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Effective Psychotherapeutic Approaches to Treatment for Ethnic Minorities

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Abstract

Members of the Sikh *Khalsa* who make their residence in the United States represent a psychologically underserved and understudied population. A lack of awareness of psychological services contributes to this status; however, the challenges inherent in reconciling cultural norms within the United States with the native cultures of immigrant populations should not be neglected. As a consequence of the paucity of ethnically Sikh psychotherapists, the number of therapists with a competent cultural understanding of this population is limited. By sharing the insights and observations culled from dialogue with members of a Sikh community recovering in the wake of a national tragedy, we present our insights and an approach to therapeutic intervention developed to facilitate future psychotherapeutic endeavors both in Sikh communities and other ethnic minorities at large. The model developed in this study identifies demographic issues, therapeutic approach, gender bias, language, confidentiality, peer support, and immigrant status as the most important factors when treating this population. Ultimately, it is our intention to elevate awareness of some of the idiosyncratic complexities involved in treatment and research of this underserved minority group, particularly as our population continues to diversify.
Key words: Sikh, cultural sensitivity, psychotherapy, multicultural competence.

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Novelty and Significance

What is already known about the topic?

- Psychotherapeutic interventions must be modified with ethnic minorities.
- There are limited studies delineating the needs of psychotherapy with Sikhs.
- There is stigma surrounding mental illness and psychology in many cultural sects, which add additional barriers to treating these population.

What this paper adds?

- A thorough history of Sikhism written from a psychological perspective, which will aide future therapists who work with Sikhs.
- A consolidation of barriers to treatment with this population, along with suggestions for establishing rapport.
- Establishes guidelines for treating minorities after a traumatic event.

Relative to the general population, ethnocultural immigrant minority communities are underserved by the mental healthcare system in the United States (US Department of Health and Human Services, 2002). In a focus-group survey of five ethnolinguistic communities including Punjabi Sikh Canadians, Simich, Maiter, Moorlag, and Ochocka (2009) identified numerous potential causative factors for this marginalization. Communities from different cultural backgrounds did not always perceive mental health from a psychobiological perspective; additionally, members of immigrant communities often emphasized healthy adaptation "to life in a new society" as a critical aspect of mental

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health (Simich et alii, 2009). One Sikh participant cited a lack of awareness of available services (Simich et alii, 2009). This lack of awareness is more than reciprocated by counseling professionals, many of whom report unfamiliarity with the Sikh community (Arora, 2013). Psychotherapeutic and psychiatric services in India are not as readily available as they are in the United States; as much as 80% of the rural population or 55% of the total population cannot readily access the services of the National Mental Health Program (Parkar, Dawani, & Apte, 2001; Ministry of Home Affairs, 2011). These factors contribute to lack of awareness of mental health services in Indian immigrants to the United States, while psychotherapists' failure to recognize the particular circumstances of the Sikh community further deters members from seeking therapy. It is of significant note that members of ethnic immigrant communities including the Sikh community often believed that their cultural communities either did not take mental health issues seriously or else perceived treatment for mental illness in a negative or shameful light (Simich et alii, 2009). Individuals often noted unawareness or distrust of mental health providers, potentially as a consequence of associating them with treatment of individuals entirely unable to function in society, a condition they perceived as shameful (Simich et alii, 2009).

There are about 25.8 million Sikhs in the world and between 78,000 and 750,000 in the United States alone (US Census Bureau, 2012; Mann, Numrich, & Williams, 2007). Some 2-3 million Sikhs are settled abroad, but the world's largest Sikh population is concentrated in the Punjab region of the Indian subcontinent, where Sikhism originated (Ministry of Home Affairs, 2011; Singh, 2000). Self-discipline and humility are virtues in Sikhism; they are cultivated by overcoming *haumai*, or egotism (Miller, 2003). The concept of *Hukam*, or God's will, is central to the *Sri Guru Granth Sahib*, the sacred text of Sikhism; adherents of the Sikh faith are urged to submit to *Hukam*, accepting the tribulations that they experience as ordained by God (Singh, 2012). The *Sri Guru Granth Sahib* furthermore proscribes ephemeral or materialist pursuits, noting their irrelevance after death and even associating them with continuation of the reincarnative cycle. Sikh patients may simultaneously hold the spiritual convictions of their faith and become troubled by temporal conflicts. This cognitive dissonance may elicit strong feelings of shame or guilt and undeniably complicates the therapeutic process (Miller, 2003).

