone expects me to be violent because I have a mental health diagnosis."*
Prejudice	
• When negative emotional reactions occur based on stereotypes	• *"I can see the fear in people's eyes when they find out about my diagnosis."* • *"My neighbor won't let her kids play with mine since she found out I take medication."* • *"People cross the street when they see me coming because I look 'different.'"*
Discrimination	
• When negative behaviors, actions, or unfair treatment occur based on prejudicial attitudes	• A qualified job applicant is denied a position because the employer assumes their accent means they are less competent. • A landlord refuses to rent an apartment to a family after learning they are immigrants, despite their ability to pay. • A health care provider spends less time with a BIPOC client and dismisses their symptoms compared with white clients with similar concerns.

Impact of Historical Trauma

The impact of historical trauma on BIPOC individuals is profound, shaping not only their identities but also their access to safety, opportunity, and well-being. "Historical trauma" refers to the cumulative emotional and psychological wounds that are transmitted across generations as a result of violent and oppressive events (Cacace & Summers, 2025). For BIPOC individuals, these events include slavery, colonization, forced migration, land theft, cultural genocide, and systemic disenfranchisement. These experiences did not end in the past; their legacy is still embedded in social institutions, laws, and everyday life.

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As a result, many BIPOC individuals grow up with an inherited sense of grief, vigilance, and survival, even if the original trauma is not consciously remembered.

Psychologically, historical trauma can affect emotional regulation, sense of self-worth, and mental health. BIPOC individuals may experience chronic anxiety, depression, or mistrust rooted in inherited experiences of oppression and marginalization (Cénat, 2023). This trauma can manifest in complex ways, such as disconnection from culture, shame around language or identity, or internalized racism. These patterns are not just individual reactions but are also responses to a long history of being devalued or erased. For example, Indigenous youth may feel alienated from their ancestral traditions as a result of forced assimilation. In contrast, Black youth may experience identity struggles shaped by generational messages about worth and survival in a racist society.

Healing from historical trauma requires more than individual therapy or personal resilience. It demands collective action, cultural reclamation, and systemic change. When BIPOC individuals have access to spaces that affirm their histories, celebrate their cultures, and acknowledge the truths of the past, healing becomes possible. Reconnecting with traditional knowledge, language, and community can serve as powerful tools of resistance and restoration. Moreover, institutions must be willing to confront the legacy of racism and its ongoing effects. Only then can BIPOC individuals and communities begin to break the cycle of trauma and move toward healing, dignity, and liberation.

What Is a Typical Approach When Working with BIPOC Clients?

Many books and publications that focus on working with BIPOC individuals have traditionally emphasized cultural competency as the primary framework. Cultural competency is often presented as the acquisition of knowledge about different racial or ethnic groups, along with an understanding of their traditions, communication styles, and worldviews. These texts frequently aim to provide you with guidelines or strategies for interacting with BIPOC clients in ways that avoid offense and demonstrate respect. The intent has been to equip practitioners with a baseline level of cultural knowledge, enabling them to recognize differences, reduce misunderstandings, and provide care that is more attuned to BIPOC clients' cultural values. Within this framework, you are encouraged to expand your awareness of cultural factors that influence BIPOC clients' mental health, identity development, and engagement in therapy. Cultural competency sounded great and had good intentions.

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Traditional Therapist Training

Cultural competency and anti-bias training have become standard components of traditional therapist education, often positioned as essential tools for working effectively with BIPOC clients. These trainings typically aim to increase awareness of cultural differences, reduce implicit bias, and promote respectful engagement across diverse identities. While well intentioned, these approaches often fall short of preparing practitioners to navigate the complex realities of systemic oppression, historical trauma, and racialized power dynamics that shape the lives of BIPOC individuals. The problem lies not in their existence but in their scope: Cultural competency and anti-bias training tend to emphasize surface-level understanding rather than profound structural critique.

