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I am pleased that this issue of the Winter Roundtable Forum is devoted to cultural competence. Cultural competence has been a topic of concern in counseling psychology and psychology in general for some 30 years. Derald Sue (2001 [this issue]) offers a model for achieving cultural competence. There exist several such models in the psychology literature (e.g., Carter, 1998, 2000; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994).

Sue has been a significant voice and leader in the effort to bring cultural competence to the training of psychologists and counselors. His cultural competence model presented here adds significantly to his work and writing in this area. In his competence model, he reminds us of the complexity associated with developing cultural competence. He argues that the traditional and standard principles of helping are culturally bound and are at odds with the cultural norms and expectations of racially and ethnically different people. Sue posits that cultural competence must be understood and acquired from many dimensions. He argues that it is imperative that the social and organizational context in which cultural competence is learned become a part of competence training (e.g., Carter, 2000). The view from the many perspectives or dimensions that Sue (2001) presents is necessary if one is to grasp the obstacles and barriers as well as the strengths and benefits of a racial cultural understanding of human development, social structures, and effective helping. Sue indicates that exclusive attention on the individual and personal aspects of learning about culture ignores and de-emphasizes other meanings and important dimensions essential for cultural counseling competence. One must also learn about his or her reference group memberships as well as the various meanings reference groups hold for others. Organizations and society are also significant influences on the learning process associated with cultural competence. In addition, researchers have found that racial identity development and the counseling relationship are also important components to developing cultural counseling competence (Sue, 2001).
I would like to highlight several points that Sue makes with which I concur that are essential to developing cultural competence. It is imperative that society, the profession of psychology as reflected in its professional associations, and educational institutions within which programs are housed support and value cultural competence training. It is also essential for psychologists and counselors as well as faculty members to personally understand the role of culture in their personal development, training, and professional behavior. Lastly, to build effective counseling relationships and to develop one’s racial identity center on self-knowledge and motivation.

One important aspect of Sue’s model is his assertion that counselors and psychologists learn about the cultures of racial/ethnic groups. I would like to highlight the fact that knowledge of self would facilitate this, and I believe it is essential for learning about others. Torres-Guzman and Carter (2000) put it this way:

The goals of cultural education are not solely to create tolerance of diversity but to change existing structures that perpetuate intolerance, oppression, and inequity. . . . The broader message is that our society needs to change drastically, but that the paths toward those changes are multiple and must be undertaken in a concerted, interactive way. By looking at self, one sees the other. We should each take on the task of understanding self. But we come to see self through the eyes of others, thus we must implicate ourselves in the development of the other if we ourselves wish to develop. This is a call to all [irrespective of one’s race or culture]. (p. 952)

I think our future in psychology and the process of developing cultural competence require that we return to the past and adopt a component of classical analytic training. The aspect of classical psychoanalytical training that I consider important is the process of self-exploration (then called analysis). The training in psychology that emphasizes cultural knowledge and skill has tended to teach about cultural others. Less attention has been given to self-exploration and personal development. The emphasis on knowledge and awareness of cultural others often promotes cognitive learning, whereas emotional components are given less attention. However, self-knowledge and awareness are by their natures both cognitive and emotional. Thus, I would suggest that the lack of emphasis on self-knowledge and exploration in cultural competence training supports and highlights what Sue (2001) describes as the culture-bound and oppressive characteristics of mental health care as it is delivered to visible racial/ethnic group populations.

Sue (2001) notes that at the professional level, the field of psychology still delegates cultural learning to the sidelines and tends to ignore the cultural context of learning and human development. Many training programs have a course or two in the curriculum that focus on racial or cultural issues or prac-
tice but do not teach trainees that humans develop within a cultural context. Even in programs in which such courses do exist, the course composes a small fraction of the curriculum. Carter (1998) maintained, for instance, that a 2-year master’s degree training program might require 60 credits or about 20 courses. At the doctoral level, it would be as many as 90 credits or some 30 courses. Of these, there may be 1 or 2 courses that have an explicit cultural focus. It may also be the case that such courses are cognitive in content and focus. Even when more cultural courses are offered, the traditional “Eurocentric perspective” is still present in other courses.

The continued lack of application and commitment to cultural competence in our profession and training programs weakens our effectiveness as helping professionals. The return to the past with an emphasis on integrative self-exploration and development in which cognitive, affective, and behavioral learning and skill development occur in our training of practicing professionals and trainees could move us to value cultural competence.

It is not possible for training to matter unless our institutions and profession move from rhetoric to reality in their adoption of cultural competence as an emerging and powerful force in psychology and education that enriches our knowledge and ability to serve all people. As has been true of other movements in psychology, there is resistance and doubt. My hope is that future psychologists and counselors will look back to this time and note how the reluctance to broaden our perspective on human development was a temporary phase in the field’s evolution.

REFERENCES
Calls for incorporating cultural competence in psychology have been hindered for a number of reasons: belief in the universality of psychological laws and theories, the invisibility of monocultural policies and practices, differences over defining cultural competence, and the lack of a conceptual framework for organizing its multifaceted dimensions. A proposed multidimensional model of cultural competence (MDCC) incorporates three primary dimensions: (a) racial and culture-specific attributes of competence, (b) components of cultural competence, and (c) foci of cultural competence. Based on a 3 (Awareness, Knowledge, and Skills) × 4 (Individual, Professional, Organizational, and Societal) × 5 (African American, Asian American, Latino/Hispanic American, Native American, and European American) factorial combination, the MDCC allows for the systematic identification of cultural competence in a number of different areas. Its uses in education and training, practice, and research are discussed.

Calls for cultural competence in psychology are not new and have been voiced by many psychologists and groups for more than two and half decades (American Psychological Association, 1993; Arredondo et al., 1996; Council of National Psychological Associations for the Advancement of Ethnic Minorities, 2000; Cross, Bazron, Dennis, & Isaacs, 1989; Dulles Conference Task Force, 1978; C. Hall, 1997; Korman, 1974; Marsella, 1998; President’s Commission on Mental Health, 1978; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue, Bingham, Porche-Burke, & Vasquez, 1999; D. W. Sue et al., 1982; D. W. Sue, Carter, et al., 1998). Yet, demands for integrating multicultural perspectives into the profession have often resulted in resistance for several reasons: belief in the universality of psychological laws and theories (Miller, 1999; D. W. Sue, Carter, et al., 1998) and the invisibility of monoculturalism (D. W. Sue & Sue, 1999). Increasingly, however, psychologists are recognizing that psychological concepts and theories are developed from a predominantly Euro-American context and may be limited in application to the emerging racial and cultural diversity in the United States (Kim & Berry, 1993; Marsella, 1998). Some
have even warned that Euro-American psychology may become “culturally obsolete” unless revised to reflect a multicultural perspective (C. Hall, 1997; D. W. Sue & Sue, 1999).

Even among proponents who agree on the importance of cultural competence, implementing guidelines has been hindered by several problems in the field: (a) differences over defining cultural competence (Ridley, Baker, & Hill, 2000; Ridley et al., 1994) and (b) the lack of a conceptual framework for organizing its multifaceted dimensions (Atkinson, Morten, & Sue, 1998). In the latter case, cultural competence has been conceptualized as either universal (etic) or culture specific (emic) (Dumas, Rollock, Prinz, Hops, & Blechman, 1999), studied from the vantage of a particular racial ethnic group (African Americans, Asian Americans, Euro-Americans, Latino/Hispanic Americans, or Native Americans) (Paniagua, 1998) or focused on different micro/macro levels of analysis (individual, institutional, etc.) (Lewis, Lewis, Daniels, & D’Andrea, 1998). Although all of these dimensions are legitimate aspects of cultural competence, what is sorely lacking is a conceptual framework that would organize these dimensions into a meaningful whole and provide direction for practice, education and training, and research (Dumas et al., 1999).

**MULTIPLE DIMENSIONS OF CULTURAL COMPETENCE (MDCC): A PROPOSED MODEL**

The MDCC offers a conceptual framework for organizing three primary dimensions of multicultural competence: (a) specific racial/cultural group perspectives, (b) components of cultural competence, and (c) foci of cultural competence. Based on a $3 \times 4 \times 5$ design, the model, as shown in Figure 1, allows for the systematic identification of cultural competence in a number of combinations. Each cell represents a confluence of these three major dimensions.

**Dimension 1: Race- and Culture-Specific Attributes of Competence**

One of the most problematic issues in defining cultural competence deals with the inclusive or exclusive nature of multiculturalism. A number of psychologists have indicated that an inclusive definition of multiculturalism (gender, ability/disability, sexual orientation, etc.) can obscure the understanding and study of race as a powerful dimension of human existence (Carter, 1995; Carter & Qureshi, 1995; Helms, 1995; Helms & Richardson, 1997). This stance is not intended to negate the importance of the many cul-
Cultural dimensions of human identity but notes the greater discomfort that many psychologists experience in dealing with issues of race rather than other sociodemographic differences (Carter, 1995). As a result, race becomes less salient and allows us to avoid addressing problems of racial prejudice, racial discrimination, and systemic racial oppression. This concern appears to have great legitimacy. I have noted, for example, that when issues of race are discussed in the classroom, a mental health agency, or some other public forum, it is not uncommon for participants to refocus the dialogue on differences related to gender, socioeconomic status, or religious orientation. On the other hand, many groups often rightly feel excluded from the multicultural debate and find themselves in opposition to one another. Thus, enhancing multicultural understanding and sensitivity means balancing our understanding of the sociopolitical forces that dilute the importance of race and our need to acknowledge the existence of other group identities related to culture, ethnicity, social class, gender, and sexual orientation (D. W. Sue et al., 1999).

I have found the following tripartite framework useful in exploring and understanding the formation of personal identity (see Figure 2).

The three concentric circles illustrated in Figure 2 denote universal, group, and individual levels of personal identity. The universal level is best...
summed up in the following statement: “All individuals are, in some respects, like all other individuals.” Because we are members of the human race and belong to the species *Homo sapiens*, we share many similarities. Universal to our commonalities are (a) biological and physical similarities, (b) common life experiences (birth, death, love, sadness, and others), (c) self-awareness, and (d) ability to use symbols such as language. The character Shylock in Shakespeare’s *Merchant of Venice* attempts to acknowledge the universal nature of the human condition by asking, “When you prick us, do we not bleed?”

The group level of identity is best exemplified in the following statement: “All individuals are, in some respects, like some other individuals.” All of us are born into a cultural matrix of beliefs, values, rules, and social practices. By virtue of social, cultural, and political distinctions made in our society, perceived group membership exerts powerful influence over how society views sociodemographic groups and how its members view themselves and others (Atkinson et al., 1998). Group markers such as race, gender, disability/ability, and age are fixed and unchanging. Those that are relatively nonfixed, such as education, socioeconomic status, marital status, and geographic loca-
tion, are more fluid and changeable. Although culture and ethnicity are fairly stable, some argue that they can also be fluid. Likewise, debate and controversy surround the discussion about whether sexual orientation is fixed or nonfixed. Despite their characterization, membership in these groups may result in shared experiences and characteristics. They may serve as powerful reference groups in the formation of worldviews. Figure 2 reveals that people may belong to more than one cultural group (i.e., race, gender, and disability), some group identities may be more salient than others (race over religious orientation), and the salience of cultural group identity may shift from one to the other depending on the situation (disability among able bodied, but sexual orientation among the disabled).

The individual level of identity is best summed up in the following statement: “All individuals are, in some respects, like no other individuals.” Our unique genetic endowment guarantees that no two individuals are identical. Even identical twins, who theoretically share the same gene pool and are raised in the same family, are exposed to not only shared but also many nonshared experiences. Different experiences in school and with peers and qualitative differences in how parents treat them will contribute to individual uniqueness. Research indicates that psychological characteristics and behavior are more affected by experiences specific to a child than by shared experiences (Plomin, 1989; Rutter, 1991).

A holistic approach to understanding personal identity demands that we recognize all three levels: individual (uniqueness—like no others), group (shared cultural values and beliefs with reference groups), and universal (common features of being human). Confusions occur in research and practice when social scientists fail to clarify or acknowledge the existence of these multiple levels of personal identity. For example, psychological explanations that acknowledge the importance of group influences such as gender, race, culture, sexual orientation, socioeconomic class, and religious orientation lead to more accurate understanding of human psychology. Failure to do so may skew research findings and lead to biased conclusions about human behavior that are culture bound, class bound, and gender bound. Although the concentric circles in Figure 2 might unintentionally suggest a clear boundary, each level of identity must be viewed as permeable and ever changing in salience. Likewise, even within a level of identity, multiple forces may be operative. As mentioned earlier, the group level of identity reveals many reference groups, both fixed and nonfixed, that might affect our lives. Being an elderly, gay, Latino male, for example, presents four potential reference groups operating on the person. The complexity of human psychology is clear in this diagram.

Unfortunately, psychology and specifically mental health professionals have generally focused on the individual and universal levels of identity
while placing less importance on the group level. There appears to be several
reasons for this orientation. First, our society arose from the concept of rug-
ged individualism, and we have traditionally valued autonomy, indepen-
dence, and uniqueness. In our culture, there is an assumption that individuals
are the basic building blocks of our society. Sayings such as “be your own
person,” “stand on your own two feet,” and “don’t depend on others but your-
self” reflect this value. Not only do psychology and education represent the
carriers of this value, but also the study of individual differences is most
exemplified in the individual intelligence-testing movement that pays hom-
age to individual uniqueness (Samuda, 1998). Second, the universal level is
consistent with the tradition and history of psychology where it has histori-
cally sought universal facts, principles, and laws in explaining human behav-
ior. Although an important quest, the nature of scientific inquiry has often
meant studying phenomena independently of the context in which human
behavior originates. Thus, therapeutic interventions from which research
findings are derived may lack external validity (S. Sue, 1999). Third, we have
historically neglected the study of identity at the group level for sociopolitical
and normative reasons. Issues of race, gender, sexual orientation, and disabil-
ity seem to touch “hot buttons” in all of us because they bring to light issues of
oppression and the unpleasantness of personal biases (Carter, 1995; Helms &
Richardson, 1997; D. W. Sue, Carter, et al., 1998). In addition, racial/ethnic
differences have frequently been interpreted from a deficit perspective and
have been equated with being abnormal or pathological (Guthrie, 1997; Lee,
1993; White & Parham, 1990). Yet, a discipline that hopes to understand the
human condition cannot neglect any level of our identity. Because group
identities such as race and ethnicity have historically occupied a tangential
role in psychology, the focus of my model on cultural competence operates
from a group perspective that is race based (Carter, 1995).

Accepting the premise that race, ethnicity, and culture are powerful vari-
ables in influencing how people think, make decisions, behave, and define
events, it is not far-fetched to conclude that such forces may also affect how
different groups define a “helping relationship” (Dumas et al., 1999; Fraga,
Atkinson, & Wampold, 2000; D. W. Sue & Sue, 1999). Multicultural psy-
chologists have noted, for example, that theories of counseling and psycho-
therapy represent different worldviews, each with its own values, biases, and
assumptions about human behavior (Ivey, Ivey, & Simek-Morgan, 1997; Katz,
1985; D. W. Sue & Sue, 1999). Given the fact that schools of counseling and
psychotherapy arise from Western-European contexts, the worldview they
espouse as reality may not be that shared by racial/ethnic minority groups in
the United States nor by those who reside in different countries (Parham,
White, & Ajamu, 1999). Each cultural/racial group may have its own differ-
ent interpretation of reality and offer a different perspective on the nature of
people, origin of disorders, standards for judging normality and abnormality, and therapeutic approach. Among many Asian Americans, for example, a self-orientation is considered undesirable, whereas a group orientation is highly valued. The Japanese have a saying that goes like this: “The nail that stands up should be pounded back down.” The meaning seems clear: Healthy development is considering the needs of the entire group, whereas unhealthy development is thinking of oneself only (D. W. Sue & Sue, 1999). Likewise, many African Americans, relative to their Euro-American counterparts, value the emotive and affective quality of interpersonal interactions as qualities of sincerity and authenticity (Parham, 1997; Parham et al., 1999). Euro-Americans, however, often view the passionate expression of affect as irrational, a loss of objectivity, impulsivity, and immaturity on the part of the communicator. Thus, in these two examples, where both Asian American and African American groups view the world differently, the goal of counseling and psychotherapy toward autonomy for Asian American clients and the process of therapy that stresses objectivity for African American clients might prove antagonistic to their worldviews.

