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In mental health care, internationalization and globalization have increased the
need for countries to look beyond their borders in order to promote effective health
and mental health care. Indeed, in the last decade we have seen numerous gov-
ernmental and nongovernmental organizations that have evolved to promote and
support developments worldwide. However, globalization has generally led to
the domination of Western views of mental health as well as the policies and inter-
ventions associated with it. Integration of foreign values and ideas has been more
apparent in non-Western countries than Eurocentric nations, in part because of
the “well-established status and specialty of Western psychological theories as the
standard approach to counseling and psychotherapy” (Moodley, Gielen, & Wu,
2013, p. 2). Clearly, as globalization and internationalization continue to intensify,
“it is imperative for practitioners, clinicians, educators, and those in training to
abandon their sense of self-sufficiency and actively increase their understanding
of counseling and psychotherapy practices as they exist across cultures and na-
tions” (Moodley et al., 2013, pp. 2–3).

The counseling profession began this process long ago. Theory, research, and
counselor training have focused on issues of immigration, multiculturalism, cul-
tural diversity, and all of the Group of Seven identity categories (race, gender,
class, sexual orientation, disability, religion, and age), also known as the “Group of
Seven” sociocultural identities (see Moodley, 2011, for discussion). These identities
must be seen as fluid, shifting over time in accordance with contextual influences,
such as sociopolitical realities, economic possibilities, developmental transitions,
personality variables, and cultural histories. Moreover, a holistic approach to un-
derstanding one’s identities demands that we explore them at three levels: the in-
dividual level (uniqueness; like no other individual), the group level (shared val-
ues and belief systems with important reference groups), and the universal level
(common features shared by all human beings; Sue, 2001). For instance, each case
in this text contains features that no other cases share (e.g., a client’s developmen-
tal background), collective experiences that other cases of similar reference groups
share (e.g., shared experiences among Muslim women), and universal character-
istics that all cases share (e.g., experience of pain and suffering). At a most basic
level, the counselor’s own awareness and perceptions of him- or herself as a com-
plex, multidimensional being are critical in working across cultures. Cultural sen-
sitivity, or “cultural empathy” (Ridley & Lingle, 1996), expressed by a counselor is a key ingredient in ensuring that the clinician is culturally competent (Dyche & Zayas, 2001).

As the current high rate of immigration is driving many demographic changes in the United States, Canada, and Europe, counselors and psychotherapists must acquire the ability to interact effectively with people of different cultures, ethnicities, sexual orientations, and religions. These new configurations inevitably bring about different worldviews, belief systems, values, customs, and lifestyles as well as different mental health representations, presentations, enactments of psychological disturbances, and help-seeking behaviors. In order to meet the multicultural and diverse needs of all these varied individual and groups, counselors will need to be much more sophisticated, astute, and complex in the way they formulate and conduct counseling to ensure a culturally responsive service. We believe that the study of an individual case can provide counselors with a breadth and depth of knowledge about groups and communities, because

Each individual is a component part of numerous groups, he is bound by ties of identification in many directions, and he has built up his ego ideal upon the most various models. Each individual therefore has a share in numerous group minds. Those of his race, of his class, of his creed, of his nationality, etc.,—and he can also raise himself above them to the extent of having a scrap of independence and originality. (Freud, 1921, p. 129)

The case studies in this book therefore illuminate the various ways in which counselors and psychotherapists across the globe work with clients in ways that enhance the practice of counseling and therapy. The many different ways in which counseling is understood and undertaken across the various countries represented in this book are described and illustrated through the case studies. Each case study is unique and distinctive, with each offering a rare opportunity for mental health practitioners to get a bird’s-eye view of what happens around the world. Therefore, the study of these cases individually and collectively will yield a wealth of information about the theory and practice of counseling and psychotherapy across the globe. Engaging the case study in this way will provide counselors with more than just a comparative analysis of practice; indeed, it will offer process and contextual insights into how current theories of counseling are formulated, modified, and reconstituted within different country contexts. Such an analysis will highlight the weaknesses and strengths of particular theories of counseling and psychotherapy.

As scholars and mental health practitioners bound by ethical standards for the practice of counseling, psychology, and psychotherapy, we are acutely aware of the key ethical issues that may arise when publishing a case studies text. Primarily, striking a balance between protecting a client’s anonymity and providing a rich, detailed account of the client’s clinical history to make it useful is a common ethical dilemma of case study publication. Furthermore, dual roles of this text’s contributors and their associated obligations (acting as both a scholar and a clinician) may result in conflicts, undue influences, and power imbalances that could affect the therapeutic relationship as well as decision-making procedures (e.g., consent of subjects). Although a universal code of ethics has not been formally recognized, it is the duty of our contributors to adhere to the standards and principles adopted by their respective nations to mitigate these risks (for more information about pro-
professional regulations in counseling and psychotherapy in various nations around the globe, refer to Moodley et al., 2013).