JS Neki (1973, 1974) reconciles the beliefs of Sikhism with the context of psychotherapy by drawing parallels between the therapist-patient dialogue and a *guru-chela* (master-disciple) relationship and by positing a psychotherapeutic paradigm based upon the *guru-chela* relationship. The *Advayatārakopaniṣad* traces the etymology of the term guru to the roots *gu* (darkness or ignorance) and *ru* (an individual who disperses or obliterates that darkness, *Advayatārakopaniṣad*, pp. 14-18). A *guru* encourages dependency in his *chela* by assuming responsibility for the *chela's* mastery of self through self-discipline (Neki, 1974). The *guru-chela* relationship is one of continuous and permanent growth (Neki, 1974). In this type of dialogue, the *guru* will often posit and then answer their own questions (Neki, 1974). According to Neki, "the *guru-chela* relationship appears most suited to cultures valuing self-discipline rather than self-expression, and creative harmony between individual and society" (Neki, 1974). These virtues align very well with those of Sikhism.

In this article, we provide an overview of observations collected during the psychotherapeutic process in the *sangat* of Oak Creek, Wisconsin in the wake of the tragedy of August 5th, 2012; in particular, we will delineate the differences observed in response to therapy in this community versus the population normally treated by

mental health experts in the United States. The qualitative data presented below are the results of our extensive interviewing of the Sikh and non-Sikh population in Oak Creek, Wisconsin over a period of 12 months. We collected all of the data here presented during the course of our psychotherapeutic dialogue with the Oak Creek Sikh community.

The Oak Creek temple was founded in October 1997 by a group of devotees who contributed their own money to erect a temple according to the traditions of the religion (History of Gurudwara Sahib, 2011). According to the temple's statistics, there were about 350 to 400 people in the congregation, or *sangat*, at the time of the temple's construction; it has since considerably expanded, and a new *gurdwara*, or temple, is under construction (History of Gurudwara Sahib, 2011). Many immigrant members of the *sangat* work difficult jobs in order to earn money to send to their families in Punjab or else to bring the remainder of their families to the United States.

On August 5, 2012, an American white-supremacist entered the *gurdwara* in Oak Creek, Wisconsin, and indiscriminately shot and killed 6 individuals and injured many (Leitsinger, 2012). Five men and one woman were killed. The tragedy was perceived by the community as a hate crime against the Sikh population; *sangat* members subsequently disclosed that the man who perpetrated this act had been eyeing this community for a long time. A number of individuals were deeply affected by this tragedy -some directly and some more indirectly. Once it had been established that the perpetrator was dead, the community faced the significant challenges of recovery from this unexpected crisis. A number of law-enforcement agencies and other supportive organizations offered their assistance with the intention of accelerating the healing process. Many volunteer organizations offered to contribute to the crisis intervention effort and to help in restoring the mental health of the community as a whole (Bhatia, 2012). Individuals of the same religion and of other religions came forward to provide support. Political figures -such as Prime Minister of India, Manmohan Singh (Ramde, 2012), and President of the United States (Obama, 2012)- expressed their solidarity with the community and offered financial, emotional, social, and religious help. Many learned members of the community included in their sermons the teachings of Sikhism, a faith whose basic tenet is *charhdi kala*, or maintaining an attitude of optimism despite adversity as a demonstration of contentment with *Hukam* (e.g., *Guru Granth Sahib*; The Sikh Anonymous, 2012).

The incident at Oak Creek is by no means an isolated incident; it must be comprehended against the wider backdrop of historical violence against Sikhs, a population that has frequently been targeted by ethnically motivated violence. In 1746 and again in 1762, Punjabi Sikhs were murdered indiscriminately by the ruling Mughals and Afghans, respectively (Singh, 2004). In 1984, in retaliation for the assassination of Indian Prime Minister Indira Gandhi by Sikhs, members of the Indian government organized or else turned a blind eye toward a systematic destruction of Sikhs by mobs (e.g. 1984 anti-Sikh riots, Public Trust of India, 2013). The assassination itself occurred as a response to an attack on Sikh holy sites in Amritsar by Indian military forces in Operation Blue Star. Most recently, Sikhs have been targets of racial violence in the United States in the wake of the September 11 attacks (e.g. Arora, 2013). In a manuscript submitted prior to the events of August 5th, 2012, Arora (2013) highlights the stories of several turbaned Sikh men who were targets of ethnic violence in the United States because of their appearance -Sikhism mandates men wear a *dastar*, or turban. Arora suggests that these episodes of violence challenge the spiritual convictions of Sikhs living in the United States, calling into question the safety and social ramifications of their religious practice.