Clearly, the cultural context of mental health theories shapes the definition of the problem and influences the appropriate therapeutic response. Just as race, culture, ethnicity, and gender may influence and shape worldviews, the theoretical orientation of mental health professionals may also influence their conceptions of the world. Most Euro-American psychotherapies share some common therapeutic characteristics: They are conducted generally in a one-to-one relationship, the primary responsibility for change resides with the person, the medium by which helping occurs is verbal, achieving insight is valued, and clients are expected to self-disclose their most intimate thoughts and feelings (D. W. Sue & Sue, 1999). Likewise, certain culture-bound therapeutic taboos are present in definitions of the helping role: (a) Therapists do not give advice and suggestions (it fosters dependency), (b) therapists do not self-disclose their thoughts and feelings (it is unprofessional), (c) therapists do not barter with clients (it changes the nature of the therapeutic relationship), (d) therapists do not serve dual-role relationships with clients (there is a potential loss of objectivity), and (e) therapists do not accept gifts from clients (it unduly obligates them) (D. W. Sue & Sue, 1999). Although these characteristics and admonishments are derived from the profession’s standards of practice and ethical codes of conduct, many of these taboos are intimate aspects of help giving in other cultures. Gift giving in many Asian cultures has a long-standing historical/cultural sanction in the helping relationship (S. Sue & Zane, 1987); expression of the helper’s thoughts/feelings is seen as evidence of sincerity and humanness—necessary attributes of the helping relationship among many Africans/African Americans (Parham, 1997); the giving of advice and suggestions is perceived as a helping charac-
teristic among many Latino groups (Comas-Diaz, 1990); and, among many African Americans, multiple-role relationships are often associated with greater probability of seeking help from the healer (Parham et al., 1999; White & Parham, 1990).

Thus, it is highly possible that different racial/ethnic minority groups perceive the competence of the helping professional differently from mainstream client groups. If that is the case, culturally different clients may see a clinician who exhibits primarily therapeutic skills associated with mainstream therapies as having lower credibility. The important question to ask is the following: “Do different racial/ethnic minority groups define cultural competence differently from their Euro-American counterparts?” Anecdotal observations, clinical case studies, conceptual analytical writings, and some empirical studies seem to suggest an affirmative response to the question (Fraga et al., 2000; McGoldrick, Giordano, & Pearce, 1996; Nwachuku & Ivey, 1991; D. W. Sue & Sue, 1999; Wehrly, 1995). Yet, an equally important question is the following: “Do different racial/ethnic minority groups define cultural competence differently from one another?” For example, do African American clients perceive therapeutic competence in the same way as their Native American counterparts? The answers to these questions are important because a helping professional’s therapeutic effectiveness is strongly linked to how clients perceive the expertise of their clinicians. Although some studies have been conducted on culture-specific methods of intervention, there is a noticeable lack of studies aimed at the multicultural competencies identified in the D. W. Sue et al. (1992) report and those currently being proposed along the dimensions of awareness, knowledge, and skills. Fraga et al. (2000) used a paired-comparison method to explore ethnic group preferences for the 31 multicultural competencies identified in the D. W. Sue et al. report. They found significant preferences for many of the competencies that differentiated Asian American, European American, and Hispanic/Latino groups. There were similarities as well, lending support for both a culture-specific (emic) and a culture-universal (etic) perception of cultural competence. As shown in Figure 1, research into identifying culture-specific interventions for the various racial/ethnic minority groups is sorely needed.

**Dimension 2: Components of Cultural Competence**

Any definition of cultural competence is fraught with potential disagreements and differences. Some have focused on “cultural sensitivity” in the form of a perceptual schema (Ridley et al., 1994), knowledge of culture and differences (Pedersen, 1994), awareness of one’s own cultural assumptions (Pope-Davis & Ottavi, 1994), skills necessary for successful cultural intervention (D. W. Sue, 1990), levels of worldview (Trevino, 1996), universal
healing conditions moderated by culture-specific contexts (Fischer, Jome, & Atkinson, 1998), the inclusive or exclusive nature of multiculturalism (Helms & Richardson, 1997), and/or some combination of these factors (D. W. Sue, Carter, et al., 1998).

In their review of cultural competence, Helms and Richardson (1997) believed that the Division 17 Education and Training Committee’s (D. W. Sue et al., 1982) position paper on cultural competence had become a landmark and seminal work on the topic. In that publication, competencies were divided into three categories: (a) attitudes/beliefs component—an understanding of one’s own cultural conditioning that affects personal beliefs, values, and attitudes; (b) knowledge component—understanding and knowledge of the worldviews of culturally different individuals and groups; and (c) skills component—use of culturally appropriate intervention/communication skills. This three-domain division was later updated into a 3 × 3 matrix (Characteristics of Culturally Skilled Helpers × Awareness, Knowledge, and Skill), resulting in 31 different competencies shown in Table 1 (D. W. Sue et al., 1992).

Most measures of multicultural counseling competencies use this framework in developing and validating their instruments: the Cross-Cultural Counseling Inventory–Revised (LaFromboise, Coleman, & Hernandez, 1991), Multicultural Counseling Awareness Scale–Form B (Ponterotto, Sanchez, & Magids, 1991), Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), the portfolio method (Coleman, 1997), and the Multicultural Awareness-Knowledge-Skills Survey (D’Andrea, Daniels, & Heck, 1991). Furthermore, many proposed multicultural training programs have been based on these domains as well (Carney & Kahn, 1984; Nwachuku & Ivey, 1991; Pedersen, 1994; Sabnani, Ponterotto, & Borodovsky, 1991; Trevino, 1996).

Some studies have indicated that the three-domain model may not fully account for multicultural competence and that other components like racial identity and a relationship factor should be added (Ponterotto, Rieger, Barrett, & Sparks, 1994; Sodowsky, 1996; Vinson & Neimeyer, 2000). Several studies, for example, indicate that multicultural counseling competency is associated with more advanced levels of racial identity development (Ottavi, Pope-Davis, & Dings, 1994; Vinson & Neimeyer, 2000), and it may prove to be a separate component of cultural competence. Likewise, Sodowsky et al. (1994) have found that in addition to the domains of knowledge, beliefs/attitudes, and skills, a multicultural counseling relationship factor is important as well. Nevertheless, these researchers all acknowledge that the three-domain division remains conceptually useful. Thus, for purposes of our proposed cultural competency model, the division of beliefs/attitudes,
TABLE 1: Components of Cultural Competence

<table>
<thead>
<tr>
<th>Belief/Attitude</th>
<th>Knowledge</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aware and sensitive to own heritage and valuing/respecting differences.</td>
<td>1. Has knowledge of own racial/cultural heritage and how it affects perceptions.</td>
<td>1. Seeks out educational, consultative, and multicultural training experiences.</td>
</tr>
<tr>
<td>2. Aware of own background/experiences and biases and how they influence psychological processes.</td>
<td>2. Possesses knowledge about racial identity development. Able to acknowledge own racist attitudes, beliefs, and feelings.</td>
<td>2. Seeks to understand self as racial/cultural being.</td>
</tr>
<tr>
<td>3. Recognizes limits of competencies and expertise.</td>
<td>3. Knowledgeable about own social impact and communication styles.</td>
<td>3. Familiarizes self with relevant research on racial/ethnic groups.</td>
</tr>
<tr>
<td>4. Comfortable with differences that exist between themselves and others.</td>
<td>4. Knowledgeable about groups one works or interacts with.</td>
<td>4. Involved with minority groups outside of work role: community events, celebrations, neighbors, and so forth.</td>
</tr>
<tr>
<td>5. In touch with negative emotional reactions toward racial/ethnic groups and can be nonjudgmental.</td>
<td>5. Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth.</td>
<td>5. Able to engage in a variety of verbal/nonverbal helping styles.</td>
</tr>
<tr>
<td>7. Respects religious and/or spiritual beliefs of others.</td>
<td>7. Understands culture-bound, class-bound, and linguistic features of psychological help.</td>
<td>7. Can seek consultation with traditional healers.</td>
</tr>
<tr>
<td></td>
<td>10. Knowledgeable about minority family structures, community, and so forth.</td>
<td>10. Works to eliminate bias, prejudice, and discrimination.</td>
</tr>
<tr>
<td></td>
<td>11. Knows how discriminatory practices operate at a community level.</td>
<td>11. Educates clients in the nature of one’s practice.</td>
</tr>
</tbody>
</table>

NOTE: Adapted from D. W. Sue, Arredondo, & McDavis (1992).
knowledge, and skills will be used. Research may ultimately identify other factors underlying cultural competence that may alter the MDCC.

Despite the numerous definitions of cultural competence, they often do not help us answer two important questions: Why is cultural competence desirable? and What specific outcomes are we seeking as we advocate for its implementation? Answering these questions requires us to deconstruct the values and assumptions inherent in cultural competence definitions. Two representative definitions are revealing.

1. Helms and Richardson (1997) stated that multiculturalism “should refer to the integration of dimensions of client cultures into pertinent counseling theories, techniques, and practices with specific intent of providing clients of all sociodemographic and psychodemographic variations with effective mental health services” (p. 70).

In other words, their definition implies that the goal of cultural competence in mental health is providing relevant treatment to all populations and that this end is desirable.

2. The Society for the Psychological Study of Ethnic Minority Issues (Division 45) and the Division of Counseling Psychology’s (Division 17) Committee on Multicultural Competencies have identified the following attributes as central to the definition: (a) balances the extremes of universalism (etic) and relativism (emic) by explaining behavior as a function of those culturally learned perspectives that are unique to a particular group and to those common-ground universals that are shared across groups; (b) on an individual level, the acquisition of attitudes, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to interact, negotiate, and communicate with peoples from diverse backgrounds); and (c) on an organizational/societal level, developing new theories, practices, policies, and organizational structures that are more responsive to all groups (D. W. Sue, Carter, et al., 1998).

This definition extends the focus from the person/individual level to the organizational/system level. It, too, acknowledges the desirability of cultural competence at all levels.

Although not directly stated, both definitions (and I believe those proposed by others) are truly about social justice. For many psychologists, such a statement may appear too political and/or unrelated to mental health. After all, shouldn’t social justice be the goal of government and a democracy? What does social justice have to do with mental health? Isn’t the goal of the mental health system to provide beneficial treatments to client populations
and to ameliorate personal suffering? First, I have argued elsewhere that counseling and psychotherapy may act as instruments of cultural oppression by defining the lifestyles of culturally different clients as deviant and abnormal, by imposing culture-bound solutions on them and by unintentionally engaging in victim blaming (D. W. Sue & Sue, 1999). Second, psychology has failed to adequately address issues of racism, bias, and discrimination as major contributors to mental distress among persons of color and has played a passive role in rectifying the inequities that affect the standard of living for racial minority groups in the United States. Its emphasis on an in-the-office, remedial, and verbal mode of intervention dictates against out-of-office activities needed to intervene in systemic causes of the problem. Unfortunately, counselors are uncomfortable with the implication that they must share responsibility with their clients in ultimately determining the outcome of an intervention. Thus, on an individual therapeutic level, minority clients are often correct when they complain that their counselors or therapists cannot relate to their life circumstances, are insensitive to their needs, do not accept or respect them, are arrogant and contemptuous, and have little insight as to their own personal biases (Ponterotto & Pedersen, 1993; Ridley, 1995; D. W. Sue & Sue, 1999). Also, a report by the Basic Behavioral Science Task Force of the National Advisory Mental Health Council (1996) makes it clear that sociopolitical forces often bias the mental health delivery systems in favor of certain groups in the population while shortchanging communities of color. It notes how mental health care for ethnic minority communities is often of an inferior quality, inappropriate, inaccessible, and discriminatory in nature.

Given these conclusions, it is clear that mental health services are often absent, inappropriate, or oppressive to minority populations. Thus, multicultural counseling competence must be about social justice—providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to fair mental health services. The MDCC being proposed here operates from a set of shared core principles considered to be the foundation of a democratic and egalitarian society: inclusion, fairness, collaboration, cooperation, and equal access and opportunity (President’s Initiative on Race, 1997; D. W. Sue et al., 1999). The underlying assumptions of social justice are consistent with the democratic ideals of cultural democracy and equity (not necessarily some of their passages) found in the Declaration of Independence, the U.S. Constitution, and the Bill of Rights. It is assumed that these overarching core principles must guide the vision, values, and practice of cultural competence. Consistent with the social justice agenda, I have proposed the following definition of cultural competence that I believe incorporates some of the important attributes of social justice (D. W. Sue, in press):
Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups.

**Dimension 3: The Foci of Cultural Competence**

In a broad sense, the foci of cultural competence examine the person/individual versus the organizational/system levels of analysis. The work on cultural competence has generally focused on the micro level, the individual. In the education and training of psychologists, for example, the goals have been to increase the level of self-awareness of trainees (potential biases, values, and assumptions about human behavior); to acquire knowledge of the history, culture, and life experiences of various minority groups; and/or to aid in developing culturally appropriate and adaptive interpersonal skills (clinical work, management, conflict resolution, etc.). Less emphasis is placed on the macro level: the profession of psychology, organizations, and the society in general (Barr & Strong, 1987; Cross et al., 1989; Jones, 1997; Lewis et al., 1998; D. W. Sue, 1991). D. W. Sue and Sue (1999) suggested that it does little good to train culturally competent helping professionals when the very organizations that employ them are monocultural and discourage or even punish psychologists for using their culturally competent knowledge and skills. If our profession is interested in the development of cultural competence, then it must proceed in a concerted fashion along four main foci: individual, professional, organizational, and societal levels. Figure 3 identifies these levels and the major barriers that must be overcome to move toward cultural competence.

At the individual level, the obstacles are biases, prejudices, and misinformation manifested via discrimination; at the professional level, they are culture-bound definitions of psychology and ethnocentric standards of practice/codes of ethics; at the organizational level, they are monocultural policies, practices, programs, and structures; and at the societal level, they are the invisibility of ethnocentric monoculturalism, the power to define reality, and a biased interpretation of history. Barriers to cultural competence and solutions for overcoming them are discussed below.

**Individual/personal level.** A basic assumption underlying the MDCC is that no one was born into our society with the desire or intention to be biased, prejudiced, or bigoted (Dovidio, 1997; D. W. Sue, 1999). Misinformation
related to culturally different groups is not acquired by free choice but imposed through a process of social conditioning; people learn to hate and fear others who are different from them (Jones, 1997; D. W. Sue, Carter, et al., 1998). It is difficult, for example, to conceive of anyone born and raised in the United States who has not inherited the racial biases of his or her forebears. These biases and prejudices are often expressed unintentionally and at an unconscious level (Dovidio & Gaertner, 1999). One might even suggest that people are taught from the moment of birth to be culturally incompetent.

