Introducing Structured Dialogue with People with Mental Illness into the Training of Social Work Students

Ron Shor & Israel J. Sykes

RON SHOR, PH.D. IS A SENIOR LECTURER AND A HEAD OF THE B.S.W PROGRAM, PAUL BAERWALD SCHOOL OF SOCIAL WORK, THE HEBREW UNIVERSITY OF JERUSALEM, ISRAEL.

ISRAEL J. SYKES, M.SC., MEL IS THE COORDINATOR, BENAFSHENU, SHEKEL (COMMUNITY SERVICES FOR THE DISABLED), JERUSALEM, ISRAEL.

FOR INFORMATION CONTACT RON SHOR, PH.D. AT THE PAUL BAERWALD SCHOOL OF SOCIAL WORK,

THE HEBREW UNIVERSITY OF JERUSALEM, MT. SCOPUS, JERUSALEM 91905, ISRAEL.
E-MAIL: *msshor@msc.huji.ac.il.*

ACKNOWLEDGMENT: THE AUTHORS WISH TO THANK ALL THE PRESENTERS FROM BENAFSHENU FOR THEIR INVALUABLE CONTRIBUTION TO THIS PROJECT AND IN PARTICULAR TO SHULA ALPEROVITZ, BATIA GELMAN, CHANI LEVOR, AVIGDOR PETRANK AND ILANA SEITZKY BUZUKASHVILI FOR THEIR ONGOING ACTIVE INVOLVEMENT IN THE PROJECT.

This paper presents the findings from an innovative project in which people with mental illness were incorporated in the classroom setting of social work students in Israel. This project was based on a model that was defined as "Structured Dialogue." Its objective was to create opportunities for students to relate to persons with mental illness in a less stigmatic and more hopeful way. One hundred and eighty five students participated in this evaluation that was conducted in fifteen social work classes. The findings indicate the potential of the Structured Dialogue model to eliminate the one-dimensional representation of people with mental illness and change preexisting stereotypes and stigma with which the students came to the meetings. Implications for training future mental health professionals are discussed.

Goffman (1986) describes the devastating and dehumanizing effects of stigma applied to any population. When viewing a person through the lens of stigma, one tends to see the stigmatic stereotype rather than the specific individual, and to make ongoing judgments and actions which end up creating realities that confirm the stigmatic perception. Through this mechanism people, often unintentionally or unthinkingly, condemn the stigmatized person to living out negative societal scripts "written" for his or her population group. As people act on these perceptions and take on the different roles prescribed by the stereotypes, they become reinforced time and again in real world interactions, to such an extent that they may come to be identified as objective and unchangeable reality.

One population group greatly affected by stigma that has received much research attention is that of people with mental illness. The stigma vis-à-vis this population is not only prevalent in general society, but also in all the helping professions, including psychiatry, psychology and social work (Minkoff, 1987; Mirabi, Weiman, Magnetti, & Keppler, 1985). The suggestion that practitioners may be biased may come as a surprise to professionals, who tend to assume that it is only the public who rejects persons with mental illness (Atwood, 1982). The reality is that all too often professional training programs have a negative bias towards persons with mental illness and their family members, and they deliberately attempt to exclude them or to "socialize" them out of their consumer perspectives (Cook,

Yamaguchi, & Solomon, 1993; Paulson, 1991).

Deegan (1997), herself a professional and a consumer, writes that this phenomenon is so prevalent that people with psychiatric disabilities must recover not only from mental illness, but also from internalized stigma, low expectations, and dehumanizing clinical practices. The great danger is that a person with mental illness may undergo a radically devaluing and dehumanizing transformation from being a person to being an illness, leaving no one inside of him or her to take on the work of recovering, healing, and rebuilding the life he/she wants to live. Accordingly, many mental health consumers and consumer organizations advocate that professionals, to be truly helpful, need to learn to view people with mental illness in less biased and more hopeful ways. The proposed shift is not only ideological, but is based on growing recognition that the possible futures of many people with mental illness are much less bleak than frequently assumed by professionals.