In order to contextualize our findings, it is important to know a little bit about the history of Sikhism and violence against the Sikh community to shed light on the course of the healing process and the application of culturally appropriate therapy. As a consequence of the dynamic nature of Sikhism during the time of the gurus, it is difficult to determine with certainty the date when the religion as it is practiced today emerged. Adherents generally agree that Sikhism originated with Guru Nanak Dev, who is considered to be the first guru of this religion (Singh, 2000). Guru Nanak dispelled many unfounded and unverified beliefs of the time. The primary tenets of his newly founded religion were *naam japo* (consciousness of God's name and presence), *kirat karo* (honesty in work and self-reliance), and *vand ke chhako* (sharing with the community) (Singh, 2012). Guru Gobind Singh, Nanak's successor and the tenth Guru of Sikhism, lost his life to one of the vassals of the Mughal Empire after establishing the *Khalsa* (Singha, 2005). Guru Gobind Singh gave credence to the secular idea of human equality, inviting five individuals representing five different backgrounds to become the first members of the *Khalsa* in defiance of the prevailing caste system (Kalra, Bhui, & Bhugra, 2012). At the end of the era of Guru Gobind Singh, he decreed that there would be no more gurus and that the Sikhs' holy book, which is called *Guru Granth Sahib*, would be the driving force of Sikhism. Upon induction into the *Khalsa*, all Sikh males would adopt the surname *Singh*, which means 'lion', while Sikh women's last names would be *Kaur*, which means 'princess' (Singha, 2005). The basic tenets of Sikhism are that God is One, has neither color nor shape nor enemies, and is omnipotent and omniscient (Mayled, 2002). The religion is also based upon seven forbidden principles -all Sikhs are expected to refrain from cutting hair, intoxication, adultery, blind spirituality, and worthless talk, among others (Singha & Kaur Hemkunt, 1994). Symbolically, every Sikh temple, known as a *gurdwara*, meaning 'doorway to god', has four doors, representative of the four cardinal directions; the doorways welcome worshippers from all four directions into the temple (Parrinder, 1999).

METHOD

Intervention Conditions

Following the incident of August 5th, we numbered among those who offered mental health services to the grieving Oak Creek community. Two licensed clinical psychologists engaged in therapeutic discourse with members of the Oak Creek *sangat* (n= 12, 3 females; 16-65 years of age) on a volunteer basis. Because participants were selected incidentally and not as a part of a formal scientific study, a demographically unbiased sample was not a possibility. Similarly, we relied upon participants' self-reports and upon our clinical observation of patient history to measure patient outcome and to judge whether symptoms arose as a consequence of the incident or were present beforehand due to unrelated factors, e.g., adaptation to life in the United States.

The individuals considered in this article are those who consistently were available for therapy and continued to receive it over the twelve-month period since the incident. Many others received only periodic psychotherapy or, for various reasons, dropped out of treatment.

Out of 9 males, all self-reported clinical improvement and alleviation of initial stress-related symptoms (incl. acute stress disorder accompanied by anxiety and depressive symptoms) and reportedly maintained this positive therapeutic outcome over a period of

12 months. Two male participants and one female were recommended medication due to acute psychiatric symptoms such as disturbed vegetative functions.

Selected Case Studies

Many tragic stories became apparent during the course of our therapeutic intervention. Selected case studies reflect the adaptivity demanded of psychotherapists treating members of this population. In one case, a child who had not seen his father since his birth arrived in the United States from India only to see his father at his funeral procession. The child presented with all symptoms of anxiety, depression, and aggression. This teenager not only had to cope with the death of his father whom he had never seen before but additionally faced the major social, school, and community adjustment challenges inherent in immigration to the United States. Although community support was enormous in the beginning, it receded over time. Conventional therapy was not possible with this child, as he was very unexpressive. The best approach to therapy available for this individual was discussion in the hallway or while having a cup of tea or eating lunch in the community kitchen area. Over a period of a year, the sixteen-year-old male demonstrated significant improvement despite several relapses and an incident with the law; he continues to show improvement and to acclimate to United States society in general.