**WHY AN INTERNATIONAL CASE STUDY HANDBOOK IS NEEDED IN A RAPIDLY GLOBALIZING WORLD**

During the last four decades, the field of psychology has rapidly expanded in many parts of the world. Stevens and Gielen (2007) estimated that more than one million psychologists are now active around the globe, with American psychologists probably making up less than one quarter of this impressive number. Very large numbers of psychologists can be found not only in European countries, such as England, Germany, Spain, and Russia, but also in Latin American nations, such as Argentina, Brazil, and Mexico (Stevens & Wedding, 2007). Whereas in Argentina, Brazil, and Uruguay psychoanalysis is especially popular among counselors, psychotherapists, and even the general public, in most other nations various forms of cognitive behavior, Rogerian, and interpersonal counseling and psychotherapy are practiced most frequently. It is also noteworthy that in the poorer as well as in many of the economically emerging countries, the more Westernized forms of counseling predominate above all in the big cities, where many of the counselors’ clients are educated and somewhat Westernized middle-class women and men. In contrast to this situation, the more traditionally oriented inhabitants of isolated villages and provincial towns are more likely to resort to traditional healers, whose treatment methods rely on explanations revolving around divination and supernatural forces, together with the administration of herbal remedies and other indigenous forms of practicing medicine. The Nigerian case study, for instance, introduces the reader to such a traditional healing approach. Indeed, in many African countries traditional healers tend to outnumber both doctors trained in allopathic (Western-style) medicine as well as psychological counselors and therapists. However, and unfortunately, most counselors (who have been exposed to modern psychological theories) and most traditional healers (who rely on invisible spirits and divine influences) tend to find it difficult to work together for the spiritual, psychological, and medical welfare of their clients. It seems that their ontological and epistemological frameworks diverge so widely from each other that they cannot find common ground for joint professional activities.

On the whole, then, the case studies described in this volume reflect a globalized world in which the field of counseling psychology represents a modern form of consciousness and theorizing about human nature and its potential strengths and weaknesses. At the same time, the studies certainly leave room for a broad variety of cultural influences on both counselor and client that manifest themselves in the form of different expectations in the counseling situation as well as varied family systems; divergent gender roles; culture-specific expectations about the roles of children, students, parents, employers and employees, friends, peers, and dating partners (if any); and so on. Indeed, we as editors like to claim that it is exactly by scrutinizing and meditating upon these highly varied case studies that the reader can learn in detail how general human nature, specific cultural expectations and norms, social institutions, a client’s individual character and psychological difficulties, and his or her counselor’s interpretations and treatment approach can come together in a series of fruitful encounters evolving over time. The case studies teach us in some detail how an international group of both Western and
non-Western counselors conceive of and approach their task of helping a broad variety of clients to achieve less troubled and more fulfilling lives—and, at times, also why counseling can be such a difficult and demanding endeavor.

Besides demonstrating how mental health practitioners in various countries undertake counseling and psychotherapy, this text also attempts to connect ethnicity and counseling as well as the specific cultural practices that are part of healing in those countries. Dyche and Zayas (2001) argued that counselors and psychotherapists who have developed the ability to be culturally empathic are well prepared to practice counseling and psychotherapy with a diverse clientele. This ability entails embracing an attitude and/or skill that effectively bridges the cultural gap between clinician and client, one that seeks to help clinicians integrate an attitude of openness, with the necessary knowledge and skill to work successfully across cultures. It involves a deepening of the human empathic response to permit a sense of mutuality and understanding across the great differences in value and expectation that cross-cultural interchange often involves. (Dyche & Zayas, 2001, p. 246)

The counselor of the future will be asked to interact with clients from an almost limitless range of cultural backgrounds. Already the schools of many of the world’s great cities, such as New York, Los Angeles, Chicago, Toronto, Vancouver, London, Berlin, and Paris, are filled with the children of immigrants. Take New York City as a striking example: In 2014, more than two thirds of all students in its public school system came from immigrant and minority backgrounds. Consequently, the school counselor in the average New York City public school has to be prepared to see in her office students whose families or parent(s) arrived in the city from some 40 nations spread around the globe. For such a counselor, reading a volume filled with international case studies is not an exotic task, but rather it constitutes an excellent preparation for helping her master her central task—a task that requires her to grasp what the world might look like from the vantage points of her student–clients as well as the students’ parents, grandparents, siblings, friends, and peers. International case studies not only tell us how cultural meaning systems work themselves out in detail and on the ground, so to speak, but also teach us how a variety of counseling theories can profitably be applied in a broad range of sociocultural situations that frequently are new to most of us.

HOW THE BOOK IS ORGANIZED

The International Counseling Case Studies Handbook is divided into three sections.

SECTION 1

Section 1 opens with an introduction that outlines the history, philosophy, and process in counseling and psychotherapy around the globe. Chapter 1 discusses ways in which counselors and mental health practitioners can use and maximize the global cases in this text and situate it in their own local communities.

SECTION 2: COUNSELING AND PSYCHOTHERAPY AROUND THE WORLD

This section (Chapters 2–34) is divided into five parts representing six continents, or regions. Each region has chapters from some of the major countries where coun-
The Client/s
In this section, authors describe the client’s diversity in terms of the Group of Seven identities, that is, gender, ethnicity (race), disability, class, age, sexual orientation, and religion. In some cases this section includes a brief description of how the client has constructed his or her subjectivity in terms of the Group of Seven identities. Some authors also comment on the various combinations and intersections of these identities within particular contexts and situations that allow for particular identity performances.

Presenting Issues and Challenges
In this section, authors comment on the client’s reason for referral, psychological difficulty, subjective distress, and any clinical observations that they have made.