An important emerging strategy for bringing about changes in professionals' perceptions of people with mental illness has been to involve consumers in professional training, providing students and practitioners with direct exposure to people with mental illness in roles that emphasize their humanity and strengths rather than their deficits. Paulson (1991) claims that the special strengths and perspectives that persons with mental illness possess are of vital importance to the learning of mental health professionals. Cook, Jonikas, and Razzano (1995) describe a variety of factors that contribute to the effectiveness of consumers in bringing about attitude change among professionals: they can serve as examples of the degree of recovery possible with effective service delivery; they can directly address questions related to consumer perspectives on treatment and what is helpful; and they can assume an "expert" role that directly contradicts commonly-held stereotypes about persons with mental illnesses.

Studies have demonstrated that user involvement in training has resulted in favorable changes in students' stereotypes about people with mental illness—leading to more humane and liberal attitudes towards people with mental illness (Cook, Jonikas, & Razzano, 1995; Drolen, 1993; Shera & Delva-Tauiliili, 1986). In isolation, academic instruction does not alter attitudes regarding people with mental illnesses to the same extent that instruction coupled with practical experience does (Drolen, 1993). Shera and Delva-Tauiliili (1986) noted that the critical mechanism of change in their training project was the social work students' structured interview of a person with mental illness, through which they were able to connect to the "person behind the disorder." Cook, Jonikas, & Razzano (1995) report that qualitative responses to the training provided to state funded service providers by persons with mental illness emphasized the positive impact on trainees of the consumer trainer's sharing of experiences as a user and a provider as well as the "eye-opening" effect of the training which led them to see old issues in fresh, new ways.

This paper will present findings from an evaluation of a project that incorporated people with mental illness in the training of B.S.W. students in a school of social work in Israel. The model that was implemented in the training is described as "Structured Dialogue," a process in which a climate is created that facilitates dialogue between professionals and mental health consumers. Structured Dialogue has been implemented in addition to this project with professionals and trainees in Israel in the areas of social work, psychology, psychiatry and nursing. It is systematically evaluated here for the first time. The aims of the study were to:

1. Learn about the perceptions that students had relating to people with mental illness prior to their meetings.
2. Evaluate the changes in perceptions, if any, after the meetings.
3. Learn about the thoughts, feelings, and dilemmas evoked by the meetings.

The Development of Structured Dialogue

Structured Dialogue evolved out of an ongoing attempt to answer a question posed by people with mental illness working in Benafshenu. Benafshenu is a consumer-based project in Israel staffed by people with mental illness and their family members. (It is part of Shekel, a non-profit organization that provides community services for the disabled.) Their question was: How can we get professionals to see and hear us in new and fresh ways, to see us as whole people of value who have struggled to cope with extremely difficult life burdens?

The Structured Dialogue model is based on two premises. The first is the simple yet elusive understanding that the traditional therapeutic context, in which one party needs help and the other gives help, affects each participant's perceptions of self and other in a way that inevitably shapes and limits how each experiences and is experienced by the other. Since professionals and people with mental illness generally meet one another only in this context, this perceptual set is rarely challenged, and thus accepted as reflecting objective reality.

The second premise is that to bring about changes in attitudes and perceptions, a way must be found to prevent

the replaying of the script which is often played out in encounters between professionals and consumer representatives: consumers vent anger, criticism, and demands at professionals, and professionals respond defensively, leaving both sides with the frustrating conclusion that attempts at dialogue are futile.

The challenge was how to create a different kind of encounter, one in which people with mental illness and professionals would meet as equals. It was hypothesized that if this could be accomplished, professionals would be enabled to discover the humanity and diversity of persons with mental illness and persons with mental illness would be positively affected by being seen and related to in ways that validated their worth.

The Structured Dialogue model that has evolved contains a number of deliberate strategies designed to create the kind of climate in which bias, stigma and stereotypes may be overcome:

1. Presenters (people with mental illness) craft their presentation so that professionals will be able to see and hear them in all their humanity. (Thereby foregoing the satisfaction of venting their anger in the belief that, in the long run, dialogues will be a more effective mechanism for bringing about change.)
2. Presenters facilitate the dialogue with groups of professionals, a surprising reversal of the ordinary hierarchical relationship.
3. Presenters meet with professionals and students in their own settings (such as joining a staff meeting or classroom session).
4. Presentations are based not on topics or critiques, but on the presenter's very personal story of coping with his/her life.