Four major obstacles seem to block the path toward attaining personal cultural competence. First, acknowledging personal biases is difficult because people perceive and experience themselves as moral, decent, and fair people (D. W. Sue, 1999). Such a realization is at odds with and threatens the self-image of those who consciously believe in justice and democracy (Fine, Weiss, Powell, & Wong, 1997). Second, many people operate from a politeness protocol and are disinclined to honestly examine, explore, and discuss in public unpleasant racial realities such as prejudice, stereotyping, and discrimination (President’s Initiative on Race, 1997). Third, personal cultural competence requires accepting responsibility for any action or inaction that
may directly or indirectly perpetuate injustice. Realizing how one’s own biases and actions may contribute to inequities means that one can no longer escape personal responsibility for change. Finally, the eradication of bias is more than an intellectual exercise. It involves dealing with “embedded emotions” (fear, guilt, anger, etc.) often associated with painful racial memories and images (President’s Initiative on Race, 1997). Most people avoid unpleasantness and are tempted not to face the reality of their fears.

Understanding personal resistance to cultural competence is important for training because it suggests the type of activities and exercises likely to produce positive change (Carter, 1995; Helms, 1995; Sabnani et al., 1991; D. W. Sue, Carter, et al., 1998). The personal journey to overcoming cultural incompetence represents a major challenge in the education and training of psychologists. To be successful, it must entail a willingness by trainers and trainees to address internal issues related to personal belief systems, behaviors, and emotions when interacting with other racial groups (Dovidio, 1997; D. W. Sue, 1999). Although many individuals are willing to acknowledge that racism must be addressed at an institutional and societal level, they often avoid addressing these on a personal level and fail to identify personal growth as a necessary element. Becoming culturally competent means acknowledging biases and preconceived notions; being open and honest with one another; hearing the hopes, fears, and concerns of all groups in this society; recognizing how prejudice and discrimination hurt everyone; and seeking common solutions that allow for equal access and opportunities (President’s Initiative on Race, 1997; D. W. Sue, 1999).

Overcoming biased cultural conditioning means conquering the inertia and feeling of powerlessness on a personal level. People are capable of change if they are willing to confront and unlearn their biased conditioning (Ponterotto & Pedersen, 1993). To accomplish this task, they must be encouraged to unlearn not only the biased misinformation on a cognitive level (factual) but also the misinformation that has been glued together by painful emotions (McIntosh, 1989). They must begin to accept the responsibility for the pain and suffering they may have directly or indirectly caused others (Ridley, 1995). Unlearning biases means acquiring accurate information and experiences. Much of how people come to know about other cultures is through the media, what their families and friends convey to them, and public education texts. These sources cannot be counted on to give an accurate picture because they can be filled with stereotypes, misinformation, and deficit portrayals (D. W. Sue & Sue, 1999).

Four principles can be personally helpful in achieving individual cultural competence (D. W. Sue, 1999). First, individuals must experience and learn from as many sources as possible (not just the media or what their neighbors may say) to check the validity of their assumptions and beliefs. Second, a bal-
anced picture of any group requires that they spend time with healthy and strong people of that culture. Third, they must supplement their factual understanding with the experiential reality of the groups they hope to understand. Finally, their lives must become a “have to” in being constantly vigilant to manifestations of bias in both themselves and in people around them (D. W. Sue, 1999). Although attending workshops and receiving continuing education on multiculturalism are helpful, people must take responsibility to initiate personal growth experiences in the real world. Thus, education and training programs must somehow build learning experiences for trainees that require personal growth through lived reality and experience (D. W. Sue et al., 1999).

Professional level. Many multicultural specialists have criticized the profession of psychology as being culture bound in that it arises from a predominantly Eurocentric perspective (Guthrie, 1997; C. Hall, 1997; Katz, 1985; Marsella, 1998; Parham, 1993; White & Parham, 1990) and is, oftentimes, inapplicable to racial/ethnic minority groups. Some African American psychologists (Parham, 1993; Parham et al., 1990; White & Parham, 1990) contend that the roots of psychology arose from African Egyptian civilizations that defined it as the study of the soul or spirit. Although this predated the laboratory work of Wilhelm Wundt in the late 1800s, psychology was translated in Western thinking to be the study of the mind, knowledge, and behavior.

It can certainly be debated historically and philosophically whether this evolution occurred, but it is clear that the Euro-American approach to psychology is imbued with a worldview quite different from its African counterparts (Asante, 1987). Likewise, Lee (1993) pointed out that bias in Western psychology is often manifested in the educational emphasis of Greek scholars such as Socrates (469–399 B.C.), Hippocrates (460–370 B.C.), Democritus (460–370 B.C.), Plato (427–347 B.C.), and Aristotle (384–322 B.C.); minimal importance is placed on the psychological theories of ancient Chinese scholars such as Lao Tzu (571–477 B.C.), Confucius (557–479 B.C.), Mo Tzu (325–238 B.C.), Chuang Tzu (369–286 B.C.), and Mencius (372–289 B.C.). These Asian theories of human behavior that stress collectivism and interpersonal embeddedness are in marked contrast to the individualism and interpersonal freedom of their Euro-American counterparts. This bias is often seen in definitions of normality and abnormality and is reflected in theories of human development as well. Most criteria used to judge healthy functioning are strongly linked to individualism: The healthy and well-adjusted person is autonomous, independent, and able to stand on his or her own (Kim & Berry, 1993). The theories of human development such as those of Jean Piaget and Erik Erikson speak to the process of individuation as equated with mature development (Ivey et al., 1997). Family systems theories see “enmeshment”
and “codependency” as potentially pathological aspects of family members, although many Asian American and Latino/Hispanic Americans perceive interdependence as healthy and desirable (McGoldrick et al., 1996). And, as indicated earlier, psychology sees the study of the mind and behavior as the legitimate domain of psychological inquiry and considers the study of the spirit or soul as nonscientific. Figure 3 clearly identifies some of the impediments to a multicultural profession. Professional cultural competence means, therefore, that psychology needs to reevaluate its definition of psychology and adopt codes of ethics and standards of practice that are multicultural in scope. Omission of such culturally sensitive standards in our profession and the failure to translate multicultural competencies into actual practice will only continue the path of cultural incompetence.

Organizational level. If we are to truly value multiculturalism, then our organizations (mental health care delivery systems, businesses, industries, schools, universities, governmental agencies) and even our professional associations must move toward cultural competence in how they treat clients, students, and workers. Much of the knowledge base on multicultural organizational development (MOD) has come from work in business and industry where the changing complexion of the workforce and marketplace has forced organizations to reevaluate their organizational cultures (D. W. Sue, Parham, & Bonilla-Santiago, 1998). MOD is a relatively new field that operates on the premise that organizations, like individuals, vary in their receptivity to racial, cultural, ethnic, sexual orientation, and gender issues. Organizations that recognize and value multiculturalism in a pluralistic society are usually in a better position to avoid many of the misunderstandings and conflicts characteristic of monocultural institutions (Thomas, 1990). They will also be in a better position to offer culturally relevant services to their diverse clientele and to allow mental health professionals, for example, to engage in organizationally sanctioned roles and activities without the threat of punishment (Lewis et al., 1998). Ascertaining what the organizational culture is like, what policies or practices either facilitate or impede multiculturalism, and how to implement change is crucial.

Some of the more helpful MOD models are found in the business sector (Adler, 1986; Foster, Cross, Jackson, & Hardiman, 1988; Jackson & Holvino, 1988; D. W. Sue, 1991), but contributions from education (Barr & Strong, 1987; D’Andrea et al., 1991; Highlen, 1994) and mental health agencies (Cross et al., 1989) are also useful. Multicultural specialists have identified three types of organizations as they move toward multicultural implementation (Adler, 1986; Barr & Strong, 1987; Cross et al., 1989; D’Andrea & Daniels, 1991; Foster et al., 1988; Highlen, 1994; D. W. Sue, 1991).
1. **Monocultural organizations.** At one extreme is organizations that are primarily Eurocentric and ethnocentric. They operate from the following assumptions: (a) There is an implicit or explicit exclusion of racial minorities, women, and other marginalized groups; (b) they are structured to the advantage of the Euro-American majority; (c) there is only one best way to deliver health care, manage, teach, or administrate; (d) culture is believed to have minimal impact on management, mental health, or education; (e) clients, workers, or students should assimilate; (f) culture-specific ways of doing things are neither recognized nor valued; (g) everyone should be treated the same; and (h) there is a strong belief in the melting pot concept.

2. **Nondiscriminatory organizations.** As organizations become more culturally relevant and receptive, they enter a nondiscriminatory stage. The following premises and practices characterize these organizations: (a) They possess inconsistent policies and practices regarding multicultural issues. Certain departments and some workers/practitioners/managers/teachers are becoming sensitive to minority issues, but it is not an organizational priority. (b) The leadership may recognize a need for some action, but they lack a systematic program or policy addressing the issue of prejudice and bias. (c) There is an attempt to make the climate or services of an organization less hostile or different, but these changes are superficial and oftentimes without conviction. They are more likely to be present because of public relations reasons. (d) Equal employment opportunities, affirmative action, and numerical symmetry of minorities and women are implemented grudgingly.

3. **Multicultural organizations.** As organizations become progressively more multicultural, they begin to value diversity and continue attempts to accommodate ongoing cultural change. Their manner of operation reflects these values: They (a) are in the process of working on a vision that reflects multiculturalism; (b) reflect the contributions of diverse cultural and social groups in mission, operations, products, and services; (c) value multiculturalism and view it as an asset; (d) actively engage in visioning, planning, and problem-solving activities that allow for equal access and opportunities; (e) realize that equal access and opportunities are not equal treatment; and (f) work to diversify the environment.

The steps to organizational cultural competence mean altering the power relations in organizations to minimize structural discrimination (Lewis et al., 1998). This may mean the following developments: (a) the inclusion of minorities in decision-making positions and the sharing of power with them and (b) constructing multicultural programs and practices with the same economic and maintenance priorities as other valued aspects of the organization. More important, programs need to be implemented that directly attack the
biases, prejudices, and stereotypes of mental health administrators, staff, and professional workers. Any multicultural initiative that does not contain a strong antiracism component, for example, will not be successful (D’Andrea & Daniels, 1991; Wehrly, 1995). What is clear from this analysis is that psychologists need to understand how organizational policies and practices may affect them and their clients, how organizational subsystems may impede multicultural development, what changes need to be made so all groups are allowed equal access and opportunity, and finally, that they need to play system intervention roles other than the traditional one that focuses solely on individual change.

Societal level. On June 13, 1997, President Clinton issued Executive Order No. 13050 that created a Race Advisory Board for the purpose of examining race, racism, and potential racial reconciliation in America (President’s Initiative on Race, 1997). It concluded that (a) bigotry and racism continue to be two of the most divisive forces in our society; (b) the need to address issues of race, culture, and ethnicity has never been more urgent; (c) most citizens of this nation seem ill-equipped to deal with these topics; (d) racial legacies of the past continue to affect current policies and practices of the present, creating unfair disparities between racial/ethnic minority and Euro-American groups; (e) such inequities are often so deeply ingrained in American society that they are nearly invisible; and (f) a constructive dialogue on race needs to occur in this nation. They recommended “looking at America through the eyes of others” (marginalized groups), searching for common values and goals shared by all groups, and developing and institutionalizing promising practices that would allow for equal access and opportunity. Although not directly stated, the report encourages people from all segments of society to become culturally aware, sensitive, and respectful in their actions toward one another (cultural competence). Figure 3 identifies the three major barriers to attaining cultural competence in our society: (a) the invisibility of ethnocentric monoculturalism, (b) the power to define reality from a singular perspective, and (c) a biased historical legacy that glorifies the contributions of one group over another.

1. Invisibility of ethnocentric monoculturalism. Ethnocentric monoculturalism has been identified as a major culprit working against cultural competence in our society (D. W. Sue & Sue, 1999). A joint Division 17 and 45 Committee recently outlined its problematic features (D. W. Sue, Carter, et al., 1998). First, there is a strong belief in the superiority of one group’s cultural heritage (history, values, language, traditions, arts/crafts, etc.). The group norms and values are seen positively, and descriptors may include such terms as more advanced and more civilized. Members of the society may
possess conscious and unconscious feelings of superiority and that their way of doing things is the “best way.” Second, there is a belief in the inferiority of all other groups’ cultural heritage, which extends to their customs, values, traditions, and languages. Other societies or groups may be perceived as “less developed,” “uncivilized,” “primitive,” or even “pathological.” The lifestyle or ways of doing things by the group are considered inferior. Third, the dominant group possesses the power to impose its standards and beliefs on the less powerful group. This component of ethnocentric monoculturalism is very important. All groups are to some extent ethnocentric; that is, they feel positively about their cultural heritage and way of life. Yet, if they do not possess the power to impose their values on others, they hypothetically cannot oppress. It is power or the unequal status relationship among groups that defines ethnocentric monoculturalism (Jones, 1997). Fourth, the ethnocentric values and beliefs are manifested in the programs, policies, practices, structures, and institutions of the society. For example, chain-of-command systems, training and educational systems, communication systems, management systems, and performance appraisal systems often dictate and control our lives. They attain “untouchable” and “godfather-like” status in an organization. Because most systems are monocultural in nature and demand compliance, racial/ethnic minorities and women may be oppressed. Fifth, because people are all products of cultural conditioning, their values and beliefs (worldview) represent an “invisible veil” that operates outside the level of conscious awareness. As a result, people assume universality; everyone, regardless of race, culture, ethnicity, or gender, shares the nature of reality and truth. This assumption is erroneous but seldom questioned because it is firmly ingrained in our worldview.

2. The power to define reality. Ethnocentric monoculturalism is damaging when one group has the power to define reality from its singular perspective. The fourth-century Chinese sage, Chang-Tsu, was fond of saying that “how we view the world is not only about what we see, but about what we do not see.” The United States was founded on basic democratic ideals of equality, fairness, and social justice. Children are taught from birth that these ideals form the fabric of our society. Yet, history is replete with actions and laws that have consistently contradicted these democratic principles (Barongan et al., 1997). In reality, people are also socialized to accept undemocratic values, attitudes and beliefs of cultural superiority, White supremacy, and behaviors that run counter to admirable ideals (Jones, 1997; Ponterotto & Pedersen, 1993). The inability to see how these more shameful values are manifested in our society has been labeled cultural racism, the individual and institutional expression of the superiority of one group’s cultural heritage over another (Jones, 1997). These biased values, assumptions, beliefs, and practices of our
society are less visible but structured in such a manner as to uphold the cultural heritage of one group over another (Ridley, 1995; D. W. Sue, Ivey, & Pedersen, 1996; Wehrly, 1995). As a result, U.S. society has been severely criticized as being ethnocentric, monocultural, and inherently biased against racial/ethnic minorities, women, gays/lesbians, and other culturally different groups (Carter, 1995; Laird & Green, 1996; Ridley, 1995; D. W. Sue et al., 1992). Rather than educate or enlighten, rather than increase freedom and goodwill, and rather than allow equal access and opportunity, the racial legacies of the past and current societal practices continue to restrict, stereotype, oppress, and damage the culturally different in our society.

3. A biased historical legacy. In his book *Even the Rat Was White*, Robert Guthrie (1997) revealed the extreme bias of psychology and how the history as told from the Euro-American perspective was and continues to be an incomplete and inaccurate one. The title of his book strikes such a responsive chord among persons of color because it asks a profound question: “Who owns history?” The answer to this question in our society is clear. When the contributions of various racial/ethnic groups are neglected and/or distorted in social studies and history textbooks, when the contributions of one group are glorified over another, and when children are socialized and educated to accept and believe in the historical legacy of the dominant society, then we set up conditions that contribute to ethnocentric monoculturalism and impose a reality among the populace with major implications (Banks & Banks, 1995; D. W. Sue & Sue, 1999).