Case History and Developmental Background
This section requires authors to write about the familial, cultural, social, ethnic, and Group of Seven identities and their contributions to the personality development of the client. Authors of some chapters comment on the relationship between the evolution of multiple identities and the life history trajectories within the context of the respective country’s sociopolitical climate.

The Therapy
In this section authors discuss the therapeutic perspectives and the particular approach or modality that was used with the client. The process of counseling and therapy is described in some detail, including the following: interventions; assessment, goals, and therapy treatment; and outcomes. Authors were asked to include introspection and self-disclosure and to reflect on the Group of Seven identities in the clinical process, particularly the use of traditional healing, spirituality, and other alternative healing modalities that support resilience.

Discussion and Analysis of the Case
In this part the authors critically discuss their cases, using theory and ideas from the published scholarship and questioning the use of counseling and psychotherapy as the best modality for the client’s particular problems. Authors were encouraged to bring several elements together in their discussion: the Group of Seven identities, problem solving, consciousness raising, and alternative healing modalities. These elements were addressed in a reflective discussion of their work with the client.

Questions
In this section, five questions are posed about the case study. These open-ended questions are designed to stimulate deeper thought and discussion about the
case study as well as how a counselor might handle similar issues with his or her own clients.

SECTION 3

The concluding chapter (Chapter 35) explores some of the main themes and ideas that can be found in the book. An overview of cultural, multicultural, and diversity contexts is discussed, and particular attention is paid to the concepts of individual culture versus the collective culture and the relationship of the self in navigating these spaces. The chapter also looks at the intersection between the body, mind, and spirit, which featured prominently in many cases. Finally, the chapter discusses some key recommendations for counselors and psychotherapists from the lessons learned from the cases in this book.

REFERENCES


About the Editors and Contributors

About the Editors

Roy Moodley, PhD, is associate professor of counseling psychology at the University of Toronto, Ontario, Canada. He is the director for the Centre for Diversity in Counselling and Psychotherapy. His research interests include critical multicultural counseling and psychotherapy, race and culture in psychotherapy, traditional healing, culture and resilience, and gender and identity. He has authored or edited several journal articles, book chapters, and books.

Marguerite Lengyell, EdD (candidate), is in the Counselling and Psychotherapy Department at the University of Toronto and is currently a psychological associate conducting psychological assessments for children, adolescents, and adults in Toronto, Ontario, Canada. Her academic research interests have focused on ideologies of multiculturalism and their application in the therapeutic process. To be specific, she has had a long-standing interest in mixed race, interracial, and interethnic relationships and children of mixed race or ethnic heritage.

Rosa Wu, PhD, is a registered clinical counselor living and working in Vancouver, British Columbia, Canada. Originally from Taiwan, she has lived in Costa Rica, Panama, Spain, New York, and Toronto and is fluent in English, Spanish, and Mandarin Chinese. Rosa’s main research interests include interethnic couple relationships, multicultural counseling competencies, and traditional and alternative methods of healing. She currently teaches in a postsecondary institution and works part-time as a counselor in private practice.

Uwe P. Gielen, PhD, is professor emeritus and executive director of the Institute for International and Cross-Cultural Psychology at St. Francis College, New York. His work centers on cross-cultural and international psychology, Chinese American immigrant children, Tibetan studies, international family psychology, and moral development. He is the senior editor, coeditor, and coauthor of 21 volumes that have appeared in five languages. He has served as president of the Society for Cross-Cultural Research, the International Council of Psychologists, and the International Psychology Division of the American Psychology Association.
About the Editors and Contributors

Mona M. Amer, PhD, is associate professor of psychology at the American University in Cairo, Egypt. She earned her doctorate in clinical psychology from the University of Toledo and her postdoctoral specialization from Yale University. She is coeditor of the book Counseling Muslims: Handbook of Mental Health Issues and Interventions.

Murat Balkis, PhD, is an associate professor in the Department of Psychological Counseling and Guidance at the Pamukkale University, Turkey. His clinical background includes working with college students and dealing with issues related to psychosocial adjustment and academic failure. His research interests include adjustment, homesickness, and procrastination.

Nicole Baudouin, PhD, is a clinical psychologist and therapist. Her research at the National Institute for Studies on Work and Vocational Guidance in Paris, France, deals with the counseling interview, supervision, and psychological processes of vocation. She is the author of the book Le sens de l’orientation [The sense of vocation].

Robinder P. Bedi, PhD, is an associate professor in the Department of Psychology at Western Washington University. His research interests include professional issues in counseling psychology, counseling men, and the therapeutic relationship. He specializes in substance abuse counseling and counseling individuals involved in motor vehicle accidents.

Sharon Ziv Beiman, PhD, is a clinical psychologist; works as a faculty member at the College for Academic Studies in Or-Yehuda, Israel; is comanager of Siach-Group, an institute for relational psychotherapy, in Tel Aviv, Israel; serves as chair of the Israeli Forum for Relational Psychoanalysis and Psychotherapy; and is a board member of the International Association for Relational Psychoanalysis and Psychotherapy.

Dounia Belghazi, MD, is a psychiatrist. She graduated from the Medical University at Casablanca, Morocco, and earned a university diploma in cognitive behavior therapy (CBT) and addictology. She trained at CHU in Brugmann, Belgium. She is author of various articles and is currently a PhD student in Casablanca’s Laboratory of Mental Health.