METHOD

Sample

One hundred eighty-five students responded to a semi-structured questionnaire. One hundred seventy were women and 15 were men. Their mean age was 25.31 (SD = 6.3); 75% (n = 139) of them were not married. Eighty-four percent of them (n = 155) were Jewish, 12.4% (n = 23) were Moslems, and 3.6% (n = 7) were Christians. The majority of the students (88%, n = 163) were born in Israel.

Sixty-five students (out of the 185 participants) responded to an attitude scale before and after the meetings. Fifty-seven of them were women and eight of them were men. Their demographic background was similar to that of the larger sample [their mean age was 25.38 (SD = 6.42) and majority of them were born in Israel (84.6%, n = 55)].

Measures

Descriptions of the attitude questionnaire and semi-structured questionnaire follow:

Attitude questionnaire. The attitude scale used was a modification of the Rehabilitation Scale developed by Askenasy (1974) and was administered in 5 of the 15 classes before and after the meetings. This scale was selected because of the apparent relevance of its items for measuring the attitudes of professionals towards persons with mental illness. The Rehabilitation Scale included two major factors: The first is Qualitative Differentiation and the second is Trust and Meliorism. A Likert scale of 1–6 was used for both factors, in which 1 = strongly disagree and 6 = strongly agree.

The Qualitative Differentiation factor included items that related to characteristics that may differentiate people with mental illness from other people, such as the way they look, or the thought that they may be dangerous and that professionals should treat people with mental illness differently than people without mental illness. The Trust and Meliorism factor included items which state that people with mental illness are not dangerous, that they can be trusted and that they are capable of skilled labor. Two items in this scale that related only to rehabilitation within a hospital context were slightly modified to include a community context; one item was replaced by a new item that stated, "people with mental illness are able to succeed in the social work profession." An internal consistency test was conducted with the responses of the 65 students who completed the attitude scale a week before the meeting with the Benafshenu members. The findings indicated Cornbach's alpha of .86 for the Trust and Meliorism component and .71 for the Qualitative Differentiation Component.

Structured dialogue questionnaire. A semi-structured questionnaire, titled Evaluation of the Structured Dialogue (ESD), was constructed for this study. After each of the 15 meetings in which the dialogue was conducted, the ESD was administered. The first section of the ESD included three closed-ended questions relating to three subjects: the students' familiarity with the subjects presented; the contribution of meetings to the students' understanding of the experience of people with mental illness; and the students' thoughts about conducting such meetings in the future. They were presented using a Likert scale of 1–5, in which 1 = not at all and 5 = to a large extent. The second section of the ESD included open-ended questions which addressed the following subjects: issues which came up in the meetings and did not fit the students' expectations about people with mental illness; professional dilemmas which were evoked in the students as a result of the meetings; thoughts regarding their

methods of work with clients which were evoked by the meetings; and any other relevant thoughts that may have arisen in response to the meetings. Content analysis of the responses was done by the authors of this paper and by one of the presenters who received training in how to conduct content analysis. His analysis supported and validated the themes and categories that were drawn out of the findings.

Implementation

Members of the Benafshenu staff facilitated Structured Dialogue meetings in 15 social work classes at the School of Social Work of the Hebrew University in Jerusalem. The meetings were conducted in practice-centered classes in the B.S.W. program (which is the entry degree program for social work in Israel).

Two presenters participated in each meeting. The first presenter facilitated the meeting, itself a significant role reversal. She/he presented background on Benafshenu and on the Structured Dialogue model, as well as some information about her/himself. She/he then introduced the second presenter, who went on to tell his/her own personal story, relating particularly to: (a) how he/she experienced the difficulties related to the psychiatric disorder; (b) his/her experience of interactions with family, with helping professionals, and with society at large; and (c) what he or she has learned about the coping and recovery process. After 30–40 minutes, the facilitator opened the meeting to questions and responses from the listeners, who often asked to clarify or expand upon points in the story that were of particular interest, and explored what they could learn from the presenter that would be helpful to them in their professional work. The meetings lasted for one and a half hours. Five of these meetings were expanded to three hours, allowing two stories to be presented.

In all, eleven Benafshenu staff and volunteers participated in the program. The presenters included people with a range of diagnoses, including bi-polar disorder, schizophrenia, schizoaffective disorder, dissociative disorder, and borderline personality disorder. All but one had been hospitalized at least once, most on numerous occasions.