Because of the invisibility of ethnocentric monoculturalism and how it defines our reality, society is often unable to address or ameliorate basic social problems. The perception that affirmative action programs are inherently unfair by giving the advantage to minorities is based on the belief that we have a level playing field for everyone and such programs “unfairly discriminate against White Americans” (APA, 1997). Belief that we reside in a democratic society means assumptions of a meritocracy in which achievement is based on individual effort alone.

The civil rights movement of the 1950s and 1960s resulted in a range of policies and practices known as affirmative action that acknowledged the reality that whole groups of individuals have been denied an equal opportunity to pursue the meritocratic ideal. The goals of affirmative action are (a) compensating for past injustices, (b) correcting present inequities, (c) promoting multicultural competence, and (d) enhancing the presence of role models (APA, 1999). Yet, if people’s reality leads them to conclude that past injustices are adequately compensated, that they should not be “punished for the sins of the past,” that present inequities are greatly exaggerated, that
“competence is competence,” that there are sufficient minority role models present, and that affirmative action discriminates against Whites, then they conclude that affirmative action is not only unneeded but morally wrong (Dovidio, 1997).

Overcoming ethnocentric monoculturalism in our society, in general, and in the mental health field, in particular, is a monumental task. It means our ability to deconstruct erroneous democratic assumptions that permeate our thinking and behavior (“everyone has an equal chance in this society”; “if people work hard enough, they can succeed”; “equal treatment is not discriminatory treatment”; etc.); to identify those who deny equal access and opportunity; to change some “cherished” societal values, structures, policies, and practices; and to accept personal and professional responsibility for affecting our society through advocacy roles and legislative and public policy efforts (affirmative action programs and bilingual education).

Psychology as a profession must have the moral courage, fortitude, and political savvy to affect the broader social, political, and economic levels of the macro system within which individuals, groups, and institutions function. In truth, psychologists have played a minimal role in the formation of public policy because they have failed to understand how systemic forces affect people and because they have been adverse to becoming active in the social and political arenas (D. W. Sue, Parham, et al., 1998). They can no longer be only concerned with individual change but must use their knowledge and skills to improve conditions in the world for all groups. Unless they do so, persons of color and other marginalized groups will continue to bear the brunt of unjust policies and practices. If psychologists are to effect major improvements in the psychological well-being of people, they must be able to influence political decisions and policies regarding our institutions and society. Separating their professional roles from social and political concerns is to refuse responsibility for society’s future.

THE MDCC MODEL: IMPLICATIONS FOR PRACTICE, EDUCATION AND TRAINING, AND RESEARCH

As indicated in Figure 1, each cell on the MDCC model targets the components of cultural competence (awareness, knowledge, and skills), the foci of analysis (individual, professional, organizational, or societal), and racial/cultural group attributes (African American, Asian American, Latino/Hispanic American, Native American, and European American). Several examples illustrate how the MDCC model may help direct our attention to specific areas for practice, education and training, and research.
The MDCC in Action:
Multicultural Mental Health Issues

At the clinical level, it has been found that many racial/ethnic minorities may underutilize traditional mental health facilities and often prematurely terminate sessions when compared to their Euro-American counterparts (Atkinson et al., 1998; Barney, 1994; Leong, Wagner, & Tata, 1995; Neighbors, Caldwell, Thompson, & Jackson, 1994). Given the conclusion that all groups may have similar rates of mental disorders and that racial minorities may actually be under greater psychological stress than their White counterparts, these findings are puzzling and disturbing (Atkinson et al., 1998). The reason for the disparity was originally conceptualized as residing either in the culturally different client (incompatible value system) or in the traditionally trained therapist who lacked appropriate cultural knowledge to be effective (D. W. Sue & Sue, 1999). Research and training focused on the individual level (see Figure 1, Dimension 3) where acquisition of knowledge by counselors and therapists was seen as the key solution. The other two cultural competency components of self-awareness and skills were given less emphasis because of several assumptions. It was often assumed that the process of counseling was value neutral and that mental health practitioners were free of biases when working with clients. In addition, it was believed that intervention strategies had universal applications and could easily be adapted to fit the needs of minority clients. Cultural competence, therefore, meant focusing on the knowledge component of Dimension 2, at the individual focus of Dimension 3, and on the four major racial groups in Dimension 1. Thus, a large body of knowledge began to accumulate on African Americans, Asian Americans, Latino/Hispanic Americans, and Native Americans that became a part of education and training programs. In my experience, many in-service and graduate programs in the helping professions continue to conceptualize cultural competence in this very narrow manner: acquiring racial/cultural information. Although cultural knowledge may be a necessary condition to becoming culturally competent, it is not a sufficient one.

Using the MDCC as a conceptual blueprint, however, allows us to view the issue of underutilization from a broader perspective and enables us to suggest multiple solutions. First, Dimension 3 forces us to expand our focus from the individual perspective to those at the professional, organizational, and societal levels. Second, Dimension 2 indicates that the components of cultural competence are more than just cognitive knowledge but entail an awareness of one’s own attitudes/beliefs related to race and differences as well as culturally appropriate helping skills. Thus, the MDCC suggests several factors that account for the disparity in racial/ethnic minority group underutilization of mental health services: (a) individual level—unintentional personal
bias or prejudice (attitudes/beliefs) on the part of the mental health provider (Ponterotto & Pedersen, 1993), (b) professional level—roles of helping (skills) that are antagonistic to the culturally different client (Atkinson, Thompson, & Grant, 1993), and (c) organizational level—a system of mental health care (how services are delivered) that is structured to serve the needs of only one group in the population (Cross et al., 1989). The model would suggest that a broad and systemic approach to cultural competence is required: At the individual level, it must be directed at the provider’s awareness of his or her values, biases, and assumptions about human behavior; at the professional level, it might mean changing standards of practice that allow for the practitioner to play different roles without violating ethical guidelines; at the institutional level, it might mean relocating mental health services in minority communities to increase ease of access, hiring greater numbers of bilingual and minority therapists to increase credibility, developing community outreach programs rather than the traditional in-the-office remedial approach, and offering multicultural incentives to mental health providers, staff, and administrators; and at the societal level, advocating against social policies that have a negative effect on marginalized groups in our society and for those that redress inequities.

The MDCC in Action: Multicultural Industrial/Organizational Issues

Another example of using the MDCC involves the work of an industrial/organizational psychologist in business and industry. Several years ago, I was asked by a Fortune 500 company to help with their “Asian American employee problem” by running leadership-training workshops for them. The company had recently conducted a survey and found some very disturbing results. They discovered that a majority of their Asian American employees planned to seek employment elsewhere, felt that the work environment bordered on being hostile to minority employees, believed that they were unfairly passed over for promotion when otherwise qualified, expressed anger at the low number of Asian American managers, and were resentful toward White managers/supervisors who seldom credited them with contributions to the productivity of their work teams. Because the company had a large and talented Asian American workforce, they were concerned about the future loss of “valued employees who contributed so much to the technical end of the company.” Large employee turnover meant heavy financial losses associated with recruiting and retraining new employees. It was clear that the company attributed the problem as residing within Asian American employees; they were often described as unassertive, shy, passive, and inarticulate. The company denied that they intentionally discriminated against their
minority employees and believed that leadership training was the key to the problem. They also entertained the possibility that White supervisors and managers needed training in becoming more knowledgeable and sensitive to the needs of the Asian American workforce.

Using the MDCC template to view the situation, it becomes clear that one of the goals derived from Dimension 1 must be a consideration of racial/culture-specific differences among the Asian American and Euro-American workers in the workforce. For example, research reveals major differences exist in communication styles between the two groups (D. W. Sue, 1991). Traditional Asian Americans value subtlety and indirectness in approaching problems, heavier reliance on contextual and nonverbal communications, and restraint of strong feelings. These are in marked contrast to U.S. cultural values of assertiveness; task orientation; directness; and being verbal, articulate, and forceful—qualities often associated with signs of leadership. Beliefs that Asians do not make effective leaders or managers fail to recognize that Asian countries define good leaders as people who work behind the scenes, motivating the team, building consensus, and inducing cooperative teamwork.

An organizational psychologist might approach the task by asking, “What information about Asian Americans needs to be imparted to supervisors/managers for them to move toward cultural competence at the personal level?” Conversely, “What information about Euro-American leadership criteria must be imparted to Asian American employees for them to move toward cultural competence as well?” If our purpose in the world of work, for example, is to facilitate the acquisition of cultural knowledge for White and Asian American employees and upper management, then the type of strategic intervention seems to be suggested by the model. The MDCC, however, would not allow us to stop there. For example, it would expand our analysis to two other components of cultural competence as areas of training as well: (a) self-awareness of potential biases, prejudices, and stereotypes and (b) acquisition of multicultural skills (communication or management styles).

More important, if Dimension 3 is used, it forces us to view the situation on a larger organizational level. Is it possible that the company possesses a monocultural orientation that creates systemic barriers to workers of color? This question is important in light of our earlier assertion that cultural competence is often thwarted by monocultural rules, regulations, policies, practices, and structures that are unintentionally biased. In this case, the consultant needs to seriously consider whether formal institutional policies and practices may maintain an exclusion of minorities, create culture conflicts for minority employees, lead to alienation, and result in retention and promotion problems. In addition to other factors, my assessment revealed that the company’s performance appraisal system unfairly discriminated against Asian
American employees. The criteria used by the company (seen in their job description for upper management) strongly emphasized leadership qualities as “assertive,” “visible,” “take charge,” “independent,” and “forceful.” Such descriptors, as suggested earlier, are often culture bound. Many Asian groups, for example, define leadership as the person who works effectively behind the scenes by building group consensus and cooperation. Effectiveness is measured by a team’s productivity, whereas Euro-American standards often separate individual effort from group outcome. Although many organizations may believe that their criteria are fair because they apply to everyone, they fail to realize how certain policies and practices discriminate against culturally different employees or groups in hiring, retention, and promotion (organizational level). Thus, culturally competent knowledge would need to be imparted to decision makers about Asian American values and behaviors (individual level) and how institutional policies and programs may be culturally biased (organizational level). The solution may necessitate a change in the performance appraisal system of the organization that represents intervention at a systemic level.

The usefulness of the MDCC lies in its ability to raise similar questions and issues concerning African American, Latino/Hispanic American, and Native American employees on all three dimensions. Although many similarities exist, factors unique to these racial/ethnic groups might also be revealed (Dimension 1). The underrepresentation of African Americans in upper management might be more a function of lack of mentoring programs in a company (Dimension 3), whereas for Native Americans, it may be misunderstanding reinforcement contingencies (Dimension 2) that motivate productivity (overt public praise may not work as well as private praise). Although these last few statements are gross oversimplifications, I hope they convey how the MDCC may operate in practice.

CONCLUSIONS

In summary, the MDCC model seems to possess several positive virtues. First, it allows us to identify culture-specific and culture-universal domains of competence that are either unique or common across several or all racial/ethnic groups (Dimension 1). Future research might identify the ways in which American Indians, Latinos/Hispanics, and African Americans, for example, define cultural competence similar to and different from one another. Second, the schema of this model helps organize our efforts in education and training, practice, and research. It is clear from this model, for example, that much of our focus on cultural competence falls into two main cells across racial/ethnic groups: individual focus at the components of
awareness and knowledge. We tend to neglect the cells that focus on skill development (Dimension 2) and those requiring intervention at the macro levels (Dimension 3). The model is helpful for graduate training and research because it points to neglected areas. Third, the model places the Euro-American group on an equal plane with others and conceivably begins the task of recognizing that the invisible veil of Euro-American cultural standards must be deconstructed. As long as we continue to view Euro-American standards as normative, we unwittingly set up a hierarchy among the groups. Fourth, the MDCC indicates that cultural competence for one group is not necessarily the same for another group. The implications in the mental health field for so-called empirically supported therapies (EST) based primarily on a Euro-American population (G.C.N. Hall, in press) must be cautiously interpreted with respect to minority groups. A critical analysis of EST studies reveals few if any validated on minority populations (S. Sue, 1999). To assume universality of application to all groups is to make an unwarranted inferential leap. Fifth, the model suggests that psychologists must play different roles to move toward cultural competence. Simply concentrating on the traditional clinical role ignores the importance of interventions at other levels. New helping roles like consultant, advisor, change agent, facilitator of indigenous healing systems, and so forth have been suggested as equally valuable (Atkinson et al., 1993). Unfortunately, these alternative roles are often not perceived as the domain of the helping professional, and graduate training programs lack curriculum or fieldwork toward the development of them. Sixth, the model minimizes potential misunderstandings and miscommunications likely to arise when people do not clarify the different foci of cultural competence (Dimension 3) or whether they are conceptualizing at the individual, group, or universal levels of identity (Dimension 1) in which they do research, practice, or training. Seventh, although the model emphasizes racial/ethnic minority groups, it is potentially useful in the study of other marginalized groups as well. For example, gender, sexual orientation, and ability/disability may be substituted for a racial/cultural minority group dimension.

Finally, but more important, the path to cultural competence requires a broad and integrated approach. Because psychology concentrates primarily on the individual, it has been deficient in developing more systemic and large-scale change strategies. Although the focus on the individual is important, there are inherent limitations. Oftentimes, psychologists treat individuals who are the victims of failed systemic processes (cultural conditioning and biased education). Intervention at the individual level is primarily remedial when a strong need exists for preventive measures. Furthermore, the road to cultural competence must recognize the interrelationship and interaction of the multiple dimensions described in this article. Concentrating our efforts at the individual level and neglecting the organizational one, for example, is
not to understand the concept of system interdependence. In family systems theory, it is often stated that treating the “identified patient” without intervening in the family system may prove to be futile. The assumption is that the problems or pathology observed in one member of the family are not necessarily due to internal conflicts but to unhealthy values and pressures of family life (D. Sue, Sue, & Sue, 2000). Treating a child in individual sessions, for example, may appear to eradicate the symptoms as long as the child remains outside of the family. Once the child reenters the family, however, he or she may again be forced to play the “sick” role because the subsystems and rules of the family remain unchanged. Such a mistake can also occur when we perceive the mental health provider, manager, teacher, or trainee as needing to develop cultural competence and lose sight that he or she functions within an organizational and societal context. In closing, the development of cultural competence will only be successful if we take a systemic and holistic approach to infusing cultural competence throughout. The MDCC model provides such a conceptual framework to aid us on the road to cultural competence.

REFERENCES


Sue's contribution concerning cultural competence is reviewed and critiqued. General issues provoked by Sue and found in the emergent discourse on the topic are discussed, including concerns about its operationalization, its purpose, its parameters, issues pertaining to training, and considerations for evaluation. Specific issues related to Sue’s model are highlighted with suggestions for improvement and clarification. The specific issues critiqued include the following strengths: continued leadership in the field, inclusion of social justice, multidimensionality of cultural competence, and the tripartite conception of personal identity. Issues of concern include the lack of a solid rationale for the model, definitional difficulties, the lack of prescription, and limitations based on the race-based group perspective. Suggestions for future scholarship are offered.

APA [American Psychological Association] has a moral and ethical obligation to take the lead in seeing that multicultural competence becomes a defining feature of the profession and that we produce psychologists with the awareness, knowledge, and skills to function in a pluralistic society.

—Sue, Bingham, Porché-Burke, & Vasquez (1999, p. 1068)

Sue and his colleagues (1999) made the preceding statement in a summary of progress made at the National Multicultural Conference and Summit held in January 1999. Since then, the cultural competence of mental health practitioners has continued to receive considerable attention. Counseling psychology stands at the forefront of the conversation. We believe that the attention is justifiable. In our opinion, the need for cultural competence is one of the most important considerations facing applied psychology.