Behrooz Birashk, PhD, is associate professor of psychology at Iran University of Medical Sciences, Mental Health Research Centre, and Tehran Psychiatric Institute. He is a member of eight national and international associations. Besides his teaching and research, he is editor in chief of a psychology journal and serves on the editorial boards of eight journals of psychology and psychiatry.

Olaniyi Bojuwoye, PhD, is a professor of educational psychology at the University of the Western Cape, South Africa. He has published many peer reviewed journal articles and book chapters on cross-cultural counseling, African traditional healing, and contextual influences on children’s development.

Thierry Bonfanti, PhD, is a professor at the Centro Studi Interculturali of the University of Verona and is on the sociology faculty at the university of Trento. He is a psychologist, psychotherapist, and mediator and is the leading exponent of the nondirective intervention approach in Italy. He has worked in different countries, such as France, Greece, and Spain.
Samuel Jurado Cárdenas, PhD, is full-time professor at the Graduate Studies Division, Faculty of Psychology, National Autonomous University of Mexico. His lines of research and interest include the following: CBT, behavioral medicine, history of psychology in Mexico, and biofeedback.

Doris F. Chang, PhD, is an associate professor of psychology at the New School for Social Research and a research scientist at the Center of Excellence for Cultural Competence, New York State Psychiatric Institute. Her research addresses disparities in the quality of mental health services for racial and ethnic minorities and issues in Chinese mental health.

Maria Damianova, PhD, is an associate professor in the School of Health Sciences at Monash, South Africa. She is a registered counseling and educational psychologist with the Health Professions Council of South Africa.

Andrea L. Dixon, PhD, is an associate professor of counseling at Georgia State University in Atlanta, Georgia. She specializes in multicultural awareness and training and conducts research in these areas and in mattering and wellness across the lifespan.

José F. Domene, PhD, is Canada Research Chair in the School to Work Transition, Faculty of Education, University of New Brunswick, Fredericton. His research interests include social–relational contexts of career development, young adults’ health and wellness, and professional issues in Canadian counseling psychology.

Vânia Maria Domingues is a specialist clinical psychologist with more than 30 years of private practice with adolescents and adults.

Carol Zerbe Enns, PhD, is a professor of psychology at Cornell College and is a contributor to the Ethnic Studies program and the Gender, Sexuality, and Women’s Studies program. She teaches courses in multicultural psychology and has served as the resident director of the Japan Study Program in Tokyo. Carol’s scholarly interests include gender issues, feminism, and feminist psychotherapy in Japan and East Asia.

Yasmine I. Fayad, MA, is an instructor in the Psychology Department at the American University of Beirut, Lebanon. She also worked as a therapist at SKOUN, a nongovernmental organization in Beirut, Lebanon, that provides mental health services to patients with substance abuse problems.

María Fregoso-Vera, PhD (candidate), studies psychology and health and is on the faculty of the Psychology Department at the National Autonomous University of Mexico. For 5 years, she has worked with children who have allergies and their caregivers. She has worked as a teacher at various levels of education, including the college level and higher.

Tony Sam George, PhD, is associate professor and head of the Department of Psychology at Christ University, Bangalore, India. He is also a practicing psychotherapist and works with couples, families, and adolescents.

William B. Gomes, PhD, is a professor of psychology at the Federal University of Rio Grande do Sul, Porto Alegre, Brazil. He has conducted research on psychotherapeutic and counseling effectiveness with Brazilian populations since the early 1990s.

Nanja H. Hansen, MC, is a licensed psychologist in Denmark and a licensed professional clinical counselor in California. She works at Stanford University at the Staff Faculty Help Center. Her clinical interest areas are compassion for self and others, multicultural issues, and life transitions.
Gerard Hutchinson, PhD, is a professor of psychiatry, head of clinical medical sciences, and coordinator of the master’s of science in clinical psychology program at the University of the West Indies, Mount Hope, St. Augustine campus, Trinidad and Tobago. He is also the head of Mental Health Services, North Central Regional Health Authority, Mount Hope.

Giel Hutschemaekers, PhD, is full professor in mental health care at the Radboud University Nijmegen (the Netherlands) and is a therapist in a large integrated institute for mental health care in the Nijmegen Arnhem region (Pro Persona). His research is focused on professionalization issues, such as the implementation of evidence-based guidelines and its consequences on professionals’ expertise and on patient outcomes.

Shigeru Iwakabe, PhD, is an associate professor in the Developmental Clinical Psychology Program at Ochanomizu University in Tokyo, Japan. He conducts psychotherapy research on client emotional processes, therapeutic failures and impasses, and therapist empathy. He is also interested in cultural issues associated with the practice of psychotherapy.

Naomi James, MA, is a counseling psychologist and trainer at Oasis Africa Training and Counseling Centre in Nairobi, Kenya. She is also head of the counseling department, is in charge of the intern training program, and is head of the psychology department at Oasis Africa Institute of Leadership and Professional Psychology. Oasis Africa provides counseling and psychotherapy services, training, and employee assistance services to organizations.

Roberto E. Javier, Jr., PhD, is a licensed psychologist in the Philippines. He is currently a full professor in the Department of Psychology and is a fellow at the Social Development Research Center of De La Salle University, Manila. He is a board member of the National Association for Filipino Psychology.