Results

Attitude Questionnaire

Responses to the attitude questionnaire revealed no significant differences before and after the meetings with the presenters. In both measurements, the results of the Trust and Meliorism component were high and the results of the Qualitative Differentiation component were low to medium. The mean score of the Trust and Meliorism component before the meeting was $M = 4.51$ ($SD = .73$) and after the meeting was $M = 4.42$ ($SD = .67$). The mean score of the Qualitative Differentiation component before the meeting was $M = 2.56$ ($SD = .75$) and after the meeting was $M = 2.62$ ($SD = .73$). Significant differences were not found in a comparative analysis of the pre-test and post-test in which t tests for dependent samples were utilized to compare the mean scores of each factor and of each item.

Evaluation of the Structured Dialogue

In response to the first of the three structured questions of the ESD, students indicated that the level of their familiarity with the subjects presented in the meetings was low to medium ($M = 2.64$, $SD = 1.16$). Their assessment of the extent to which the meeting contributed to their understanding of the experience of people with mental illness was high ($M = 4.21$, $SD = .64$; no student indicated that the meeting did not contribute to his/her understanding of the experience of people with mental illness), and most of the students thought that it would be important to continue to conduct such meetings in the future ($M = 4.73$, $SD = .48$).

Correlation tests were conducted between the first two structured items of the ESD and the pre-and post-test results of the two factors of the attitude scales. A significant association was found only between the post-test measurement of the Qualitative Differentiation scale (their level of disagreement with differentiating statements) and the second item in which students related the benefit of the meeting to their understanding of the experience of people with mental illness (with an alpha level of .05, $r = .3$, $p = .012$).

Two major interrelated themes were identified in the content analysis of the qualitative material: the students' attitudes, perceptions, and feelings vis-à-vis people with mental illness prior to the meeting, and the changes they experienced as a result of the meetings.

Perceptions about People with Mental Illness Prior to the Meeting

Students' perceptions about people with mental illness prior to the meeting were indicated in direct statements regarding these perceptions. Students (29%) reported that they had been unaware of the extent to which they themselves viewed people with mental illness in stigmatic ways. Especially telling were the instances in which students reported that they had been surprised by the unanticipated qualities of the presenters that were revealed to them during the meetings. They (23%) were surprised to discover that people with mental illness were able to function in normal ways. People with mental illness were initially viewed by the students as people who are incapable of conducting even basic life activities, such as communicating

properly, making choices about how to conduct their lives, and functioning independently. They were surprised to learn that the people who spoke with them had developed family lives and managed to build independent lives within the community: "I didn't know that it was possible, if with great effort, for people with mental illness to lead normal lives." Several of the students believed that mental illness could happen only to uneducated people: "I was surprised to find out that the people who spoke with us have academic degrees." Students were also surprised to discover that the presenters appeared "normal": "I didn't know that they look like the rest of us and behave completely naturally."

The stereotypes associated with the illness affected the way the students perceived people with mental illness, and the fact that they had overlooked the "person" behind the illness: "I expected that they would talk about the difficulties they encounter as people with mental illness and about their status in their family and society, but they spoke about their relations with their spouses, and this surprised me." Students had not realized the humanity and capabilities that people with mental illness may have. They were not viewed as people with desires, wishes, feelings, strengths and capabilities, but as people who only have difficulties.

Students (11%) were surprised to discover that the presenters were highly aware of their illness and its effects, and that they have knowledge, opinions, thoughts, and feelings as well as insights about their situation and life history: "I didn't know that there were people with mental illness who were so well educated about their illness." "Their ability to speak about the illness, and the ways in which they coped with it, surprised me." Students (12%) also reported that they had feelings of fear and anxiety in relation to people with mental illness and therefore they did not sign up for field placement in the mental health field.

Perceptions about People with Mental Illness after the Meeting

Contradicting stereotypes. Students (22%) learned that the differences between themselves and people with mental illness are not always clear. Replacing the stigmatic image of people with mental illness with a real life image of a person with whom they could identify left the students with a disturbing realization—if it happened to the presenters, it could happen to them: "There is a very thin boundary between a person who is considered to have a mental illness and a person who is not. There are events in life which they described and which I experienced as well—it is often scary to think how I could react."