Cultural competency training, despite its widespread adoption in mental health education and practice, operates from a problematic foundation that treats culture as a static set of characteristics to be learned and mastered, rather than recognizing it as a dynamic, lived experience that varies significantly among individuals within any cultural group. This approach encourages practitioners to develop what amounts to cultural checklists, learning about BIPOC culture or traditions, without acknowledging the vast diversity within racial and ethnic communities or the ways that factors like socioeconomic status, immigration history, sexual orientation, and regional differences create unique intersectional identities (Fisher-Borne et al., 2014). The cultural competency model inadvertently promotes a form of sophisticated stereotyping, where practitioners may feel confident in their knowledge about a particular culture while remaining blind to how their assumptions about cultural characteristics might not apply to their individual BIPOC clients. Furthermore, cultural competency training often focuses on learning about "other" cultures while leaving dominant cultural norms and white supremacist assumptions unexamined, failing to help practitioners recognize how their cultural socialization influences their therapeutic approach and potentially perpetuates harm.

Anti-bias training, while well intentioned in its focus on reducing prejudice and discrimination, typically operates at an individual level of consciousness raising that fails to address the systemic and institutional dimensions of racism that profoundly affect BIPOC clients' lives (Carter et al., 2020). These trainings often emphasize recognizing personal biases and minimizing aggressions without providing frameworks for understanding how historical trauma, structural inequities, and ongoing systemic oppression shape the psychological experiences of marginalized communities. The focus on individual attitude change, while necessary, can create a false sense of competence among those who

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complete bias training yet remain unprepared to address the complex ways that racism manifests in therapeutic relationships and treatment outcomes. Additionally, anti-bias training frequently frames racism as a problem of individual prejudice rather than a system of power that advantages white people while disadvantaging communities of color, potentially leaving you without tools for recognizing how your privilege and the institutional contexts in which you work contribute to therapeutic inequities.

Perhaps most significantly, both cultural competency and anti-bias training approaches fail to adequately prepare practitioners for the ongoing, relational work required to provide effective therapy with BIPOC clients. These training models typically present culture and bias as problems to be solved through education, rather than as ongoing dynamics that require continuous self-reflection and a willingness to be challenged and corrected by BIPOC clients. They often fail to address the emotional labor required of those who must confront their complicity in systems of oppression, navigate difficult conversations about race and discrimination, or provide culturally responsive care that may require departing from standard treatment protocols. Such trainings rarely prepare you to serve as allies or advocates for your BIPOC clients, to address structural barriers that affect treatment access and outcomes, or to integrate social justice considerations into your therapeutic work.

The inadequacy of traditional cultural competency and anti-bias training models becomes particularly apparent when considering their failure to prepare you for the complex intersectional identities and experiences that BIPOC clients bring to therapy. These approaches often treat race and culture as the primary or only relevant identity factors, failing to acknowledge how gender, sexual orientation, disability, immigration status, and other identities intersect with racial experience to create unique forms of oppression and resilience. The training models typically lack frameworks for understanding how historical trauma affects contemporary psychological presentations, for distinguishing between adaptive responses to oppression and symptoms requiring intervention, and for validating clients' experiences of discrimination without pathologizing their emotional responses to injustice (Devine & Ash, 2022). This inadequacy suggests that meaningful preparation for working with BIPOC clients requires more comprehensive approaches that integrate cultural identities and specific skills for addressing racism, oppression, and historical trauma within therapeutic relationships. When working with BIPOC clients, you may want to shift your approach from the cultural competence framework (a "way of doing" things) to a new orientation focused on a "way of being" with diverse clients: the multicultural orientation (MCO) framework.

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What Is the MCO Framework?

The MCO framework is a therapeutic approach that emphasizes the dynamic interplay between you and your clients' cultural identities, focusing on how these identities shape the therapeutic relationship. Rather than relying solely on static knowledge of cultural groups, the MCO framework centers on three core pillars: cultural humility (your openness and willingness to learn from your BIPOC clients' lived experience), cultural comfort (your ease in engaging in conversations about culture and race), and cultural opportunities (markers in therapy where aspects of your BIPOC clients' cultural identities can be explored and deepened) (D. Davis et al., 2018). By prioritizing relational responsiveness over rigid competence checklists, the MCO framework fosters stronger therapeutic alliances, enhances client satisfaction, and helps reduce disparities in treatment outcomes, especially for clients from marginalized communities—more on this in Chapter 2.