Eunsun Joo, PhD, is a professor in the Department of Psychology at Duksung Women’s University. She is a certified counseling psychologist in Korea and a certified focusing trainer and coordinator in the United States. She has published numerous articles and books in the areas of culture and psychology, person-centered and focusing approach, and development of psychotherapists.

Nadia Kadri, MD, is a professor of psychiatry. She introduced the first academic training in Morocco on CBT, clinical sexology, and behavioral medicine. She is the author of hundreds of articles published on the national and international levels and of several books on general psychiatry, mental health of women, stigma, CBT, and sexuality.

Bhisham Kinha, MEd, is a counseling psychologist in private practice.

Alla Kholmogorova, PhD, is professor of psychology, head of the Department of Clinical Psychology and Psychotherapy at the Moscow Research Institute of Psychiatry, council member of the Russian Society of Psychiatrists, founder fellow of the Academy of Cognitive Therapy, and head of the faculty of Counseling and Clinical Psychology at Moscow State University of Psychology and Education.

Brigitte Khoury, PhD, is an associate professor in the Department of Psychiatry at the American University of Beirut in Lebanon and is director of the clinical psychology training program. She is also the director of the Arab Regional Center for Research, Training and Policy Making in Mental Health as well as a consultant for the World Health Organization in Geneva, Switzerland.
Lonzo Zou Kpanake, PhD, is an associate professor in the Department of Psychology at the University of Québec (TÉLUQ), Canada. He received his PhD in psychology from the University of Toulouse, France, and completed his postdoctoral training in transcultural psychiatry at McGill University, Canada. His research has focused on health issues among African populations.

Karen Krause, MD, is head of the ambulatory care clinic for child and adolescent psychotherapy at the Mental Health Research and Treatment Center, Ruhr-Universität, Bochum, Germany. She is a licensed psychotherapist (CBT) for children, adolescents, and adults and is a licensed clinical neuropsychologist. She is a trainer and supervisor for CBT in children and adults.

Eunjung Lee, PhD, MSW, is an associate professor at the Factor-Inwentash Faculty of Social Work, University of Toronto, Ontario, Canada. She is a psychotherapy process researcher focusing on cross-cultural clinical practice. Using case studies and critical theories of discourse analysis, her research explores how clinical theories are signified in sociocultural contexts and how immigration and education policies (re)produce current transnational families.

Del Loewenthal, PhD, is director of the Research Centre for Therapeutic Education and Doctoral Programmes in Psychotherapy and Counselling at the University of Roehampton, London, England. He is an analytic psychotherapist and chartered counseling psychologist. His most recent book (with Andrew Samuels) is titled Relational Psychotherapy, Psychoanalysis and Counselling: Appraisals and Reappraisals.

Diego Benegas Loyo, PhD, is a psychoanalyst and researcher of subjectivity and social action. A Fulbright grantee, he participated with the Bellevue Hospital/New York University (NYU) Program for Survivors of Torture. Currently, he is professor of emergencies in psychology at the University Institute Barceló Foundation and teaches at NYU Buenos Aires in Argentina.

Carolina Marín-Martín, PhD, is an associate professor in clinical psychology in the Department at Complutense, University of Madrid, Spain. She works as part-time lecturer of clinical assessment and as a clinical psychologist at the Association for Aid to the 11 March Victims. She is a specialist on posttraumatic stress disorder (PTSD) and addictions problems.

Shafiq Masalha, PhD, is a clinical psychologist and supervisor. He is a senior lecturer at the College for Academic Studies in Or-Yehuda and at the Hebrew University in Jerusalem, Israel. He serves as the president of ERICE, a nongovernmental agency that aims to advance the mental health of children in war areas, especially in the Middle East.

Maria Isabel E. Melgar, PhD, is a clinical psychologist and faculty member with the Ateneo de Manila University in the Philippines. She also serves as the faculty coordinator of the PhD program on clinical psychology. She is the director for counseling and community services at the Fr. Bulatao Psychology Center in Manila.

See Ching Mey, PhD, is a professor at the Universiti Sains, Malaysia. She is an educational and counseling psychologist. She has published 15 academic books, more than 200 international and national academic journal articles, and more than 300 academic papers at national and international seminars. She is the chief editor of the Journal of Counseling for the Association of Psychological and Educational Counselors of Asia Pacific and is an editorial board member for 11 international journals and two national journals.
Gladys K. Mwiti, PhD, is a consulting clinical psychologist, a pioneer for transformational and integrative psychology in Kenya, and the founder and CEO of Oasis Africa Center for Transformational Psychology and Trauma Expertise. She is also chair of the Kenya Psychological Association, is both a member and serves on the board of directors for the International Society for Traumatic Stress Studies, and was the 2014 Distinguished Alumni of the Year for the Fuller Graduate School of Psychology.

Rana G. Nashashibi, PhD (candidate), is a counselor, is the director of the Palestinian Counseling Center—Jerusalem, and is a lecturer in counseling theory and practice. She was born and lives in Jerusalem. She earned her bachelor’s degree from Birzeit University in 1982 and her master’s degree in counseling psychology from Indiana State University (Fulbright Scholar). She was a Humphrey fellow in 1995 at Washington State University and is currently a doctoral candidate at Lesley University in Cambridge, Massachusetts. She has several publication credits.