Students (62.5%) noted that the meeting opened their eyes to the person behind the illness. They recognized that each presenter has his/her own unique humanity: "It strengthened my sense that we need to relate to every person, even if he has a mental illness or any other disability, first and foremost as a human being, not as a walking illness." Students emphasized that they learned about the importance of relating to the subjective experience of each person in a nonbiased manner. It helped them confront and release stereotypes they had believed about people with mental illness.

Respondents (11%) commented that before the meeting they felt "threatened" and would not have considered doing a field placement in the mental health field; however, as a result of altering the stigma they had, they were more open to the possibility.

The Experiential World of People with Mental Illness

Participants (47%) related to the fact that the meetings enabled them to learn about and become familiar with the world of persons with mental illness. Hearing the personal stories of the presenters and listening to their experiences with mental health services provided the students with some understanding of what a person with mental illness may feel and what kind of help they may need: "The meeting gave me a brief peek into a world I hadn't known before, enabling me to understand (if only a little) the world of people with mental illness. Suddenly it's not so vague and general, but a little more clear." The meeting enabled students to learn more about the needs and capabilities of people with mental illness as well as about the suffering that they may experience, such as the feeling of being hospitalized against one's will.

Students (19%) noted that for the first time they were made aware of the effects of stigma upon the people who were stigmatized: "I became aware that people with mental illness carry a negative label throughout their lives, and that society, me included, does nothing to change this. What is more, I was not always aware that the label is wrong."

Awareness of Strengths

Students (17%) noted that they were impressed by the strengths possessed by the presenters that enabled them to cope with their difficult life circumstances, to be active in working to make a difference for themselves and others, and to share their experiences with the others. The meetings changed their unidimensional view of people with mental illness: "Sick people also have a healthy side, and some even have amazing strength that many healthy people don't have." Respondents (17%) noted that while prior to the meeting they had felt hopeless about the possibility that people with mental illness could nonetheless lead meaningful lives, following the meeting they felt much more hopeful: "The meeting showed me that it is possi-

ble to cope with mental illness, that it is not a final station in a dead end road like I had thought. It is possible to rehabilitate and lead a more or less normal life."

Reactions of the Presenters

All presenters were given copies of the responses to the open-ended questions for their own sessions and for those of the others. Presenters reported subsequently that this feedback was enormously important to them. While they had presented before many groups, they always were left with an uncertainty as to how they were perceived by many of the group members—even though there is almost always positive feedback from some of the participants. Having such explicit, open and sincere testimony about the ways in which the meetings affected the many students who had not spoken during the sessions was tremendously affirming, and relieved some of the anxiety aroused by the earlier uncertainty.

There was agreement among presenters that the project, despite the difficulties of self-exposure, was valuable to them. All the presenters gave examples of how the meetings were supportive of their own recovery and empowerment. For example: "I felt that the interaction is among equals, and this has even changed my relationship with my therapist, who sees me with more respect." "The meetings have greatly improved my own self-esteem. I feel much more confident, that I can talk to the students as equals, person to person."

Discussion

The findings indicate that the two most common themes that were identified by students as benefits of the meetings were that they had the opportunity to become familiar both with the humanity of persons with mental illness and with their experiential world. Through listening to the personal stories and developing a dialogue with the presenters, they were able to relate and think about persons with mental illness in new and fresh ways. The meetings enabled the students to see persons with mental illness not only as "patients," "clients," or "consumers," but as people who have dimensions to their lives other than the illness, and as people whose efforts at coping and recovery have led them to understandings and abilities that are valuable and worth learning from. These findings are in line with the association found between the degree to which the students felt that the meeting contributed to their understanding of the experience of people with mental illness and their level of disagreement after the meeting with statements in the attitude scale which differentiate people with mental illness from people without mental illness (The Qualitative Differentiation factor).

The results of the attitude scale indicate that both before and after the meetings students tended to express views that were based on nonjudgmental attitudes (e.g., acceptance) towards persons with mental illness. The responses to the ESD show that such attitudes were not indicative of the actual extent to which the students were aware of the person behind the illness and were familiar with the world of persons with mental illness. The students "discovered" the multidimensional facets of persons with mental illness (i.e., their humanity) along with the realization that mental illness could happen to anyone, and that there are more similarities than they had thought between themselves and persons with mental illness. Learning about these components could provide the opportunity, as some of the students indicated, to confront and correct their stereotypical perceptions.