Another survivor, a 47-year-old male who was a cab driver, developed a novel conceptualization of the world around him, describing his growing fears of driving a cab at night. Despite its setting in the temple hallway, the therapeutic intervention we employed in this case resembled cognitive-behavioral therapy and psychoeducation. Reassurance and support also helped him to understand that the behavior exhibited by the shooter was not representative of all non-Sikhs. After a period of a year, the cab driver no longer had the fear of non-Sikh passengers in his cab and had resumed his normal work schedule, which included night driving. He additionally displayed significant improvement in his sleep and a reduction in anger, irritability, and frustration, which he had initially reported to the therapist.

Discussion

Although a multitude of organizations and government agencies offered mental health services to individuals directly or indirectly affected by the tragedy, few members of the *sangat* took the initiative of seeking professional help. Initially, the number of therapists exceeded that of individuals who requested help. Many Punjabi-English bilingual mental health professionals numbered among those who volunteered their services; Punjabi-English bilingual mental health professionals were not generally welcomed as therapists but were more welcomed as members of the Sikh community. After the Sunday services following August 5th, psychotherapists introduced themselves to a congregation of over 500 men, women, and children with the intention of familiarizing their audience with the services they offered. As a consequence of the low response rate, it was often the professionals who took the initiative of approaching individuals after learning of their involvement with the tragedy. On the rare occasions that community members approached mental health professionals, it was more often than not with the pretext of requesting sleep medication rather than discussing the tragedy and its effects. (Refer to "Acute stress reaction" below.)

Because prayer, meditation, and a visit to the temple are integral in the daily routines of many congregation members, it was in the temple that therapists would usually

initiate dialogue with members of the Oak Creek temple community. The *sangat* members' individual recovery processes often began with faith, prayer, donation, and a sense of resilience, not with a request for professional help. During the first several weeks, those professionals who consistently visited the temple were only able to briefly speak with a few affected individuals before departing. We did not observe strong emotional responses in the survivors of the tragedy or in the bereaved. Nor did community members at any point express anger either toward the individual who perpetrated the act or toward the community to which he belonged.

Members of other churches and mosques, community leaders, the mayor of the city, and law enforcement agencies provided enormous support and reassurance to survivors and affected individuals, most particularly in the immediate aftermath of the event. We observed children from local schools visiting the temple and learning about the tragedy and about the Sikh religion. The community as a whole opened the door for offers of help but did not often accept the help offered. We recall that immediately in the wake of the tragedy, the space in the hallways was completely occupied by flowers that were sent by unknown individuals from all over the country.

We observed that many individuals present during the tragedy displayed multiple somatic complaints, unusual stress, and intense fear, but their desire was to obtain proper medication rather than psychological assistance. Survivors construed the acute stress reactions that they experienced as originating from physical rather than psychological sources. When we inquired into the mental status of individuals, the usual answer would be "I'm fine. Everything is fine." However, they would not hesitate to share physical symptoms which may have been manifestations of psychological stress. The symptoms experienced by some survivors were consistent with a diagnosis of acute stress disorder which subsequently developed into post-traumatic stress disorder.

Professionals who volunteered their services soon discovered that the convenience of traditional therapy settings was not an option for many members of this community. We hypothesize that a mutual lack of awareness in the Oak Creek and mental health communities was compounded by spiritual and community pressures to preclude application of a conventional therapeutic mode.

Awareness barriers. Survivors were not always aware of the breadth of applications of psychotherapy, associating psychological services with severe psychoses and an inability to function in society and in their community. Many of them considered seeking counseling to be a sign of weakness. Perhaps even more significantly, few of the therapists who initially offered their services made themselves aware of the particular challenges inherent in treating Sikh patients -potentially as a consequence of the dearth of available literature about this understudied population.

Spiritual barriers. As a consequence of the relationship between humanity and God in Sikhism, community members would often affirm their acceptance of God's will in preference to expressing grief. Community members demonstrated optimism and at least a superficial acceptance of stress and loss in accordance with their religion's teaching of *charhdi kala*.