Lionel J. Nicholas, PhD, is the head of Department of Psychology at Monash, South Africa, and is past president of the Psychological Society of South Africa.

Nadine Pelling, PhD, is a senior lecturer in clinical psychology and counseling at the University of South Australia. She is a fellow of the Australian Counselling Association and was awarded an early career teaching award from the Australian Psychological Society. She teaches, creates scholarship, and maintains a limited private practice.

Maria Adélia Minghelli Pieta, PhD, is a clinical psychologist with a PhD in psychology from the Federal University of Rio Grande do Sul in Brazil.

Vincent Pignatiello, PsyD, is a postdoctoral fellow at the William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology in New York City. He is also an adjunct professor in the Department of Clinical Psychology at Antioch University New England in Keene, New Hampshire.

Yu Ping, PhD, is clinical psychologist of the Wuhan Mental Hospital for Psychotherapy in China. She received her PhD in psychosomatic medicine and psychotherapy from the University of Duisburg-Essen. She engaged in clinical psychotherapy and research for 8 years, served as vice executive secretary of the Mental Health Association of Hubei Province, and is a member of the standing committee of the Tumors Association of Hubei Province.

Priya Pothan, PhD, holds a clinical psychology doctoral degree from the National Institute of Mental Health and Neuro Sciences, Bangalore, India. She conducts mental health awareness and enrichment programs with schools, corporations, wellness centers, and churches. She currently runs her own psychological clinic and supervises therapists in training and practice.

Jacques Pouyaud, PhD, is lecturer in vocational psychology at the University of Bordeaux, France. He also serves on the board of the Unesco Chair of Lifelong Guidance and Counseling. His researches deal with counseling and processes of self-construction throughout the life course and during psychosocial transitions.

Senel Poyrazli, PhD, is a counseling psychologist in private practice and teaches at the Pennsylvania State University. Her clinical background includes working with a large number of counseling groups and dealing with issues related to relationships, psychosocial adjustment, decision making, depression, and trauma. Multicultural competency training is one of her research areas.
José M. Prieto, PhD, is a senior professor in personnel psychology at the Complutense University, Madrid, Spain. His fields of expertise include assessment and training in occupational settings as well as the nexus between Zen meditation and psychological/spiritual well-being. He lectures and publishes in English, French, and Spanish on psychology and other cross-cultural topics.

Shi Qijia, MD, is clinical professor of neurology and psychiatry and is director of the Institute for Mental Health of Wuhan, at the Wuhan Mental Health Center, China. His primary fields of expertise in psychology include field PTSD therapy, severe personality disorder, eating disorders, and inpatient psychotherapy. He served as president of Mental Health Association of Hubei Province.

Angélica Riveros Rosas, PhD, has been a full-time tenured professor at the National Autonomous University of Mexico since 2008. She has written a test/scale and 18 articles or chapters in peer-reviewed sources. She has advised 10 licensing and master’s theses and is currently advising seven doctoral dissertations.

Gargi Roysircar, PhD, is the founding director of Antioch University New England’s Multicultural Center for Research and Practice and is a professor of clinical psychology. She conducts research on immigrants, multicultural competencies, cultural personality assessment, and training in culturally sensitive practice. She leads disaster mental health services internationally and is a fellow of the American Psychological Association.

Silvia Schneider, PhD, is professor of clinical child and adolescent psychology and head of the Mental Health Research and Treatment Center at the Ruhr-Universität Bochum, Germany. Her research focus is on the etiology of anxiety disorders in children, their familial transmission, and the treatment of anxiety disorders in children and adolescents.

Wubbo Scholte, PhD, is head of the Addiction Department of De Hoop Mental Health Care and is head of psychotherapy training of the SPON (part of the Radboud University Nijmegen, the Netherlands). His research is focused on the clinical utility of personality assessment.

Wolfgang Senf, MD, is a tenured clinical professor of psychotherapy and psychosomatic medicine and is former director of the Psychosomatic and Psychotherapy Department of Duisburg-Essen University, Germany. He is the former president of the International Federation for Psychotherapy, and he also served as former chairman of German Society for Psychosomatic Medicine and Medical Psychotherapy.

Wiede Vissers, PhD, is mental health psychologist at the Ambulatorium, an outpatient mental health center, and is assistant head of the postgraduate education of mental health psychologists (SPON), both of which are part of the Radboud University Nijmegen, the Netherlands. Her research is focused on remoralization as an outcome measure in psychotherapy research.

Svetlana Volikova, PhD, earned her doctorate in psychology and is a researcher in the Department of Clinical Psychology and Psychotherapy at Moscow Research Institute of Psychiatry, Russian Federation Ministry of Public Health. She is also an assistant professor in the Department of Clinical Psychology and Psychotherapy, Faculty of Counseling and Clinical Psychology, Moscow State University of Psychology and Education.
Caroline Vossen, PhD (candidate), is a clinical psychologist and psychotherapist. She works as a teacher and as coordinator of the ambulatorium for adult patients at the outpatient mental health center of the Department of Social Sciences, Radboud University Nijmegen, the Netherlands. As a researcher, she is preparing her dissertation on cognitive bias medication for patients with common mental disorders.