In his major contribution, Sue (2001 [this issue]) continued as the leading voice on this topic. We are pleased to join the conversation and react to his substantial effort. We feel it is our responsibility to hold Sue to his own high bar of expectation for counseling psychology and for the APA. In reference to their above declaration, we asked ourselves, How well can Sue’s model of cultural competence help to “produce psychologists with the awareness,
knowledge, and skills to function in a pluralistic society” (Sue et al., 1999, p. 1068)? Our reaction is organized into two major sections: (a) general issues provoked by Sue’s contribution and (b) specific issues pertaining to Sue’s model.

GENERAL ISSUES PROVOKED BY SUE’S CONTRIBUTION

Cultural competence has been given considerable attention in the discipline’s leading journals and textbooks for the past two decades. Despite the many publications, conference presentations, and symposia, the profession struggles to advance the conversation regarding cultural competence beyond its current position. Most professionals, for instance, cannot verify that their clinical practices actually demonstrate cultural competence. A significant reason for the troubling inertia, we believe, is the well-meaning but often-times misdirected inquiry of scholars and researchers in this area. There have been lofty attempts to devise instruments that measure cultural competence, create models that reflect its most salient features, and infuse training programs with the basic tenets of this construct.

What remains elusive is a collectively agreed on operationalization that comprehensively and accurately captures the quintessence of the construct cultural competence. Sue (2001) prompts us to revisit this issue. Until a solid definition is elucidated in the literature, researchers and clinicians alike will continue to find their conversations steeped in misunderstanding, confusion, and cross-purpose. Conversely, once there is such an operationalization, meaningful discourse regarding its basic tenets and most salient components can progress and purposeful models and instruments that capture these will be more relevant and forthcoming.

Some questions linger in pursuit of such a definition. What is cultural competence? Does it entail only culture, race, and ethnicity, or is it more encompassing? Is it desirable for clinicians, clients, and/or laypersons? Does it vary depending on to whom we are referring? For example, does achieving cultural competence signify different goals for teachers in the classroom, clinicians in the office, and citizens in their neighborhoods? Is the consideration of cultural competence for organizations the same as it is for individuals? Is there a distinction between competence and competencies? Is there a distinction between cultural competence and multicultural counseling competence?

Researchers in psychology and other disciplines have grappled with the problem of operationalizing the construct of competence. For example, Wood and Power (1987) challenged definitions that reduce competence to the acquisition of skills and knowledge. They argued that competence rests
on “an integrated deep structure (‘understanding’) and on the general ability to coordinate appropriate internal cognitive, affective and other resources necessary for successful adaptation” (p. 414). In the literature, little attention has been given to the integration and coordination of the most salient features of multicultural counseling competence. Constantine and Ladany (2000) echoed this concern: “In the future, counselors and counseling psychologists may wish to consider whether the current definition of multicultural counseling competence sufficiently captures its presumed meaning” (p. 162). We suggest that the aggregate of skills, attitudes/beliefs, and knowledge without purposeful integration and coordination—although pivotal in instigating the initial discussion—may not achieve this objective.

A natural progression from the operationalization of cultural competence is an examination and clarification of its purpose. Sue’s (2001) contribution tacitly provokes us to consider two purposes of the construct—general and specific. In its general use, the construct is construed as a way of relating to or interacting with others cross-culturally. Apparently, the purpose is to build effective relationships, which is achieved in part by overcoming the cultural differences of the individuals involved in the relationship. An executive of a multinational corporation headquartered in the United States needs this type of competence when conducting business abroad. In its specific use, the construct is understood as a means of enhancing therapy. In addition, although retaining the goal of relating effectively across cultures, there is another purpose: therapeutic gain. A White psychologist treating a depressed client from Southeast Asia needs this type of competence. Sue intimates both purposes of cultural competence. Unfortunately, he neither acknowledges that these purposes are different nor states which purpose should be given priority. We propose that therapeutic gain—the purposeful, positive change elicited by the therapeutic process—is the superordinate purpose of cultural competence. Therefore, all parameters of the construct should revolve around this purpose. We also contend that this purpose is integral to the operationalization of cultural competence. In our opinion, the failure to clarify the purpose of cultural competence and integrate it explicitly into its definition are major roadblocks to advancement of the conversation.

Once cultural competence is operationalized and the purpose clarified, an explication of the parameters of the construct must follow. It is not sufficient to define cultural competence. The desired outcomes and steps needed to achieve this purpose must be set forth. Consider the specific application of systematic desensitization, the objective of which is to eliminate phobia. Merely knowing the definition of the concept does not provide clinicians with sufficient information to perform competently. The steps clinicians must take include progressive relaxation, establishing an anxiety hierarchy, interposition, and in vivo desensitization. Models that attempt to capture the
most salient features of cultural competence tend to beg the questions, What are the desired outcomes, and How can they be achieved?

An additional concern evoked by the current discussion pertains to the evaluation of cultural competence. How do we currently evaluate cultural competence, and is the current methodology adequate? Several measures have been developed to capture clinicians’ abilities to function competently with diverse clients. The most widely used instruments are based on the early works published by Sue and his colleagues (1982; Sue, Arrendondo, & McDavis, 1992) that emphasize the tripartite model of awareness/beliefs, skills, and knowledge. Because the majority of these instruments rely on self-report methods, an inherent social desirability confound is introduced. In fact, this has been demonstrated in the literature and is part of the conundrum (Constantine & Ladany, 2000; Ladany, Inman, Constantine, & Hofheinz, 1997; Pope-Davis & Dings, 1994). Obviously, a solution would benefit the field.

SPECIFIC ISSUES PERTAINING TO SUE’S MODEL

Strengths of Sue’s Model

1. Continued leadership in the field. The advances in Sue’s model indicate he continues to be the leading authority on multicultural competence. He builds on the legacy of landmark publications (Sue et al., 1982, 1992) and ensuing works (Sue et al., 1998, 1999; Sue & Sue, 1999) that he and his colleagues authored. The field of counseling psychology has appropriately acknowledged Sue’s contributions for their resounding impact; multicultural counseling competence is now considered essential for best practices.

   At this crucial juncture in the discourse, we believe Sue’s earned respect as one of the foremost scholars on this topic encompasses the continued ability to influence as well as the responsibility to advance the dialogue. This entails facilitating the conversation, improving and revising existing models, and incorporating the works of other acknowledged multicultural scholars. Only by advancing the discussion will the most salient aspects of this topic be fully realized and integrated into the scholarship on multicultural counseling competence.

2. Inclusion of social justice. Sue’s (2001) interpretation of cultural competence includes the issue of social justice. We applaud this interpretation because it reminds us that psychology can and should advance the public interest. As Misra and Varma (1994) indicated,
Under the impact of the natural science paradigm, psychologists have maintained a value neutral posture and have remained preoccupied with the analysis of variables and their interrelationships in a decontextualized manner. Consequently, socio-historical and cultural factors that shape social reality have largely been ignored. (p. 97)

Because of this effort to rigidly emulate the natural sciences, psychology has largely failed to look “outside of the box” and realize its potential for, and relevance to, achieving social justice in our society.

Sue (2001) noted that a statement about social justice might sound too political or unrelated to mental health. Certainly, “any attempt to advance the public interest is inherently political” (Smith, 1990, p. 530). The point is that politics and psychology are not mutually exclusive, and treating them as such thwarts societal progress. In addition, several psychologists have argued that social justice, and specific instances of social injustice, is intricately related to mental health (e.g., Martin-Baro, 1994; Thompson & Neville, 1999).

Although we support the inclusion of social justice in the conceptualization of cultural competence, it would have been beneficial for Sue (2001) to provide a clear definition of social justice and an explanation of how to work toward it on a professional basis. He does list three examples of social justice in the mental health delivery system: (a) providing equal access and opportunity, (b) being inclusive, and (c) removing barriers to fair mental health services. But how do these examples translate to specific actions individuals can execute within their work environments? Clinicians may not know how to navigate the organizational system in which they work or be in an optimal position to do so. Clear suggestions are needed about how to infuse social justice interventions with other psychological activities. Examples include making facilities handicapped accessible, offering a sliding fee scale, providing transportation vouchers, and employing bilingual clinicians.

2. Multidimensionality of the construct. Most psychological constructs are complex, consisting of a variety of dimensions or factors. One of the goals of science and scholarship is to deconstruct or simplify complexity without oversimplification. This process enables the scientist-practitioner to put science and theory into practice more effectively. The familiar activity of driving illustrates this point. Driving involves negotiating traffic signals and road signs, manipulating control instruments, monitoring weather and road conditions, maintaining alertness, yielding to pedestrians, and so forth. No one could adequately understand or learn to drive without referencing these competencies and microskills. Sue (2001) is helpful in describing three primary dimensions of cultural competence: (a) specific racial/cultural group
perspectives, (b) components of cultural competence, and (c) foci of cultural competence. He further describes specific aspects of each dimension. Although we would conceptualize the primary dimensions of cultural competence differently, Sue moves the profession in a positive direction. The movement is in concert with the scientist-practitioner model because it reflects purposeful simplification instead of oversimplification. We believe that oversimplification of important constructs has been a serious problem in multicultural scholarship.

3. Tripartite conception of personal identity. Sue (2001) asserts that attending to the inclusivity/exclusivity debate is necessary in defining cultural competence. This debate hinges on whether cultural competence should be limited to consideration of only race or should be more encompassing to include other social identities. We agree with Sue. Multicultural scholars who attempt to define cultural competence must take a balanced approach by considering both sides of the debate. However, we also believe they must resolve the issues underlying the arguments. Without examining the philosophical underpinnings polarizing the conversation, the debate is irresolvable, and a widely agreed on definition of cultural competence is impossible.

We appreciate Sue’s (2001) shedding additional light on the debate. Drawing on the original work of cultural anthropologists Kluckhohn and Murray (1948), Sue’s tripartite framework is useful in conceptualizing personal identity. The framework is indeed holistic and has the potential for enabling practitioners to integrate all three levels of personal identity—individual, group, and universal—in assessment and case conceptualization. Avoiding the extremes of either inclusive or exclusive multiculturalism, Sue lays the groundwork for a more acceptable definition of cultural competence. We applaud this effort, although we believe more guidance is needed in how to integrate the three levels of identity. For example, we ask, What practical steps can clinicians take to integrate the various levels of identity in their assessments, and what assessment instruments are available to achieve this end? Perhaps, there is a need for new assessment protocols.

Issues of Concern

1. Lack of a solid rationale for the model. In his introduction section, Sue (2001) lamented, “What is sorely lacking is a conceptual framework that would organize these dimensions into a meaningful whole” (p. 791). Although other models may fall short of sufficiently capturing the dimensions of cultural competence, in fact, several have been proposed and discussed in
the literature (see Ponterotto, Fuertes, & Chen, 2000, for a review). Despite
the acknowledged merits of Sue’s new model, it is disconcerting that he
neglected to give credit to those models already developed. A cogent review
and critique of the strengths and limitations of extant models are necessary to
lay the foundation for the establishment of a new model. Otherwise, we have
no basis for determining why his model is needed or how it is an improvement
over existing models.

2. Definitional difficulties. Sue (2001) is to be credited for defining cul-
tural competence—an achievement conspicuously absent from the writings
of many multicultural theorists. Unfortunately, there are several problems
that need to be addressed. First, he creates confusion by equating the phrases
cultural competence and multicultural counseling competence. He defined
cultural competence in behavioral terms (e.g., “the ability to engage in
actions or create conditions”), emphasizing what the counselor does. How-
ever, he subsequently defined multicultural counseling competence more
complexly (e.g., “the acquisition of awareness, knowledge, and skills”),
emphasizing the multivariate nature of the construct. In addition, this com-
plex definition is developmental (e.g., “the acquisition”), emphasizing what
the counselor is to become. This definition also includes a behavioral compo-
nent (e.g., “skills”), which seems important to us. By implication, the behav-
ioral component predicates the developmental emphasis, suggesting that
what the counselor does in practice is a result of what the counselor has
become through training. This assumption is reasonable. However, acquisi-
tion is the process of becoming competent but not competence itself. The dis-
cussion leads us to ask several questions: Are cultural competence and
multicultural counseling competence identical or different constructs? If
they are identical, is it a univariate or multivariate construct? If they are dif-
ferent, in what ways is each unique? Answers to these questions require more
concrete operationalization.

Second, Sue’s (2001) definition of multicultural counseling competence
is circular. Rules of logic and discourse dictate that a word cannot be used to
define itself. A definition is a formal statement of the meaning and signifi-
cance of a word. Although Sue does not directly use the word competence in
his definition, he uses phrases that are nearly synonymous (e.g., “function
effectively” and “advocating effectively”). These phrases are not meaning-
fully different from the phrases function competently and function effectively,
which the author could use just as easily. The inclusion of the word effectively
is a subtle but critical substitute for the word competently. Readers are posed
with the problem of attempting to gain added meaning and significance from
its use. The discussion leads us to ask a couple of questions: What does it
really mean to function effectively in a pluralistic democratic society? And What does it really mean to advocate effectively? Answers to these questions require further elaboration.

3. *Descriptive but not prescriptive.* Sue’s (2001) model is descriptive but not prescriptive. It is descriptive because it depicts a sorely needed, broad representation of cultural competence in psychology. However, although the model portrays several dimensions of cultural competence, it really does not illustrate how these dimensions interact or operate as an aggregate construct. Hence, it is difficult to extract from it clear guidelines about how to execute the model to reflect cultural competence in everyday professional life.

The model needs to be prescriptive as well as descriptive for it to be actualized in the profession. One way to make the model more prescriptive would be to provide case examples. These could delineate how the various dimensions of the model interact and how mental health professionals can use the model to facilitate, for example, therapeutic gain on an individual level, systemic effectiveness on an organizational level, or social justice on a societal level. We question whether mental health professionals, after reading Sue’s (2001) article, would know what to do differently within specific instances of their work to be more culturally competent.

4. *Limitation of a race-based group perspective.* We respect Sue’s (2001) decision to focus his model on a race-based group perspective. It is understandable to want to highlight a group identity that has historically been neglected in psychology. However, there are also limitations to this choice. First, the historical neglect of group identity is not itself an adequate rationale for an exclusively race-based model of cultural competence. Sue even stated that “a discipline that hopes to understand the human condition cannot neglect any level of our identity” (p. 795). The rationale for development of a model in any discipline should be based on the consideration of all the relevant variables—not simply those that have been historically neglected. Second, people do not always fit neatly into one of the five race-based groups in Sue’s model. This is problematic because it is unclear how the model should be utilized when the individual, organization, or society of interest spans more than one of the five race-based groups. In a paradoxical kind of way, Sue’s attempt to be inclusive is subtly exclusive, especially of individuals who are biracial or bicultural.

Another limitation is that Sue (2001) assumed that race is the most salient dimension of identity for every individual, organization, or society. Although he has not stated this as a formal position, his model of cultural competence entails a de facto minimization of other social identities. According to the
idiographic perspective (Ridley, 1995; Ridley, Hill, Thompson, & Ormerod, 2001), each individual is a blend of many social identities that are important to consider in assessment and treatment. It follows that organizations and societies also are dynamic blends of multiple social identities. Social identities other than race may be more salient in the psychological presentation of a particular individual, organization, or society. For example, sexual orientation, gender, age, socioeconomic status, or religious affiliation may be more salient in some cases. Does this mean that cultural competence is not relevant to these cases? We do not think so. We believe that cultural competence is relevant to every professional endeavor, whether or not the individual, organization, or society of interest experiences race as its most salient social identity. Therefore, cultural competence must address more than race. It must address multiple social identities and their unique intersection for each individual, organization, and society. Admittedly, Sue did suggest that other “marginalized groups” may be substituted for the race-based group dimension. However, suggesting a substitution instead of an expansion implies that only one dimension needs to be considered in each professional encounter. This is still problematic, and we suggest that multiple social identities always should be considered.