Community barriers. Sikh leaders in the Oak Creek community emphasized the resilience and independence of Sikhs. Affected individuals who might have otherwise sought therapy doubtless were concerned that community leaders or their peers might perceive it as a rejection of *Hukam* or *charhdi kala*, a selfish departure from religious teachings, or an otherwise shameful act. Some survivors who were directly affected by the tragedy had internalized shame because they feared that members of their community

and the wider population might label them as "cowards" because they had left the dangerous area or hid during the massacre. Many affected individuals were distrustful of therapists' assurances that conversations between them would remain confidential. They voiced concerns that information they shared with the therapist would be available to the rest of the community. An individual's reputation in the *sangat* correlated inversely with the chances that that individual would initiate or respond to therapeutic dialogue.

Therapeutic intervention proceeded informally. For instance, a therapist engaged survivors by asking them to identify sites at which they were hiding during the shooting or at which they witnessed the gunman's attacks. Survivors demonstrated keen interest in reconstructing the scene with therapists. Scenarios such as the aforementioned reconstructive process functioned as a means of grounding the events in reality and acclimating survivors to a setting in which discussion of the event was permitted by making them aware that others who had been present shared their desire to communicate about the event.

Members of the grieving community subsequently organized a sort of makeshift group therapy. One could walk into a room where several men and women were sitting and discussing their whereabouts and what they had been doing that day. In order to effectively initiate therapeutic dialogue with survivors while avoiding the stigma of a traditional therapeutic setting, the professional would engage in conversation as a member of one of these groups and take part in it as any layman would. In this sense, conventional group therapy was not possible. Individuals were, however, very keen to share their emotions regarding the events of August 5th. Many individuals voiced their fear of the recurrence of such an event; they needed reassurance, support, and a sense of security even though they were unable to pursue these directly. When approached individually in the temple hallway, many of the survivors confessed they had been experiencing difficulty sleeping as a consequence of lingering memories of and flashbacks to the events.

The Hallway Therapy Model. "Therapy in the hallway" numbered among the few environments in which survivors appeared comfortable disclosing the major psychological impact the tragedy had upon them. As the survivors did not formally request our professional help, we did not engage survivors in a traditional private therapeutic setting. Instead, we conducted therapy by taking one individual at a time aside. We believe that this mode of therapy was perhaps as effective as conventional psychotherapy in a quiet room with a closed door. The normal course of therapy with this population would begin with a greeting in a common language with the same dialect as the "patient." If the therapist saw an older man, he would bow to offer respect as a convention; in the case of an elderly woman, the therapist would greet her with the gesture of touching her feet, which is a conventional way of giving respect to an elderly person in this community. Therefore, in contrast to the conventional mode of therapy, this mode of therapy traced a paradigm of companionship.

Sessions with survivors and affected individuals were brief but productive. Dialogue would frequently focus on sleep or flashbacks, and the therapist would indirectly offer a solution to their problems. Invariably, affected individuals would be more interested in asking for a sleeping pill than psychological help for depression, anxiety and other symptoms.

Therapeutic alliances emerged in a very indirect way between the therapist and the patient. For instance, after several informal social meetings with a particular therapist, a member of the community might automatically approach the therapist; the therapist

would steer the course of the ensuing conversation toward a one-on-one hallway therapy session. Establishment of rapport between a Sikh therapist and an affected individual was facilitated by the therapist's sharing of details about their geographic region of origin. Genuine support, understanding, empathy, and reassurance were no less important than they would be in a formal therapeutic setting.

Response by demographic. Most adult males demonstrated a tendency to avoid discussion of the tragedy. We also gradually discovered that these individuals began to avoid therapists as community leaders reinforced their beliefs that Sikhs are strong and resilient and that they do not need external assistance to recover and survive. We noticed that males would refrain from engaging in one-on-one discussions with therapists, fearing that male peers would observe them talking to a mental health doctor privately; they were concerned that male peers might construe such a discussion as a disclosure of personal information reflective of their inability to manage their own stresses. Consequently, conventional and even informal modes of therapy became increasingly difficult. Children participated in group activities and were quite vocal in expressing their feelings of fear and trauma regarding the tragic events. The focus of the children's group was encouraging them to express their emotions, to share their experiences, and to freely ask questions. The group setting fostered a sense of security, and participants were encouraged to ask any questions they might have regarding their future security. Many children were rarely part of these groups, and it is possible that their parents sought help elsewhere. The constitution and size of groups varied from week to week. The gender constitution varied from time to time, and the age was not homogeneous.