Humair Yusuf, EdD (candidate), is studying counseling psychology at the University of Toronto, Ontario, Canada. His research interests include representations of illness as well as indigenous healing and spirituality in counseling and psychotherapy. He is the publications editor for the Centre for Diversity in Counselling and Psychotherapy. Currently, he is editing a book titled *Islamic Healing Traditions: Implications for Health and Mental Health*. 
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Part One
WORKING WITH CASE STUDIES
Chapter 1

How to Critically Use Globally Discerned Case Studies in Local Contexts

Eunjung Lee

After an initial consultation with a client, some experienced clinicians not only capture a comprehensive picture of the client in context, propose explanatory working hypotheses of the client’s presenting issues, and develop customized treatment plans but they also suggest a prognosis of the case. How can they tell the differences among cases after the intake in terms of prognosis? They often note that, “I learned from experience.” What does that mean? From years of experience meeting different clients as well as reading and listening to other clinicians’ case studies, they develop bit by bit their own inner data files for each unique client in a particular context, which become more elaborate over time, are tested for or against other similar or dissimilar cases, and are validated with successful or unsuccessful outcomes. With time, practice, and intentional professional attention, they develop a frame of reference or organizing principles that identify significant themes in each client’s struggles, what works in similar cases, and how to monitor indicators for desirable changes. This inductive process of clinically based knowledge building is the case study. Documenting this “disciplined inquiry” of practice (Peterson, 1991, cited in Fishman, 2005, p. 1), selecting appropriate interventions from “case-based reasoning” (Fishman, 2005, p. 11), and transferring the cumulative clinical knowledge to similar cases is the case study based practice and training in counseling and psychotherapy. This cumulative clinical knowledge within a clinician is transferrable not only to his or her other cases but also to fellow clinicians’ cases through case conferences, workshops, and/or publications. Therefore, the case study is beyond a clinician’s hunches or personal clinical wisdom. In reality, it is an inductive, cumulative, and systemic inquiry of human existence and sufferings—a scientific, empirical approach (Lee, Mishna, & Brennenstuhl, 2010). The active pursuit of this wealth of clinical knowledge truly is an accountable practice for a service provider and a necessary quality, especially when serving clients with diverse cultural backgrounds in a global world.

Lee et al. (2010) proposed ways to critically evaluate the case study in clinical practice and proposed case study evaluation criteria. By incorporating these criteria as well as other findings from cross-cultural clinical practice research (Lee, 2010; Lee & Bhuyan, 2013; Lee & Horvath, 2013, 2014), I delineate in this chapter ways to use and maximize a case study approach that is situated in a global context for clinicians in their own local community.
A main purpose of case study is the intensive investigation of the client system/case under study in naturalistic (not controlled) real contexts, while examining multiple variables using multiple sources of evidence with the aim of providing in-depth rich information (Lee et al., 2010). Providing a thick description of the client in context considering “contextual inclusiveness” (Bergen & While, 2000, p. 932) or “the proximity to reality” (Flyvbjerg, 2006, p. 236) then assists mental health practitioners to “conceptually decide to what extent the case as described” (Fishman, 2005, p. 17) can be applicable to their own cases. Although not exhaustive, the following list is a compilation of areas to consider in developing a rich case study description: the case selection, collection points of clinical information, source of clinical information, intervention procedures and ingredients, interpretation of clinical information, and clients’ feedback.

Why is this case selected? The clinicians choose a particular case because it is “typical, extreme/deviant, critical, or pragmatic” (Lee et al., 2010, p. 685) among other cases in their caseloads. This purposeful sampling is referred to as “information-oriented sampling” (Flyvbjerg, 2006, p. 230) to describe the process of maximizing the use of information from the chosen case or “theoretical sampling” (compared with “statistical sampling”) to “choose cases that are likely to replicate or extend the emergent theory or to fill theoretical categories” (Meyer, 2001, p. 332). Therefore, the selection of the case itself is informative to mental health practitioners and assists them to reflect on the clinicians’ purposeful attention to the case and its underlying cultural and theoretical orientations.

How frequently and over how long a period of time is clinical information collected? One of the great benefits of conducting a case study is an in-depth understanding of the case under study. Accordingly, not only the end product of therapy but also a whole therapy process can be zoomed in and out to monitor the progress and impasses in the clinical processes and, if necessary, to revise the course of the selected intervention. In the description of the case, it is thus important to see whether the clinicians delineate and elaborate the clinical information over time to highlight the clinical processes. The multiple points of clinical data collection then would assist counselors and psychotherapists to make a decision as to whether the interventions caused changes in the case rather than the alternative explanations, such as the changes stemmed from the client’s maturation or else the problem itself faded away (Kazdin, 1981).

