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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 governmental 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 interventions 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 nations” (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, cultural 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 understanding one’s identities demands that we explore them at three levels: the individual level (uniqueness; like no other individual), the group level (shared values 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 developmental background), collective experiences that other cases of similar reference groups share (e.g., shared experiences among Muslim women), and universal characteristics 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 complex, multidimensional being are critical in working across cultures. Cultural sen-
sensitivity, 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-
fessional 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, Rogersian, 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-
Preface

Counseling and psychotherapy is undertaken. Countries were selected on the basis of (a) their population size, (b) how well they represent a given region in the world, (c) how well they represent global cultural variability, (d) how well developed their counseling and psychotherapy traditions are, and (e) whether we could find a good author(s) for a chapter on a given country. Regions are presented in alphabetical order, beginning with Africa; followed by Australia and Asia; Central, North, and South America; Europe; and the Middle East. Counseling and psychotherapy scholars and psychology researchers from these countries were invited to submit a case, which was written to the following specifications:

**The Clients**
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


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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 cumulated 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