How Has the MCO Framework Been Addressed to Date?

Over the years, efforts have been made to adapt mainstream interventions such as *cognitive-behavioral therapy* (CBT), *motivational interviewing* (MI), and *marital and family therapy* (MFT) to better support BIPOC clients. These adaptations have been necessary and long overdue, responding to critiques that these traditional therapeutic models often overlook cultural identity, racial trauma, and systemic oppression. Modifications have included integrating cultural values, acknowledging discrimination as a source of psychological distress, and using culturally relevant language and metaphors. These changes have helped make therapy more accessible and relatable for BIPOC individuals, but despite these advancements, significant limitations remain.

Regardless of significant efforts to culturally adapt CBT for BIPOC clients, fundamental limitations persist that reflect the approach's deeply embedded Western individualistic assumptions. While culturally adapted CBT (CA-CBT) has made strides in incorporating discussions of racism and discrimination, these adaptations often remain superficial modifications to existing protocols rather than fundamental reconceptualizations of how psychological distress operates within systems of oppression (Kelly, 2019). Many adapted CBT approaches still maintain the core assumption that individual cognitive and behavioral change is the primary mechanism of healing, potentially underestimating how structural barriers limit genuine choice and agency for BIPOC clients. CBT sessions' emphasis on present-focused problem solving, while valuable, can

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inadvertently minimize the profound impact of historical trauma and intergenerational wounds that require different healing approaches than traditional cognitive restructuring. Even when you are trained to recognize realistic appraisals of discrimination, the fundamental CBT framework continues to locate the primary site of intervention within individual thoughts and behaviors rather than addressing the environmental sources of distress, potentially perpetuating what critics describe as the "psychologization" of social problems (Adolfsson & Finyiza, 2024).

MI's cultural adaptations, while promising, continue to struggle with the approach's fundamental assumption that individuals possess equal autonomy and access to change opportunities. Culturally adapted MI (CAMI) and other modified MI approaches have attempted to incorporate discussions of cultural values and systemic barriers. Still, these conversations often remain peripheral to the core MI focus on individual motivation and behavior change (Self et al., 2023). The approach's client-centered philosophy, while respectful, can become problematic when BIPOC clients need direct guidance about navigating discriminatory systems or accessing culturally appropriate resources. Yet MI's traditional reluctance to provide advice may leave BIPOC clients without crucial support. Even "macro M" approaches that attempt to integrate social justice concerns often struggle with the inherent tension between MI's individual change focus and the collective action required to address systemic oppression (Avruch & Shaia, 2022). The adapted approaches frequently fail to address how internalized oppression affects motivation, how cultural mistrust may influence the therapeutic relationship, or how the concept of "readiness for change" may be complicated by survival strategies developed within oppressive environments.

Marital and family therapy adaptations have made significant strides in recognizing diverse family structures and cultural practices. Yet they continue to operate within theoretical frameworks that were fundamentally designed for nuclear family configurations and may pathologize culturally adaptive responses to oppression. While contemporary approaches acknowledge external stressors like racism and poverty, the field's primary focus remains on modifying family interactions rather than addressing the systemic conditions that create family stress. Many family therapy models still emphasize Western communication patterns and emotional expression styles as therapeutic goals, potentially invalidating cultural approaches to conflict resolution, emotional regulation, or family decision making that differ from dominant norms (McDowell et al., 2022). The adapted approaches often fail to adequately incorporate Indigenous healing practices, community-based interventions, and the extended family and community networks that are central to healing in many BIPOC cultures. Even after receiving cultural competency

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training, the underlying theoretical models may still reflect Western psychological assumptions about healthy family functioning that may not align with diverse cultural values and practices.