CONCLUSION

Cultural competence has become one of the most important topics in applied psychology. Sue’s works have contributed significantly to this discourse, stimulating professionals to critically consider how race, ethnicity, and culture are integrated in their professional activities. We reviewed and critiqued his most recent contribution with the intent of participating in the advancement of this dialogue.

Although many scholars and researchers have strived to move the discussion forward, certain areas of deficit persist. We agree with Constantine and Ladany (2000) that the current definition of multicultural counseling competence as the aggregate of awareness/beliefs, knowledge, and skills may not fully capture the construct. We call for prompt revision so that more fruitful research and better multicultural training can ensue. In addition, we echo the need for comprehensive models to “address the ‘how to’ component of counseling, providing an explication of how therapy is conducted, the role of the clients and counselors, and the mechanisms for client change and growth” (Ponterotto et al., 2000, p. 640). It is injudicious to continue the discourse without first clarifying and gaining consensus on the very foundation on
which this conversation has been built. We encourage our colleagues to join in this endeavor.

REFERENCES


Multidimensional Cultural Competence: 
Providing Tools for Transforming Psychology

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This comment on the major contribution addresses the conceptual richness and strength of the model; offers some possible extensions to enhance its application to counseling psychology; and discusses its implications for practice, training, and research. Academic programs can use the multiple dimensions of cultural competence (MDCC) model to assess their curriculum and policies and design new approaches to infusing multiculturalism. The conceptual framework of the MDCC also can be used to customize counseling services to better meet the needs of a diverse client base. Future implications for use of this model as a transformative tool for counseling psychology are also explored.

The field of multicultural counseling has continually evolved in its focus and approach to addressing multicultural issues. According to Reynolds and Constantine (2001), “Multicultural counseling competence has become a cornerstone of the multicultural counseling literature.” The writings of multicultural counseling competence have focused primarily on three areas: (a) theoretical and conceptual (e.g., Pedersen, 1988; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982, 1998), (b) empirical studies (e.g., Ladany, Brittan-Powell, & Pannu, 1997; Pope-Davis, Reynolds, & Dings, 1994), and (c) assessment (e.g., Ponterotto, Rieger, Barrett, & Sparks, 1994; Pope-Davis & Dings, 1995). In his major contribution, Sue (2001 [this issue]) has done an exceptional job of conceptually enhancing and deepening an already extensive literature base by offering a rich yet parsimonious model—the multiple dimensions of cultural competence (MDCC). The MDCC effectively integrates his prior writings on multicultural counseling and competence and multicultural organization development and offers a conceptual tool that can be used to enhance multicultural assessment, organization development, and training. It is important to note that at every pivotal step of the process of introducing, defining, clarifying, and applying our understanding of multicultural counseling competence, Derald Wing Sue has been a leader, offering his expertise and insight and thus strengthening the field and the profession (cf. Sue et al., 1982, 1992, 1998). In reacting to his article, I would like to (a) address its strengths; (b) offer some extensions and additions to enhance its
conceptual capabilities and application potential; and (c) discuss its implications for practice, training, and research in counseling psychology.

STRENGTHS

The virtues of the MDCC offered by Sue (2001) are both in the richness of its underlying beliefs and philosophy and in the heuristic value of the conceptual model itself. Sue has proposed a dynamic, complex, yet very accessible framework for deepening our understanding of multicultural competence and creating more options for intervention. As always, Sue builds a strong case for multicultural issues with a positive and powerful perspective, embracing the centrality of race without diminishing the significance of other social identities. His strong critique of the field of multicultural counseling offers challenges and opportunities to the many psychologists committed to making multiculturalism one of the cornerstones of counseling psychology.

Although Sue and others have attempted to offer multicultural counseling theories or philosophies (Speight, Myers, Cox, & Highen, 1991; Sue, Ivey, & Pedersen, 1996), the field of multicultural counseling continues to lack a unifying conceptual framework. The MDCC is an attempt to create solidarity in the philosophy and action needed to transform psychology into a profession that fully embraces multiculturalism at its roots. In reviewing this model, there are two key conceptual strengths that build the foundation for MDCC: (a) emphasis on the multidimensionality of identity and (b) attention to social justice and advocacy issues.

Sue (2001) emphasized the importance of multidimensional identities; all individuals belong to more than one cultural group (e.g., race, gender, class, sexual orientation). Although some group identities may be more prominent than others, all individuals are profoundly shaped by these social identities regardless of whether they are a member of a dominant group (e.g., White or male) or encounter prejudice or oppression (e.g., people of color and/or lesbians, gays, or bisexuals). Recognizing the multidimensionality of identity is central to multicultural competence. Understanding the true complexity of most individuals’ identities is a prerequisite to more fully appreciating their daily experiences and challenges (Reynolds & Pope, 1991). Sue also highlighted the three levels of personal identity (individual, group, and universal) as central to effective counseling research and practice. All individuals are influenced by their individual experiences, their reference groups, and their universal or human realities.

Beyond the obvious importance of this type of complex thinking in working with others, such complicated reasoning offers evidence of an even more crucial multicultural competence that Sue (2001) implied but did not address
directly. Without the ability to use diunital (union of opposites or both/and thinking) reasoning, we are destined to conceptualize individuals as well as the field of multicultural counseling in dichotomous or either/or thinking (Speight et al., 1991). For example, it can be difficult to decide whether multicultural counseling is a specialty or a core competency. It can be, and should be, both. We must move beyond the reductionistic thinking that allows us to effectively perform other aspects of our jobs as therapists or researchers such as diagnosis or statistical analysis. A worldview based in diunital reasoning means we are able to see multiple realities and true complexity (Myers, 1988). Without the ability to see what is and is not present in a client’s story, a psychological theory, or the profession’s values (all at the same time), we lack the ability to deconstruct reality. Minnich (1990) has written about the need to decontextualize our assumptions about the world to discover the underlying values present in our perceptions and actions. This critical skill is necessary for multicultural counseling to make progress in its effort to transform psychology. This is one of the unspoken assumptions of the MDCC and also needs to become a major tenet of multicultural counseling.

The second strength of Sue’s (2001) model is its focus on social justice and advocacy. For years, many within the multicultural counseling movement have argued for a sociopolitical analysis that includes changing the helping philosophies and foundations of counseling (Katz, 1985; Locke & Faubert, 1999). The inability of psychology to address the many ways that oppression has been institutionalized into its theories and practices inhibits any efforts to transform the profession so that all individuals find it relevant and meaningful. Sue argued that it is not enough to simply change our counseling skills to make us better able to meet the needs of individual clients who may be culturally diverse from us. He emphasized the need to develop skills so we can intervene effectively, sometimes on a client’s behalf, in a pluralistic society that includes advocating within the profession to develop new and more inclusive theories, practices, and organizational systems. This is a profoundly important shift in the definition of multicultural competence that holds great promise in providing new ways of thinking about and achieving multicultural transformation. Sue issued an important warning when stating that unless these core definitions begin to change, it may be impossible to change psychology.

Although the MDCC does not explain how one changes psychology to be more pluralistic and inclusive at its roots, it provides the conceptual tools to broadly rethink our approach to multicultural counseling. His three primary dimensions of multicultural competence incorporate much of the important work within the multicultural counseling field during the past three decades. The first dimension, specific racial/cultural group perspectives, emphasizes the importance of cultural group knowledge that is necessary to fully under-
stand clients and other professionals who may be culturally different from us. Research about various racial/ethnic groups has been enriching the field of psychology for decades, and such knowledge is essential to achieving multicultural competence. Knowledge of the different racial/ethnic groups allows us to rethink key issues such as dual relationships rather than continue to nonreflectively engage the underlying assumptions and values of psychology. The second dimension, components of cultural competence, is rooted in one of the most commonly explored areas within the multicultural literature. Sue (2001) emphasized the tripartite model of multicultural awareness, knowledge, and skills first introduced by Sue et al. (1982). Many assessment instruments and training models use this tripartite perspective as a basis for their work. Finally, the third dimension, the foci of cultural competence, borrows most heavily from the more recent addition to the multicultural counseling literature—multicultural organization development (Sue, 1995). By expanding the use of cultural competence beyond the individual, Sue practiced what he preached—altering the foundational definitions and assumptions about the field.

EXTENSIONS AND ADDITIONS

Although the MDCC has considerable potential as a transformative model for multicultural counseling, some areas need further development. I have identified three key concerns that I believe warrant further attention. As is often the case, that which is a strength may create challenges as well. An example of this complexity is the model’s emphasis on multidimensionality of identity. Although the MDCC focuses specifically on race as a defining variable that influences how people make meaning and view the world, Sue (2001) highlighted the importance of acknowledging and honoring other group identities that are part of an individual’s personal identity. Yet, there is very little advice offered to assist the professional in achieving this important dual task of centralizing race while considering other important social identity influences. More attention needs to be focused on fully accepting the simultaneous nature of individual, universal, and cultural influences and making assumptions and decisions that embrace that complexity.

A second area that needs more attention and study is the MDCC model itself. Although the counseling field has historically utilized cube models, they are, at times, unwieldy and overwhelming to some professionals. Their gift, the breadth and depth of their conceptualization, often makes it challenging to apply them in concrete and pragmatic ways. Sue (2001) offered two excellent case examples that provide reasonable solutions and approaches for real problems. However, more is needed. It may be that a case-
book that extends and expands the illustrations offered by Sue is needed so that Sue and others can suggest a range of solutions that exist for the many challenges facing multicultural counseling. What are the unique issues that exist for each of the racial groups, and how can the model be used to address them? What are concrete interventions that can be used on the individual, professional, organizational, and societal levels? Such case studies could probably be gathered from actual training programs, professional associations, and direct service agencies and centers. Ideally, these cases could be developed in the context of a conference where the goal was to systematically and systematically address each of the barriers that Sue so effectively elucidated. This is where the cutting-edge strategies and tools of multicultural organization development can be applied to psychology and used to transform the core structures and practices of the profession.

The third and maybe the most crucial issue to be addressed is how to move from a vision and goal of transforming psychology to creating a unified and strategic plan that seriously begins to address the core philosophical issues that create barriers to infusing multiculturalism into psychology at every level. Sue (2001) articulated that addressing social justice issues is central to this transformation. Psychologists who address social policy issues have been arguing this point for years; what we do in our individual offices is not enough if it does not alter the social conditions that lead to sexual abuse, addiction, or depression. Sue stated, “Multicultural counseling competence must be about social justice—providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to fair mental health services” (p. 801). By identifying and describing the various barriers that exist, Sue provided opportunities for interventions. The next step is even more challenging and involves the creation of a strategic plan that must be broad based and inclusive. Multicultural psychologists, those of us whose life work is invested in these issues, cannot put forth these solutions on our own. We must work in coalitions with those in psychology who might not agree with our views, who at times might work against us. This means building working coalitions within academic programs, professional associations, and the workplace. Bernice Johnson Reagon (1983), in writing about coalition building among feminist women, believed that it is in our best interest to build alliances with those who are different from us. In fact, she, and others such as Audre Lorde (1984), firmly believed that our survival is dependent on our ability to build connections and coalitions with others. Reagon made a distinction between doing coalition work and coming home. Coalition work is about having challenging conversations and difficult dialogues that always have the potential to create something new and exciting. It is not meant to be easy. According to Reagon, if it feels comfortable, it is not true coalition work. Coming home is going to multicultural conferences and workshops,
surrounding ourselves with people who view the world like us. We all need to do that on a regular basis so that we have the energy to do the really challenging work of building coalitions. Maybe, “the process of talking about and working through differences is what can lead to individual and group transformation” (Reynolds & Constantine, 2001, p. 15). Of course, talking is not enough. To be effective, we need a strategic plan to address these issues, especially in the areas of practice and training within counseling psychology.

**IMPLICATIONS FOR PRACTICE AND TRAINING**

There are important implications of Sue’s (2001) MDCC model for counseling psychology practice and training. This model must move from a conceptualization of the problems and potential solutions to a practical application of how to use the model in academic programs and practice sites across the country. With limited training in multicultural issues, organization development perspectives, and other related literature, many faculty members, therapists, and supervisors may have a difficult time implementing segments of the MDCC. Ongoing efforts toward professional development and reeducation of senior professionals in the area of multicultural competence are a necessary and ongoing aspect of this process. Assessing and redesigning counseling psychology training programs to more systematically address multicultural issues are vital to the future of multicultural counseling.

Modifying academic programs is one of the most important aspects of a plan to transform psychology (Reynolds, 1995, 1997). Because the MDCC provides a conceptual rationale of the multicultural counseling competency movement, it is an ideal tool for counseling psychology programs to use for assessment of their multicultural change efforts. It is, as Sue (2001) articulated, “a conceptual blueprint” (p. 812) that training programs will need to individualize and apply to the particular needs of their faculty, students, and curriculum. Creating a working group of students and faculty to study and apply the MDCC to their program would be an ideal place for training programs to begin. These groups could systematically address the various aspects of the cube model and use that information to create specific strategies. For example, programs could identify how to infuse cultural knowledge about various people of color groups throughout the curriculum. In ethics and professional socialization courses, programs could read multicultural and social policy literature and discuss psychologists’ role as advocates. Full analysis of the barriers to cultural competence at the individual, professional, organizational, and societal levels could occur in a variety of professional training courses, including practicum courses where students could be asked
to assess their practicum sites. The curriculum opportunities are endless. A group of concerned and committed students and faculty who can identify strategies and gather broad-based support for their implementation is needed.

Central to such efforts is making sure that the racial makeup of students and faculty is diverse, and if such diversity does not exist, then a strategic plan must be created to accomplish this goal. There are many successful counseling and counseling psychology programs that have developed successful approaches to increase the diversity of their student bodies and the multicultural nature of their curricula (Rogers, Hoffman, & Wade, 1998). In addition, there are important frameworks that address how to create systemic organizational change that allows academic programs to more fully integrate multicultural values and practices (Ponterotto, Alexander, & Grieger, 1995; Sue et al., 1998).

Similar strategies can be developed within counseling to apply the conceptual knowledge and tools of the MDCC to diverse professional settings to ensure that the services they offer meet the criteria put forth by Sue (2001) for multicultural counseling competence. Counselors can use the model to assess their own awareness, knowledge, and skills working with different people of color groups as well as to assess the extent to which their counseling center, hospital, or agency has incorporated any of the important multicultural organization policies or practices articulated as part of the MDCC and elsewhere (Sue, 1995; Sue et al., 1998). By using a conceptual framework such as the MDCC, clinicians and supervisors have a greater likelihood of designing their services to meet the needs of a diverse client population. Various clinical agencies can examine their client base and attempt to assess why certain populations do not access their services. Sue (2001) offered an empowering perspective in his suggestion that we ask clients from various racial and ethnic groups how they define cultural competence. We need to be asking clients, those we serve as well as those we do not, what would make counseling relevant and meaningful to them.

Finally, we need to use research to further study the MDCC and assess its validity and heuristic value. Without such research, we cannot know if the model works or is meaningful to those it is meant to help. Identifying concrete research questions that use both quantitative and qualitative paradigms with clients, counselors, and faculty is a necessary next step to transforming psychology. To be successful, we must have faith in the tools and models that we are using.

As Sue (2001) stated, “The path to cultural competence requires a broad and integrated approach” (p. 816). Counseling psychology must continue its leadership efforts to influence the profession to more effectively infuse multicultural values, knowledge, and practices into all aspects of psychology. Providing new models like the MDCC is a powerful and important strategy
for transforming psychology. However, we must remember that often models are not enough; it is essential that we demonstrate how to apply these important conceptual ideas in pragmatic and meaningful ways. And even more important, we must remember that our multicultural change efforts must be systematic, systemic, and persistent. Transformation does not occur overnight, and we must actively engage in the process each step of the way. Although the challenges are great, luckily the rewards are even greater.