Misperceptions, lack of hope that change is possible, not seeing the human being behind the illness and fears about engaging with persons with mental illness may have a major impact on the therapeutic approach, relationship and objectives of professionals who work with this population. Structured Dialogue is a model which has the potential to reduce these risks and to advance culturally affirmative therapy—therapy that is socioculturally informed, utilizing culturally relevant tools, seeking to empower clients and their communities (Glickman, 1996). Sue, Arredondo, & McDavis (1992) note that there are two important factors in developing culturally skilled counseling. They are, first, that the counselor is in an ongoing process of becoming aware of his or her own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth; and, second, that the counselor actively attempts to understand the world view of his or her culturally different client without negative judgment.

Enabling students to develop a culturally affirmative orientation could be essential for successful work with persons with mental illness. Thus, there is a need to provide students with an appropriate educational and training context. The traditional academic training model is based on a professional's providing his or her knowledge and experience to the students. However, teaching students in a classroom setting about desirable professional values or even working with persons with disabilities in their field placement may not provide students the opportunity to develop a multidimensional view of persons with mental illness. Structured Dialogue is an example of an experiential model that can enable students to interact with and learn from people with mental illness in an open, non-threatening situation as part of their academic learning experience, thus complementing the expert-

based teaching model. In this approach to training, the professional knowledge is not viewed as sacrosanct, but as one small piece of a much larger puzzle (Small & Sudar, 1995).

Students in this study stated that one of the changes that they experienced was a better understanding of the world of people with mental illness. There remains, however, the question of to what extent students can develop a better understanding of the world of mental illness through one meeting in a university setting. Such encounters run the risk that students may develop incomplete perceptions by overgeneralizing from the personal stories that they have heard. Even though one meeting may not be sufficient to gain a full understanding of persons with mental illness, it may provide an important introduction and supplement to traditional training programs.

The present study focused on the short-term impact of Structured Dialogue; future studies should evaluate its long-term impact and its applicability to other populations with special needs. The evaluation of Structured Dialogue presented in this paper has illuminated its significance and demonstrated the importance of its expansion and development as part of the training of future practitioners in the helping professions.

References

Askenasy, A. (1974). *Attitudes toward mental patients: A study across cultures* Hague, Netherlands: Mouton & Co.

Atwood, N. (1982). Professional prejudice and the psychotic client. *Social Work*, 172–177.

Cook, J. A., Jonikas, J. A., & Razzano, L. (1995). A randomized evaluation of consumer versus nonconsumer training of state mental health service providers. *Community Mental Health Journal, 31*(3), 229–238.

Cook, J. Y., Yamaguchi, J., & Solomon, M. L. (1993). Field-testing a postsecondary faculty in-service training for working with students who have psychiatric disabilities. *Psychosocial Rehabilitation Journal, 17*(1), 157–169.

Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care, 25*(3), 11–24.

Drolen, C. S. (1993) The effect of educational setting on student opinion of mental illness. *Community Mental Health Journal 29*(3), 223–234.

Glickman, N. S. (1996). What is culturally affirmative psychotherapy? In N. S. Glickman & M. A. Harvey (Eds.). *Culturally affirmative psychotherapy with deaf persons* (pp. 1–56). Mahwah, New Jersey: Lawrence Erlbaum Associates.

Goffman, E. (1986). *Stigma: Notes on the management of spoiled identity*. New York: Simon and Schuster Inc.

Minkoff, K. (1987). Resistance of mental health professionals to working with the chronic mentally ill. In A. T. Meyerson (Ed.). *Barriers to treating the chronic mentally ill* (pp. 3–20). San Francisco, CA: Jossey-Bass.

Mirabi, M., Weiman, M. L., Magnetti, S. M., & Keppler, K. N. (1985). Professional attitudes toward the chronic mentally ill. *Hospital and Community Psychiatry, 36*, 404–405.

Paulson, R. I. (1991). Professional training for consumers and family members: One road to empowerment. *Psychosocial Rehabilitation Journal, 14*(3), 69–80.

Shera, W., & Delva-Tauiliili, J. (1996). Changing MSW students' attitudes towards the severely mentally ill. *Community Mental Health Journal, 32*(2), 159–169.

Small, D. R., & Sudar, M. (1995). Islands of brilliance. *Psychosocial Rehabilitation Journal, 18*(3), 37–50.

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 10*(2), 45–52.