What is the source of clinical information? It is crucial to indicate sources of clinical information that lead to a clinician’s clinical working hypothesis and treatment selection. For example, instead of relying solely on a clinician’s observation or a client’s verbal indication, for example, “I am depressed,” multiple sources of clinical evidence can be collected from multiple subjects (e.g., the client and his or her significant others, the clinician), multiple perspectives (e.g., the client’s in-session report vs. homework report, a clinician’s observation of the client in individual vs. group sessions), and multiple places (e.g., school, home, therapy sessions). It does not have to be clinicians who contact the multiple subjects and visit multiple places. Rather, clinicians could ask questions pertaining to multiple sources of clinical information, such as the following: “How do you think your partner/children/friends
perceive and react to you when you feel depressed?” (multiple subjects); “You look very down and have little energy today. I notice this month you have often looked this way” (a clinician’s observation); “Am I getting it right? Do you sometimes feel this way at your school/work?” (multiple places); and “Do you feel the same way that this month is getting harder for you?” (multiple perspectives). In a case study, clinicians may describe these multiple sources of information. If the collected multiple sources of clinical information capture converging changes after the selected intervention, counselors and psychotherapists can have stronger evidence that the changes occurred because of the intervention than if only one source of clinical information is described (Lee et al., 2010).

What are intervention procedures and ingredients? Providing detailed description of the intervention is extremely useful in that it helps mental health practitioners “decide whether the intervention context or content is transferable to their own practice” (Lee et al., 2010, p. 687). Even if some results are less positive, “detailed description can provide information that can lead to altering the intervention” (Lee et al., 2010, p. 687). Gilgun (1994) articulated that clinicians who attempt to replicate interventions described in the case study often become frustrated and may doubt their own competence when the particular interventions fail when applied to their practice. If the interventions had been “more thoroughly described, practitioners might have been able to decipher the differences between their interventions and those interventions in research reports and subsequently understand why their interventions and evaluations might not replicate published reports.” (p. 374; cited in Lee et al., 2010, p. 687)

Mental health practitioners may ask the following questions to see whether the case study captures detailed description of the selected intervention: Is the target of the intervention/phenomenon of interest similar to my client’s?; How often does the intervention occur? (dosage); What constitutes the intervention? (not the brand name of the selected intervention but ingredients and contents of the intervention); Is this intervention applicable to our setting? (context); and Can I use this intervention for my client? (clinician’s qualifications and training; Lee et al., 2010). The detailed description of the intervention may help counselors and psychotherapists to imagine their selection and use of the intervention for their own cases. This process may increase potential for their preparedness and attunement to the chosen intervention, which would increase their performance competence in delivering the intervention to the clients and possibly bring more positive outcomes.

What is the clinician’s interpretation of clinical information? It is important to make clinicians’ working hypotheses, or interpretations of the collected clinical information, as transparent as possible by illustrating a clear “chain of evidence” between the raw clinical case information and the clinicians’ interpretations (Lee et al., 2010, p. 687). It is similar to differences between data collection and data analysis when conducting research. Comprehensive clinical information of the client in context using various subjects, perspectives, and places over time is like data collection that attempts a strong power and rigor in data. Clarifying the clinicians’ understanding of, working hypotheses of, and critical analysis of the collected clinical information is like the data analysis process and the results section in the documentation of research findings. Clear documentation of the clinicians’ interpretation would help counselors and psychotherapists consider alternative points that they have not
thought about from the clinical information described. Or it may help mental health practitioners to reinterpret the raw clinical information and/or develop their own ideas and new perspectives, thus building a clinical knowledge base.

What is the client’s feedback? Case study researchers argue that subjective data are subject to bias yet provide “the opportunity to develop in-depth and holistic descriptions of the participant’s experience and behaviors, an essential feature of case study research” (Yin, 1994, p. 686). Therefore, “guidelines specific to evaluating the usefulness of case studies should include whether they convey the subjective experience of subjects” (Gilgun, 1994, p. 376). Case study is an in-depth study about clinicians as much as it is about clients under study. While reflecting clinicians’ cultural values and theoretical orientations, case studies also clarify clinicians’ interpretations of clinical information; clinicians say outwardly who they are in terms of personal and professional identities in many aspects of case study. Therefore, a central reference point as to whether the clinical information is comprehensively and exhaustively collected, whether the intervention is appropriately selected, and whether the clinician’s interpretation is accurately capturing the client’s experiences is the client. Every aspect of case study thus should incorporate the client’s feedback. A case study should report how the client feedback was pursued and reflected in the course of therapy and evaluation of the case study outcome.

Guiding questions that mental health practitioners could ask include the following:

- Do the clinicians clearly document their working hypothesis/critical analysis/interpretations of clinical information?
- Do the clinicians collect and elaborate the clinical information over time to highlight the clinical processes?
- Do the clinicians describe the multiple sources of information (e.g., multiple subjects, multiple perspectives, and multiple places)?
- Do the clinicians note their rationale of choosing the particular case? What does this choice mean in terms of their cultural and theoretical orientations?
- Do the clinicians provide detailed descriptions of the selected interventions, including, for example, the target of the intervention, the intervention dosage, the intervention contents, context, and clinicians’ qualifications and trainings?
- Do the clinicians report how the client feedback was pursued and reflected in the course of therapy and evaluation of the case study outcome?

In a similar manner, counselors and psychotherapists are encouraged to reflect on why they chose a certain case for an intensive case study, how they collected and elaborated their own clinical data over time to capture the intervention process, whether they used multiple sources of clinical information and clarified their own interpretation of clinical information, whether they provided details of their own choice of intervention procedures and ingredients, and whether they clearly incorporated their client’s feedback and explained how they did so.

**Clarifying and Reflecting a Close Association With Theories**

Although there have been some variations in terms of how closely the case study should be associated with theories, most scholars agree that one distinctive feature