The persistent limitations across these adapted therapeutic modalities reflect a more fundamental challenge: the difficulty of truly decolonizing therapeutic approaches developed within and that continue to operate within systems of cultural dominance. While surface-level adaptations, such as using culturally relevant examples or acknowledging discrimination, represent important progress, they often fail to address the deeper epistemological assumptions about the nature of psychological distress, the mechanisms of healing, and the role of individual versus collective intervention. These therapies continue to privilege individual change over environmental modification, present-focused solutions over historical healing, and professional expertise over community wisdom and cultural knowledge. These limitations suggest that meaningful therapeutic work with BIPOC clients may require not just adaptation of existing approaches but also the development of an entirely new framework that centers the experiences of marginalized communities from the outset rather than attempting to retrofit dominant-culture approaches to serve populations they were never designed to support. This recognition points toward the need for a more radical reimagining of therapeutic practice that honors both empirical rigor and cultural authenticity while explicitly addressing the systems of power and oppression that shape clients' lives.

What Is Missing?

Contemporary therapy practice faces a significant gap in the practical integration of the MCO framework with existing evidence-based interventions, leaving you with theoretical knowledge of cultural responsiveness but limited guidance on how to adapt therapeutic approaches meaningfully. While you may complete cultural competency training and learn about the importance of considering cultural factors, you may often struggle to translate these concepts into concrete modifications of your CBT protocols, MI techniques, or family therapy interventions. The absence of step-by-step guidance for integrating cultural awareness into therapeutic techniques creates a disconnect between multicultural theory and practice, leaving well-intentioned practitioners who may acknowledge cultural differences in principle but continue to deliver culturally decontextualized interventions. This gap becomes particularly problematic when you attempt to serve BIPOC clients using therapeutic

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models that were developed for and validated with predominantly white populations and you lack the specific skills to adapt these approaches in ways that honor cultural worldviews, address systemic oppression, and leverage cultural strengths as therapeutic resources.

Perhaps most critically missing from current therapeutic training is an explicit focus on practitioner values and bias recognition as core clinical skills that require ongoing development and refinement. While many training programs include brief modules on cultural awareness or bias recognition, they rarely treat self-reflection as a fundamental therapeutic competency that requires the same sustained attention as learning diagnostic criteria or intervention techniques (Chu et al., 2022). You are often expected to examine your cultural socialization, recognize your privilege, and confront your complicity in systems of oppression without receiving adequate training in how to engage in this emotionally challenging work or how to use self-awareness as a therapeutic tool. The field lacks structured approaches for helping you develop comfort with your discomfort, learn to sit with uncertainty about cultural dynamics, or navigate the complex emotions that arise when confronting your own biases and limitations. This absence of explicit skill development in provider self-reflection contributes to therapeutic relationships where power dynamics remain unaddressed, cultural conversations are avoided, and BIPOC clients may experience subtle forms of invalidation or minimized aggressions that you remain unaware of despite your good intentions.

The need for different therapeutic attitudes and skills when working with BIPOC clients stems from recognizing the unique experiences, challenges, and cultural environments that shape these individuals' lives. One primary reason for this different approach is the overall influence of minimized aggressions, systemic racism, and stigmas. BIPOC clients often navigate a world where they regularly encounter these barriers. These experiences can significantly affect their health, self-esteem, and overall well-being in ways that may not be immediately apparent to practitioners who haven't experienced these realities firsthand. Therefore, practitioners must develop a deeper understanding of these systemic issues and their psychological impacts.

The therapeutic field also lacks specific communication strategies and therapeutic skills designed for working effectively with BIPOC populations, instead relying on generic "good therapy" principles that may not address the unique dynamics present when working across racial and cultural differences. Missing are concrete skills for recognizing when cultural themes emerge in sessions, reflecting culturally meaningful language, asking culturally responsive questions, and managing the intense emotions that can arise when discussing experiences of racism and

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discrimination. You will need specific training in validating experiences of oppression without pathologizing emotional responses to injustice, distinguishing between individual psychological issues and responses to systemic barriers, and providing culturally specific information and guidance when BIPOC clients need practical support for navigating discriminatory systems. Without these specialized communication skills, even culturally aware practitioners may inadvertently perpetuate harm by applying generic therapeutic techniques to complex cultural dynamics they are not adequately prepared to address.