REFERENCES


The Facets of Cultural Competence:
Searching Outside the Box

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Sue’s proposed model is based on a critique of the Eurocentric assumptions underlying current clinical practice and reflects his innovative thinking and unique synthesis of past research. The specific areas addressed in this article focus on an examination of the multidimensional model of cultural competence (MDCC) and issues related to the definition of competence and its measurement. Areas of needed elaboration in the model include complexities related to power hierarchies (i.e., authority, authorization, and leadership) and implications for training and practice. Particular emphasis is placed on the complexities of cultural competence and the important contributions of Sue’s MDCC as an important step in making cultural competence a reality in the practice of counseling psychology.

We are honored to write this reaction to Derald Sue’s (2001 [this issue]) eloquent treatise on the multiple facets of cultural competence. Sue is uniquely qualified to challenge our traditional thinking in the multicultural area given his long-standing expertise and commitment to the field of counseling psychology. Based on his writing, Sue advocated a critical reexamination of the existing assumptions that for decades have formed the foundation of psychology. This includes “belief in the universality of psychological laws and theories, the invisibility of monocultural policies and practices, differences over defining cultural competence, and the lack of a conceptual framework for organizing its multifaceted dimensions” (p. 790). His arguments call for the linking of issues of social justice and sociopolitical concerns along with individual and organizational levels of competence and awareness. Our reaction focuses on the nature of his multidimensional model of cultural competence (MDCC) and the complexities with respect to the “cube,” the definition, and the measures of cultural competence. The comments represent additional challenges in the area in terms of the further integration of power hierarchies as well as an elaboration on implications for training and clinical practice. The multiple complexities of cultural competence must be integrated into any model for it to reflect the realities faced by clinicians.

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EXAMINATION OF THE MODEL

Our comments regarding the MDCC focus on the discrepancies that exist between the multifaceted figure and the cultural complexities discussed in Sue’s (2001) narrative. Although we recognize that any visual representation will be oversimplified in comparison to the explanatory detail contained in a verbal narrative, nonetheless the figure does not adequately reflect Sue’s arguments. In addition, there exists a great need for further elaboration of the model in light of measures and operationalizing definitions.

The cube. The cube itself is reminiscent of Guilford’s (1967) Structure of Intellect Model highlighting the 120 facets of human ability. Guilford’s theoretical work had a major impact on the field. Although his model was comprehensive in nature and a useful heuristic for research, it proved to be clinically unwieldy. Despite clinical efforts to make use of his model, it appeared to be too detailed for actual practice.

In a different vein, the MDCC appears overgeneralized, especially as it pertains to Dimension 1, race and culture (i.e., African American, Asian American, Latino American, Native American, and European American). The usage of such general categories fails to acknowledge an often overlooked but consistent finding in the literature, that is, within-group differences exceed between-group differences. For example, to assume that all Native Americans or all European Americans can be grouped together implies some agreement that the primary group identity is salient. This should not be assumed given Sue’s earlier challenge regarding monocultural practice. Perhaps we could be committing a similar error at a “subuniversal” level by assuming that all members of a racial cultural group operate in a similar context with similar values and beliefs. Given our experience working and teaching in a large urban city, we are continually confronted by the diversity that exists within each of these categories.

As Sue (2001) noted, our focus on group categorizations is in part due to the overemphasis placed on the generalizability of results, large *ns* (i.e., statistical power), and the scientific method. This view is supported by Ingleby (1995), who wrote,

Standard psychological procedures provide us with a microscope, as it were, down which we gaze at the inhabitants of other cultures. The fact that what we see looks remarkably like ourselves—if somewhat less well-developed—
reassures us that the methods are indeed applicable to other cultures: but what we see is in fact, a construction of our own ethnocentric data-gathering procedures—and what we do not see, we never worry about. (p. 120)

Thus, there are major difficulties in attempting to conduct research free of our inherent biases. One notable psychologist put it as follows:

The ideas of a context-free environment, a meaning-free stimulus event, and a fixed meaning are probably best kept where they belong, along with placeless space, endless time, and squared circles on that famous and fabulous list of impossible notions. For when it comes to the investigation and examination of psychological functioning, there probably is no way to get rid of all the other stuff even in the lab. (Shweder, 1990, p. 49)

Thus, we are left with research findings that must be balanced to approximate the true reality of the race and cultural phenomena we are attempting to study. We cannot allow ourselves to be pulled into using convenient group labels. Instead, we must retain in the background the complex contextual factors (i.e., facets) that make up the reality of the diverse clientele we are attempting to serve. As Sue (2001) indicated in his text, cultural group identity may shift and the facets are permeable and dynamic depending in part on contextual factors. As he stated, the “complexity of human psychology is clear in this diagram”; we believe that it represents only the tip of the iceberg.

The measures. Although not a major focus of his article, Sue (2001) cited the various measures that have been developed to assess cultural competence. These instruments address facets of the MDCC. However, despite great attempts that have been made to measure cultural competencies, the scales remain limited in scope, relying on self-report, and provide little in the way of specific behavioral outcomes. This is problematic given that we must infer from the results important information regarding the individual examinee’s competence. The accuracy of this practice remains to some extent questionable and open to debate. The same problem exists for most measures in this area. For example, acculturation measures have been criticized for being “indirect measures of cultural values and beliefs,” relying solely on behavioral indices such as language usage and place of birth (Betancourt & Lopez, 1993).

The definition. According to the model, cultural competence is defined as the ability to engage in actions or create conditions that maximize the optimal development of client and client systems... acquisition of awareness, knowl-
edge, and skills needed to function effectively in a pluralistic democratic society . . . and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (Sue, 2001, p. 802)

This definition is comprehensive in nature but difficult to operationalize. What is specifically meant by phrases such as “maximize optimal development,” “function effectively,” and “advocate effectively”? Given these general terms, it could be that cultural competence may look different for each individual clinician. If it is true that we as clinicians are the most important instruments of change, then perhaps our unique profile of specific strengths and limitations determines our cultural competence. As indicated in Sue’s (2001) article, cultural competence is multidimensional and multifaceted. Different perceptions of cultural competence cannot be easily ascribed to specific racial and cultural groups. Social class, geographic location, and familiarity with other racial and cultural groups are just a few factors that may account for differences within as well as between groups.

INTEGRATION OF THE POWER HIERARCHY:
AUTHORITY, AUTHORIZATION, AND LEADERSHIP

Sue’s (2001) focus on race and culture in his model forces us to consider some very sensitive issues that are often unspoken in mixed racial cultural groups. These include power, authority, authorization, and leadership among members of particular groups, organizations, and society. For example, the following questions represent areas that need to be understood within the cultural competence framework discussed by Sue. How do race and culture influence the role that one takes in a group, organization, or society? How are the ways in which group members are authorized in their roles influenced by race and culture? How are authority and leadership viewed by members of one’s own group and others? Do members of certain groups take on the roles of authority and leadership differently? How is power used and viewed by members of different racial cultural groups? How do members of different racial cultural groups engage in discussions about power and authority? What are the experiences of power and privilege within and between groups?

Sue (2001) noted that the societal focus of cultural competence has the “power to define reality.” He described “ethnocentric monoculturalism” and a “Euro-American historical bias.” Imbedded within these concepts is the assumption that there are limited quantities of power and resources. Thus, the question of who should have power and control resources creates tension between groups and forces them to identify with the group in power to define
social reality and history (Reed & Noumair, 2000). This tension is dynamic and involves awareness of the political pull to identify with the victim and the victimizer or the oppressed and the oppressor. For example, in groups, organizations, and society, there can be competition between groups for who has the most victimized status when there is a perception that resources have been allocated for this group. Reed and Noumair (2000) called this perception the “myth of redress,” indicating that there will be some redistribution of resources and power to correct injury and oppression. One of the limitations of this myth is that there is rarely adequate compensation for past injustices. Thus, feelings of anger regarding insufficient compensation continue to permeate and affect real-life situations. As Sue noted, “if people’s reality leads them to conclude that past injustices are adequately compensated” (p. 810), then there is no need for further programmatic attempts (e.g., affirmative action) for change.

In America, race has historically been labeled as a dichotomous variable, with the lighter skin holding the positive value and the darker skin the negative value. We cannot escape the dynamic tension associated with racial attitudes and stereotypes that influence thinking and behavior. Thus, as noted in Sue’s (2001) model, developing awareness of attitudes, beliefs, and stereotypes about race and culture is central. However, one of the complexities not reflected in the MDCC is that whereas racial grouping may be defined by physical and cultural characteristics, it may be issues of power that pull individuals into other groups. The reasons for identification with these groups may be more salient than race and culture. For example, individuals may physically look like they belong to one particular group, but ideologically they may promote the social realities defined by the group with more power.

In addition, one of the consequences of power-defining-reality is that attitudes, stereotypes, and beliefs are ascribed to different racial and cultural groups. These shape the ways in which groups are treated in daily interactions both within and between groups. Authority, authorization, and leadership are connected to perceptions and stereotypes about race and culture. Authority and authorization require that one’s power is legitimized or sanctioned by others and self, making the process one of continued negotiation between those with and without power (Berg & Smith, 1990). Members of groups that are negatively stereotyped may not feel or experience themselves as being fully authorized to take on certain roles of leadership in organizations. Fiske (1993) indicated that stereotypes operate in the service of control by defining “how most people in the group supposedly behave, what they allegedly prefer and where there competence supposedly lies” (p. 623).

There are two elements of concern with negative stereotypes: perceptions of others and perceptions of oneself. Individuals may internalize negative and positive attitudes and stereotypes ascribed to their racial group and act as if
they are reality (as noted in racial identity theory). Developing awareness of attitudes, stereotypes, and beliefs about which group holds power or authority and why fosters increased understanding and appropriate skills to negotiate these issues.

**IMPLICATIONS FOR TRAINING AND CLINICAL PRACTICE**

If, as a profession, we are to achieve our goals of cultural competence, then we need to begin thinking outside of the box, examining nontraditional and nonmainstream sources. In their journal article titled “The Diversification of Psychology. A Multicultural Revolution,” Sue, Bingham, Porche-Burke, and Vasquez (1999) cited the importance of the development of multicultural change organizationally and emphasized the need for training in this area. They noted that the profession has a major impact on society and emphasized that the “profession and psychologists must respond to alleviate injustice and oppression arising from a monocultural psychology” (p. 1067). In keeping with this perspective, it is interesting to explore linkages between multicultural counseling, curricula, and sociopolitical concerns as they affect academic and clinical training environments. How would linkages between these areas be manifested for students, faculty, and administration? In reality, as Sue (2001) suggested, a specific sociopolitical climate already exists (i.e., Eurocentric) in institutions of higher learning, but until recently (the past two decades), this has been invisible and discussed by only a few professionals. It is possible that stronger connections could be made in curricula and training between the fields of psychology, sociology, anthropology, and counseling psychology. For example, the origins of counseling have their genesis in social conditions of post–World War II, wherein the profession was developed to provide vocational counseling for veterans (Whiteley, 1984). As Sue noted, the profession’s focus on multiculturalism could be viewed as reflective of the connection with the civil rights movement of the 1950s and 1960s. However, to more fully implement a sociopolitical context within the field of counseling psychology, it would be necessary for practitioners, academics, and researchers to go beyond the boundaries of the profession and incorporate the work of individuals who have written about social, cultural, and political concerns of people of color. Many professionals of color have chosen to link systemic and political concerns in a variety of cultural contexts to theory and practice. The emergence of the Nigrescence linear stage models, for example, Cross’s (1971) model of racial identity development; Helms’s (1984) racial identity development models; and Parham’s (1989) expansion of the Nigrescence construct, are all examples of integrating socio-
political concepts within psychology. Another example is Chodorow’s (1994) feminist critique and redefining of a psychoanalytic perspective on women. These brief examples represent some of the most evocative and intriguing aspects of the field of counseling psychology, but there is certainly more work to be done. What these theories offer is the potential to think outside the box of racial groupings. It is important to train counseling psychologists to not approach Asians or other groups with typical cookbook treatment interventions. It may appear as if there is one best way to work with a given group. We want to train students to examine the various racial dynamics (e.g., cognitions, emotions, behaviors) that emerge in groups and societal settings.

Sue (2001) advocated, as did Highlen (1994), the importance of uncovering systematic blockages regarding implementation of a more sophisticated approach to teaching multicultural competence. It is imperative for academic institutions to begin the challenging task of assessing their own internal climates (e.g., faculty, students, administrators) regarding issues of cultural competence. Many counseling training institutions are continually being challenged by members of diverse communities of color as well as by scholars in the multicultural area to move toward greater integration of multiculturalism into all facets of higher learning. These challenges have been met with great resistance. What does it mean to institutionalize multiculturalism? How does one know if a program, department, and/or school is truly promoting cultural competence in its students and faculty? To ensure that this agenda moves toward realization, we must continue to engage in the struggle, as Sue (2001) put it in his keynote address on which his article is based. Sue’s article issues a call for the profession to utilize theories and research of the past and the present to effect change for the future with regard to the crucial aspects of cultural competence.

CONCLUSIONS

Sue’s (2001) work represents a substantial step forward in establishing a greater understanding of the complexities of cultural competence. The MDCC is a foundation on which researchers and clinicians alike can examine the various dimensions of this complex area. As Sue noted, “Research may ultimately identify other factors underlying cultural competence that may alter the MDCC” (p. 800).

This brief reaction article has served to highlight some of our reactions to Sue’s (2001) major contribution. We congratulate him on synthesizing a complex area into a comprehensive, organized, and readily understandable model. We believe that the MDCC will provide a framework for ongoing research with important counseling applications. Given this foundation, it is up to us to
continue to search outside the box to contribute to enhance further understanding of the multidimensional complexities of cultural competence.

REFERENCES


What a pleasure and honor it is to be able to write a rejoinder to the scholarly and insightful comments of Reynolds (2001 [this issue]); Ridley, Baker, and Hill (2001 [this issue]); and Suzuki, McRae, and Short (2001 [this issue]). One always hopes for a fruitful and stimulating dialogue in professional circles, and it is always a delight when it becomes a reality. Before I comment on their critiques, however, I would like to make some general statements that should help frame my own response to their articles. I had originally thought of titling my response “Confessions of a Multicultural Psychologist” because I have inadequate answers to many of the complex problems raised by the respondents. They have all made excellent and legitimate points in their reactions to my proposed model. Furthermore, the page limitation allowed for my response makes it impossible to comment fully on all the important issues they raise. As a result, I hope the respondents will forgive me for addressing only a select few of them at this time.

First, I am humbled by the respondents’ kind remarks concerning my past contributions to the field of multicultural counseling competencies and feel quite uncomfortable about accepting credit for those achievements. One only has to look at the multiple authorships of these documents (Sue, Arredondo, & McDavis, 1992; Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vazquez-Nutall, 1982; Sue, Bingham, Porche-Burke, & Vasquez, 1999; Sue, Carter, Casas, Fouad, Ivey, Jensen, LaFromboise, Manese, Ponterotto, & Vazquez-Nutall, 1998; Sue, Ivey, & Pedersen, 1996) to note that the development of multicultural counseling competencies has always been and remains a collective endeavor. This acknowledgment does not even do justice to those in leadership positions of the Division of Counseling Psychology (17), the Society for the Psychological Study of Ethnic Minority Issues (45), and the Association for Multicultural Counseling and Development who made organizational decisions to support these projects and their eventual publications. Nor does it adequately acknowledge the many other scholars who contrib-
uted immensely to our understanding of multicultural counseling competence through their innovative ideas and research. I sorely miss their collective wisdom in aiding me to frame my response, but I am heartened by the knowledge that they, too, will enter this important dialogue.