Authoritative approach. Therapy via a directive approach was most effective in treating affected individuals. In other words, a non-directive therapeutic approach (e.g. Rogers, 2004) would have little chance with most members of this community. Almost universal among members of the Sikh community is a respect for authority figures. The observed efficacy of authoritative approaches could follow from Indian immigrants' greater familiarity with medical than with psychotherapeutic models of healing; the medical healing process generally requires that the doctor direct the patient to take medicine at a certain time. Alternatively, the relationship fostered by an authoritative approach may mimic the relationship between a *guru* and his student, a relationship important in the spiritual context of Sikhism and one that psychologist JS Neki previously hypothesized may hold value in a therapeutic setting (Neki, 1973).

Gender bias. In receptivity to the aforementioned directive approach, both male and female members of the community requested same-sex therapists for both group and individualized therapy. This may arise from cultural and religious roots that caused individuals to internalize gender roles.

Language and dialect. A therapist would connect more readily with an affected individual if the therapist spoke in the individual's native language (often Punjabi) and in the vernacular dialect and tone particular to his place of origin. These aspects became a basic tenet of forming therapeutic alliances in the unconventional setting of the hallway. Immigrants usually experienced difficulty establishing rapport with non-Sikh therapists or therapists not fluent their language, potentially because of their relative discomfort with the English language.

Confidentiality. Members of this community do not readily accept the idea of confidentiality (refer to "Community barriers" above). Therefore, it will be important to stress the nature of confidentiality, and to ensure that the patient understands what that entails.

Peer support and group cohesiveness. Peer support was intentionally or unintentionally present in two forms, a direct mode, wherein *sangat* members assured their peers and offered a safe community for discussion of the tragedy and its consequences, and an indirect mode, wherein the presence of other affected individuals fostered compassion, commiseration, and group cohesiveness. In this community, it is not uncommon for peers to render assistance to other individuals and families in the community affected by a tragedy.

Immigrant status. Many *sangat* members are bilingual; many do not speak fluent English. Almost all adult members are immigrants, though younger members who either were born or spent the majority of their lives in the United States are more inclined to be culturally Americanized than their parents. As a whole, the community demonstrated a preference for culturally sensitive therapists fluent in Punjabi (refer to "Language and dialect" above). Many individuals who entered the United States to attend the funerals of their loved ones were allowed to stay in the country legally with the promise of a path to citizenship. This particular group of people was highly affected both by the loss of their loved ones and by their adjustment and integration to the United States way of life. The initial reluctance to seek therapeutic treatment was common both among immigrants and individuals born in the United States.

Deprivation of mental health services in minority populations is not unique to the Oak Creek tragedy and is by no means an uncommon occurrence. In particular, though approximately 5 percent of the total population of the United States is of Asian origin, under 1.5 percent of individuals receiving mental health treatment represent this population (US Department of Health and Human Services, 2009). The problem is compounded when analyzing the availability of adequate, culturally sensitive mental health services to ethnocultural immigrant populations. Taking into consideration the incredible psychological challenges of adjusting to life in the United States and the frequent targeting of immigrant groups by hate crimes and their associated internalization of Otherness, there is a dire need for psychotherapists equipped to provide services to these populations. The dearth of psychological literature focusing on ethnic populations in the United States unfortunately precludes this in most cases.

In addition to cultural issues, it can arguably be generalized that first-generation immigrants to the United States are prevented from seeking psychotherapy as a consequence of insufficient information or finances. Members of immigrant populations may be unaware of the scope of mental health services available to Americans; of those who are, many will not pursue treatment for mental disorder because of the particular value systems espoused by their culture or religion or their lack of financial resources.

As a consequence of the isolated nature of the Oak Creek community within United States society, many survivors' and affected individuals' interactions with individuals outside their communities were limited; this isolation is not attributable to individuals' disinterest in the remainder of society but to their immigrant status and consequent lack of deep-rooted friendships.

Culture and religion play a significant role in both therapeutic intervention and outcome; effective therapists will consider the way in which each patient has been shaped by his or her cultural environment in devising a treatment strategy. Patient gender, native language, and directive vs. non-directive approach must be considered on a case-by-case system in interactions with members of any ethnic community to most effectively build rapport and provide meaningful treatment.

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