Finally, current therapeutic practice lacks practical application of antiracism concepts that move beyond awareness raising to concrete action within therapeutic relationships and institutional contexts. While many of you understand racism as a social problem, practitioners often lack specific skills for identifying and interrupting racist dynamics within their practice, advocating for clients facing systemic barriers, or integrating social justice considerations into treatment planning and intervention selection. Missing are frameworks for how to serve as allies to BIPOC clients, when and how to provide direct support for addressing discrimination, and how to modify therapeutic approaches to address both individual symptoms and structural oppression simultaneously. The absence of practical antiracism skills leaves you without tools for addressing the ways that systemic inequities affect therapeutic relationships and treatment outcomes, potentially limiting their effectiveness with BIPOC clients who need support not only for individual psychological concerns but also for navigating environments where they face ongoing marginalization and discrimination. This comprehensive gap in therapeutic training highlights the need for a specific framework that equips practitioners with practical skills for integrating multicultural awareness, cultural responsiveness, and antiracist practice into everyday therapeutic work. We believe the proposed AMCO framework, attitudes, and skills are consistent with emerging literature on structural competencies (Wilcox et al., 2024) and liberation psychology (Burgoon et al., 2021), and together, they will move the field forward.

How Is This Book Organized?

This book is organized around a unique case-based learning approach that follows five carefully developed BIPOC case scenarios throughout the entire book, allowing readers to see how AMCO principles and skills apply across different therapeutic contexts and client presentations. The cases represent diverse experiences within BIPOC communities.

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Lawrence: "I'm trying to get ahead, but it feels like everyone is against me because I have a record."

- I am . . .
  - A 35-year-old, Black, heterosexual, cis male
  - Context: "I currently live in Buffalo, New York, and I am on parole after being released from prison for weapons possession and assault. I'm having difficulty finding employment and housing after completing an outreach program."
- People tell me . . .
  - Parole officer (white male): "My parole officer told me, 'You must get a job and stable housing, or you will violate your parole.' I don't like him a lot. He doesn't care what happens to me. It seems like he wants me to go back to jail."
  - Outreach worker (Black female): "My outreach worker said, 'Seems like you want to make some changes in your life since you are asking for some help.' I like my outreach worker. She's in my corner sometimes, but other times, she's bossy."
- My interest is in talking about change with . . .
  - Parole officer: "I have absolutely no interest in talking to that white man about problems he wouldn't even understand or care about. I thought he was supposed to help me find a job and a place to stay. He told me that's not his job."
  - Outreach worker: "I would go to her for help, but it depends on her mood. A helping one or telling what I need to do, like my mama or something. No matter what, though, she does at least listen to me."

Luis: "It's my life, and I do what I want. Just want to make sure I'm being safe."

- I am . . .
  - A 22-year-old, Dominican, gay, cis male
  - Context: "I live in Miami, Florida, and am a full-time student at the University of Miami. My parents are very proud of me for attending college, as I will be the first in my family to graduate from college. I recently broke up with my boyfriend and have been feeling really depressed. Since the breakup, I have been doing some heavy partying, which has involved a lot of drinking and marijuana smoking, more than I have ever done before. This has led to occasionally hooking up with several people on those party nights. I want to graduate from college

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and get a well-paying job. I came to the clinic for testing for sexually transmitted infections and also to find a way to talk to my parents about being gay."

- People tell me . . .
  - Parents: "My mother says, 'You are drinking too much.' My father says, 'You have to keep your grades up so you can have a better job than I have. You don't want to work with your hands your whole life like me.' My loving Dominican traditional parents have a different value system than mine. To them, it's all about working hard and graduating from college. They are so focused on that, so they are in total denial that I'm gay. I definitely don't hide it. So it's kind of hard even bringing up the subject of sexual relationships with them, especially my father, which is what I really want to talk about with them."
  - Friends: "My friends say things like 'Don't you know you could catch something you can't get rid of if you continue to keep hooking up with all these guys?' "
  - Practitioner (Southeast Asian): "A practitioner at the clinic said, 'You need to start taking your health more seriously, but I'm glad you came in to talk about sexual health concerns.' "
- My interest is in talking about change with . . .
  - Parents: "I talk to them about a lot of things, like school or job opportunities. It's not like I can't talk to them at all. It's just specific topics, like sex and current relationships. I think it affects me more than I thought when they don't even ask me about my lifestyle or, worse yet, don't even care."
  - Friends: "I don't know if I want to talk to them about some things I want to change. Sometimes it feels like they support me and others . . . like they judge my new sex life."
  - Practitioner: "If he just gives me the information and does not lecture me about my current decisions, then I might listen and accept some of his advice. I just really want to know how to protect myself and potential partners from catching some type of disease."

Jackie: "I want to be healthier, but I can't change where I live."

- I am . . .
  - A 53-year-old, heterosexual, Black, cis female
  - Context: "I live in a low-income neighborhood on the edge of Detroit, Michigan. I have two kids in the home: a 21-year-old boy and a 23-year-old girl with a 10-month-old son. I'm dependent on local convenience stores and fast food for most of my meals. There are no real grocery stores in my neighborhood.

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These are the primary reasons for my concerns regarding diet and physical activity. I have smoked cigarettes since I was about 17 years old. I used to smoke more, but I have cut down to half a pack a day since I started gaining weight. The weight has started to get me concerned about my health. After going to see my primary health care doctor at the clinic, I was diagnosed with high blood pressure and assigned a community health worker. I also have significant anxiety."

- People tell me . . .
  - Siblings: "My sister and brother say 'When are you going to start losing some weight?' or, 'When are you going to stop smoking so much?' I'm so tired of hearing that whenever I see my sister and brother. My brother never says anything negative, but he doesn't support me either. It's my sister with the questions. That's why I'm always on edge whenever I have to see her, which is a lot since she helps take care of my sick mother at the nursing home. But I went to the doctor because I can't lose weight, and it's getting harder to breathe sometimes.
  - Community health worker (Black female): "My community health worker told me, 'Being a middle-aged Black woman, you have to be aware that your smoking and being overweight can increase your risk of heart disease, stroke, and diabetes. You need to stop smoking and lose some weight.' "
- My interest is in talking about change with . . .
  - Family: "Talking to my sister about my health will never happen, but maybe with my brother. When she's not around, he is a different person. He takes me to the doctor sometimes. He is a great listener, but now he is busy with work and raising his family. I just don't want to bother him."
  - Community health worker: "I have a good doctor who gives me OK advice. He seemed to know what he was talking about, but sometimes I felt the conversation was one-sided. He talks a lot!"

Angelica: "Part of me wants to leave the gang life, and part of me doesn't."

- I am . . .
  - A 19-year-old, Mexican, bisexual, cis female
  - Context: "I live in Los Angeles, California. I was born and raised in East LA in a heavy gang neighborhood. My parents were in gangs growing up, and so I naturally became involved with gang life. I first used alcohol at age 14 and marijuana at age 16. I have been arrested several times for disorderly

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conduct, and I'm currently on probation. Due to being in and out of jail, I did not graduate from high school. I continue to drink and smoke marijuana regularly. I really want to move out of the neighborhood, but I feel trapped. I recently saw one of my friends [Maria] who moved out of the neighborhood and is doing well. She looked like a different person. Maria told me about a program that helped clear up her arrest record and helped her get a job. Now, I'm seriously thinking about getting into that program."

- People tell me . . .
  - Probation officer (white female): "My probation officer said, 'You seem like you want to be like your parents. I guess this is all you know. We have support groups and counseling services that focus on substance abuse, but you don't ever go.' "
  - Friends: "Some of my friends say, 'Why would you want to leave the neighborhood? This will always be your home.' Others say, 'You could do so much more with your life.' "
  - Therapist (mandatory as part of probation; Hispanic female): "My therapist says, 'It's really up to you if you want to keep living this type of life. We offer opportunities for you to clear up some things on your arrest record, but it will take some hard work and discipline to get it done.' "
- My interest is in talking about change with . . .
  - Probation officer: "I just don't trust her. She has offered me help with getting jobs and counseling. But I don't want to sit in a group and talk to some 'other' who thinks they know something about my life. I hate that when they try to pretend like they know and care about you.' "
  - Friends: "I just want to talk to Maria about what's happening. I really missed her. The rest of my so-called friends only really come around when I have something to drink and smoke."
  - Therapist: "She seems to be OK. I really want to get my life back on track. I don't want to be like my parents and live in the same neighborhood in the same house my whole life. This program may help."

John: "I don't have a drinking problem. I just need to start working again."

- I am . . .
  - A 60-year-old, Native American, heterosexual, cis male
  - Context: "I live in Albuquerque, New Mexico. I used to work as a machine worker in a factory for 5 years before being recently laid off. I was making pretty good money. At first, I would

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drive around and try to find work every week, but no one was hiring at the time. It became frustrating to me. The one thing I still enjoyed was hanging out with my buddies from my old job. When I worked there, we would always meet up after work at the local bar located across the street from the factory. Soon, I stopped looking for jobs and ended up at the bar. My friends would buy me drinks, which soon became a daily routine. One evening, I got arrested after leaving the bar for driving recklessly, and now I have a DUI [driving under the influence] on my record, and probation is mandatory. Despite the DUI, I still really want to get a job and get my life back on track."

- People tell me . . .
  - Friends: "My friends say, 'You gotta stop drinking and driving. You are going to kill yourself or someone else.' They also say things like 'Seems like you can handle your liquor.' Another one said, 'Hey, I know where they are hiring, but they won't hire you if you keep drinking like that.' "
  - Probation officer (white male): "My probation officer said, 'Drinking and driving don't mix. I hope this teaches you that lesson.' "
  - Therapist (white female): "My therapist often says, 'One day at a time.' She also asked me, 'Do you want to start working again?' "
- My interest is in talking about change with . . .
  - Friends: "Some of them are pretty good guys. They have always looked after me. That's why they buy me the drinks [laughing], but seriously, they also give me tips on who is hiring."
  - Probation office: "He reminds me of my father. He is always telling me what I need to do without even listening to my side. Yeah, I don't see myself sharing a lot with him. I'm going just to do what I must to get off probation and return to my old life."
  - Therapist (white female): "I just have a hard time trusting white people. I just don't feel we are on the same page when I talk to her."

Rather than presenting these cases as isolated examples, each scenario is woven throughout multiple chapters, demonstrating how AMCO-informed practice evolves across different therapeutic modalities and stages of treatment. This longitudinal case approach allows readers to witness the complex, ongoing nature of culturally responsive therapy while seeing how specific AMCO skills and principles can be applied to address the multifaceted challenges that BIPOC clients face, from individual psychological concerns to navigating systemic barriers and cultural identity development.

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THINGS TO REMEMBER

- Racism, stigma, and historical trauma are not abstract concepts but lived realities that shape BIPOC clients' mental, physical, and social well-being.
- Intersectionality reminds us that clients' experiences are influenced by multiple overlapping identities that compound oppression and resilience.
- The MCO framework shifts practice from "knowing about cultures" to a "way of being" with clients through cultural humility, cultural opportunities, and cultural comfort.
- While adaptations of CBT, MI, and family therapy have made progress, they remain rooted in Western, individual-focused models that often miss systemic and collective dimensions of healing.
- Traditional cultural competency and anti-bias training fall short because they focus on awareness without addressing provider biases, systemic inequities, or practical therapeutic skills.
- Developing an AMCO approach requires self-reflection, skill building, and a willingness to center BIPOC worldviews while integrating antiracism into daily practice.
- This book is organized around BIPOC case scenarios, skill-building activities, and reflective questions to bridge the gap between theory and practice and to guide providers toward becoming culturally responsive, antiracist practitioners.

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