**SPECIFIC RESPONSES TO REYNOLDS, RIDLEY ET AL., AND SUZUKI ET AL.**

I am pleased that the authors have found the multidimensional model of cultural competence (MDCC) of value in the conceptualization of cultural competence. Each has been more than fair in providing a balanced picture of both its strengths and limitations. In my rejoinder, I chose to concentrate on selected areas of their concerns. As expected, all three reactions possess considerable areas of overlap as well as divergences. Although my summary of their comments, concerns, and suggestions does not do their views justice, let me briefly summarize some of them.

First, Reynolds (2001) made some very important observations regarding the MDCC that have occupied much of my own deliberations as well. There is a need to (a) define cultural competence as including diunital reasoning because it is an attribute of the ability to deconstruct reality, (b) develop a dynamic theory that addresses how the multiple social identities interact and/or relate to one another, (c) note that the model may be too unwieldy and overwhelming to be used effectively, and (d) suggest strategies or develop a strategic plan of how to transform psychology from a monocultural to a multicultural discipline. I accept her insightful observation that models are not enough if we cannot demonstrate how they can be pragmatically used and am intrigued by her suggestion of a casebook that extends and expands illustrations for each cell of the MDCC.

Much of the feedback from the other two respondents has also noted that the model does not illustrate how the dimensions of race/culture, components of cultural competence, and foci of cultural competence interact or operate as an aggregate (Ridley et al., 2001) and that it does not inform us as to how we can transform psychology (Suzuki et al., 2001). The limited state of my knowledge and experience, however, made it difficult to provide the full range of examples needed to make the model “come alive.” As Reynolds (2001) suggested, it would be both a fascinating and valuable undertaking to provide case studies with concrete interventions related to the three dimensions of the model. Perhaps such a venture would result in our ability to identify general principles or guidelines that would allow more definitive predictions and prescriptions for change.
Second, Ridley et al. (2001) identified several concerns related to the MDCC model: (a) definitional difficulties related to the precise operationalization of cultural competence and the lack of distinction between cultural competence and multicultural counseling competence, (b) the need of the model to be prescriptive rather than solely descriptive, and (c) limitations inherent in a race-based group perspective. The strength of their critique lies in the analytical nature in which they dissect the issues related to the definition of cultural competence. Does the tripartite division of cultural competence capture “its essence” or does it add to the confusion? Is cultural competence desirable for clients, teachers, administrators, and laypeople, and does it look the same for them as it does for counselors? Is cultural competence for individuals the same as that for organizations? These questions, admittedly, need to be addressed by the model. Unfortunately, space prevents me from attempting to do so.

Although all three reaction articles seek greater clarification on the definition of cultural competence, perhaps that posed by Ridley et al. (2001) is the most challenging. They pointed out that a meaningful discourse on cultural competence cannot occur without an operational definition of its basic tenets and an examination and clarification of its purpose. They contended that my definition implicitly contains two purposes, of which they believe that the latter is superordinate: effective relationship building across cultures and therapeutic gain. Among problems they associated with my definition of cultural competence are its lack of precision, its circular nature, and confusion created from a failure to distinguish between the behavioral and developmental components of cultural competence.

For many years, I have been following the writings of Ridley and colleagues (Ridley, 1995; Ridley et al., 2001; Ridley, Mendoza, Kanitz, Angermeyer, & Zenk, 1994) and have been impressed by the scholarly and clear thinking they have brought to the conversation on cultural competence. Indeed, their comments in this issue have allowed me to see problem areas in the MDCC and in my definition of cultural competence. I am disinclined, however, to personally move toward the type of precision (operational definitions) that many of my colleagues and Reynolds (2001), Suzuki et al. (2001), and Ridley et al. (2001) are advocating. Know that this statement is not based on a dismissal of the scholarly value of operational definitions but on a socio-political stance and personal observations that (a) we are not sufficiently liberated in our thinking and understanding of multiple realities to move to the type of precision required of a unified definition of cultural competence—to do so is premature; (b) in light of our lack of a unified definition, cultural competence is “the process of becoming,” an ongoing enterprise; (c) it is very possible that our scientific paradigms are inadequate to truly define the totality of the construct because it relies on the physical plane of existence and
neglects the spiritual dimension (cultural competence is spiritual as well—personal belief); and (d) as I have gotten older, perhaps not wiser, I view my role in the cultural competency dialogue as framing ideas and concepts that challenge much of what I have learned from my monocultural education. Thus, I leave it to colleagues to wrestle with the research and conceptualizing that may help us one day to have a holistic definition of cultural competence.

Third, Suzuki et al. (2001) advocated the need to think “outside of the box,” especially in the further integration of power hierarchies. Indeed, I find this aspect of their discussion most valuable, and although I differ somewhat in perspective, they are correct in saying that stronger connections between power and curricula training and clinical practice must be made. In addition, they also note that (a) my use of race/culture categories in Dimension 1 may be overgeneralized, (b) the definition of cultural competence is comprehensive but too vague, and (c) institutionalizing multiculturalism means our profession must go beyond the boundaries to incorporate the work of individuals who truly understand the concerns of people of color (regardless of their discipline).

I understand and agree with the authors that there is great danger in group-based labels such as Asian American, African American, and even European American because they potentially oversimplify and fail to recognize within-group differences. Yet, I contend that such categories are unavoidable and that attempts to specify every subgroup may lead us into the path of “individual differences.” There is, however, a difference between generalities and overgeneralizations (stereotyping), and I should have been more careful in making this distinction clear to readers. Their warning about the negative consequences related to the sociopolitical dynamics and meanings of the labels, however, warrants careful study by all of us.

Furthermore, Suzuki et al. (2001) asserted that the MDCC does not adequately deal with the issue of power in group or individual realities. Perhaps, it is my inability to articulate points clearly, but I have stressed that power is in the ability to define reality. Once a reality is defined and imposed on individuals and groups, it may become invisible, especially for those who live that reality. In the United States, the “invisible Whiteness of being” maintains its viability precisely because it is a protected and seldom spoken secret. Many White Americans, however, have distorted and/or conveniently used color blindness as a means of color denial or, more accurately, “power denial” (Sue, 2001). Although it is not my intent to deconstruct “White privilege,” getting it out of the closet is difficult because it mimics the norms of fairness, justice, and equity by “Whiting out” differences and perpetuating the belief in sameness. The denial of power imbalance, unearned privilege, and racist domination is couched in the rhetoric of equal treatment and equal opportunity. Although a two-way or multiple-path process, racial, ethnic, gender,
sexual orientation, and other group identities in the United States are radically influenced by the Euro-American worldview (imposed reality).

**CULTURAL COMPETENCE IS SUPERORDINATE TO COUNSELING/CLINICAL COMPETENCE**

In light of the three highly stimulating articles, I would like to continue the dialogue by adding more fuel to the fire. Even though there are problems in coming to an agreement concerning the definition of cultural competence, many of us know incompetence when we see it; we recognize it by its horrendous outcomes or the human toll it takes on our culturally different clients. For example, the purveyors of mental health services, counseling goals and processes, and the education and training of psychologists have been described in very unflattering terms for some time by multicultural specialists: (a) that counselors and therapists are insensitive to the needs of clients of color and their communities; do not accept, respect, and understand cultural differences; are arrogant and contemptuous; and have little understanding of their prejudices (Thomas & Sillen, 1972); (b) culturally different clients who need care frequently complain that they often feel abused, intimidated, and harassed by nonminority personnel (President’s Commission on Mental Health, 1978); (c) discriminatory practices in mental health delivery systems are deeply embedded in the ways in which the services are organized—how services are delivered to minority populations and their communities, in diagnosis and treatment, in indicators of “dangerousness,” and in the type of personnel occupying decision-making roles (Cross, Bazron, Dennis, & Isaacs, 1989); and (d) mental health professionals continue to be trained in programs in which ethnic issues are ignored, regarded as deficiencies, portrayed in stereotypic ways, or included as an afterthought (Meyers, Echemedia, & Trimble, 1991, p. 5).

From my perspective, helping professionals have seldom functioned in a culturally competent manner. They may have functioned in a monoculturally competent manner with only a limited segment of the population, White Euro-Americans, but even that is debatable. Strangely enough, the criticisms of exclusion are often leveled at attempts to develop multicultural counseling guidelines. Objections to multicultural standards have ranged from characterizing them as focusing just on racial minorities and/or their exclusion of other groups like women and gays/lesbians. The fallacies in this belief are threefold: (a) Race, culture, and ethnicity are primarily a “minority thing” and have little relevance to other populations (including White Euro-Americans); (b) current standards of therapeutic practice are based on research that makes them more valid; and (c) “good counseling is good counseling.”
First, it is clear that race, culture, and ethnicity are functions of each and every one of us. It is not just a Black thing, an Asian American thing, a Latino/Latina thing, or a Native American thing but a White thing as well. In her book, *Race Is a Nice Thing to Have*, Helms (1992) addressed how race is invisible to many White Americans because it serves as the default standard in evaluating the world around them. That criticism also applies to other group identities as well. Second, I seriously question the assumption that clinical competence is empirically based. How much empirical support, for example, is there for what I call the five therapeutic taboos: Counselors (a) do not give advice, (b) do not self-disclose their thoughts and feelings, (c) should not accept gifts from their clients, (d) should not enter into dual-role relationships, and (e) should avoid bartering with clients. What sense do we make of these admonitions in light of findings that indigenous helping practices consider such behaviors and roles to be characteristics of healing and competency (Berman, 1979; Herring, 1999; Lee, 1996; Parham, 1997; Parham, White, & Ajamu, 1999)?

I submit that much of current therapeutic practice taught in graduate programs is derived mainly from clinical experience with middle-class to upper class White folks, not research. If we are honest with ourselves, we can only conclude that much of our standards of professional competence (Eurocentric) are derived primarily through folk wisdom and the values, belief systems, cultural assumptions, and the traditions of the larger society, not science, as we would have our students believe. Thus, values of individualism, psychological mindedness, and using “rational approaches” to problem solve have much to do with how competence is defined. Furthermore, despite the fact that our profession has advocated moving into the realm of empirically supported treatments (EST), little evidence exists that they are applicable to racial/ethnic minorities (Sue et al., 1999). A review of studies on EST reveals few, if any, on racial minority populations, making assumptions of external validity invalid when applied to people of color (Hall, in press; Sue, in press).

If we truly believe that standards of practice must be research based, might we not also have to consider eliminating much of the current Euro-American standards related to counseling/clinical competence? Yet, many of my colleagues continue to hold firmly to the belief that good counseling is good counseling, thereby dismissing the centrality of culture in their definitions.

Thus, it is clear to me that the more superordinate and inclusive concept is that of multicultural competence and not counseling competence. Elsewhere, my colleagues and I (Sue et al., 1996) have proposed a theory of multicultural counseling and therapy in the form of a metatheory. The multicultural theory assumes that all helping systems are developed in a particular cultural context and reflect different worldviews; that it includes European American, Asian, African, Latin American, American Indian, and other indigenous healing
systems (Suzuki et al., 2001); that multiculturalism encompass multiple identities as philosophically equal in importance (Ridley et al., 2001); that a choice of healing systems is a both/and rather than either/or decision (Reynolds, 2001); and that all helping models derived from Western and non-Western cultures are not inherently right or wrong, good or bad. Standards of helping derived from such a philosophy and framework are inclusive and offer the broadest and most accurate view of cultural competence!

In closing, I again apologize to the three respondents for my failure to adequately and fully address the many important issues they raised to my conceptualization of cultural competence. But, I believe we are all in agreement that cultural competence is on the front burner of the profession because current forms of mental health treatment have neither been adequate nor appropriate for many culturally different groups in our society. As a result, I echo my statement once again that cultural competence is superordinate to clinical competence and must become a defining feature of the profession.

REFERENCES


Helms, J. E. (1992). Race is a nice thing to have. Topeka, KS: Content Communications.


Native American women (N = 218) living on a reservation were surveyed to assess their preferences for counselor sex, ethnicity, cultural awareness, counseling style, and commitment to Native American and Anglo-American cultures. Women generally preferred a counselor with the following attributes: female, ethnically similar, culturally sensitive, and used a nondirective counseling style. All these preferences, except for counseling style, were generally stronger for personal versus vocational problems and were stronger for women with high commitment to Native American culture. Written analogue portrayals depicted counselors in four combinations (Native American vs. Anglo, culturally sensitive vs. insensitive). The Native American/sensitive counselor was rated highest, with the Anglo/insensitive counselor rated lowest. The Anglo/sensitive counselor was preferred to the Native/insensitive counselor by women who strongly identified with Native American culture.

Native Americans (American Indians) experience higher levels of poverty, unemployment, suicide, substance abuse, alcohol-related mortality, and mental health problems than the general U.S. population (LaFromboise, Coleman, & Gerton, 1993; LaFromboise & Howard-Pitney, 1995). Although Native Americans’ need for mental health services has been well documented, and treatment is increasingly available (Attneave, 1987; Jackson, 1995), formal counseling services are underutilized by Native Americans (Price & McNeill, 1992). Among Native American clients who do use these services, the drop-out rates are among the highest of any ethnic group (D. W. Sue & Sue, 1990a; S. Sue, Allen, & Conaway, 1981). Underuse of services by Native Americans has been attributed to mistrust of White counselors.

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(LaFromboise & Dixon, 1981), differing cultural views of the healing process (Price & McNeill, 1992), and differing cultural values between European Americans and Native Americans (Bennett & BigFoot-Sipes, 1991; LaFromboise, Trimble, & Mohatt, 1990). Some experts believe that much of the mental health service provided by government agencies on reservations is culturally insensitive, biased toward dominant cultural values, and may be more destructive than helpful (LaFromboise & Rowe, 1983).

For any ethnic minority group, but perhaps especially for Native Americans, a key element for engaging and retaining a client in counseling is a positive, mutually respectful therapeutic relationship in which both client and counselor believe that the client will benefit (Atkinson, Thompson, & Grant, 1993; Gim, Atkinson, & Whiteley, 1990; LaFromboise & Howard-Pitney, 1995; McWhirter & Ryan, 1991; D. W. Sue & Sue, 1990b). A key element in forming this type of positive relationship with Native American clients is the counselor’s understanding of psychological aspects of the client’s cultural experience (LaFromboise et al., 1993). Historically, Native Americans have experienced grievous attempts to extinguish their tribal culture and language and force them to adopt values of the dominant culture. The legacy of imposed acculturation through, for example, the boarding school system, forced separation of children from parents, and punishment for speaking the tribal language (Garrett & Pichette, 2000; Little Soldier, 1985) has created special psychological and emotional problems for many Native Americans (Attneave, 1987; Morrissette, 1994). It is not surprising that many have a low level of trust for White counselors (Herring, 1990a, 1990b; LaFromboise & Dixon, 1981). Thus, the historical context and present experience of many Native American clients require counselors to express positive attitudes, knowledge, and respect for Native American culture as well as special sensitivity to the unique stresses imposed by cultural conflicts to earn the trust of Native American clients (LaFromboise et al., 1993; Trimble & LaFromboise, 1987).

Before proceeding, it is necessary to define important terms used throughout this article. Acculturation has been described as a process of socialization into an ethnic group other than one’s own, resulting from contact between persons of two or more cultures. Acculturation involves cultural learning, attitudinal change, and behavioral change (Casas & Pytluk, 1995). For Native Americans, “acculturation refers to the degree to which the individual accepts and adheres to both majority [White/Euro-American] and tribal cultural values” (Choney, Berryhill-Paapke, & Robbins, 1995, p. 76, brackets in original). A related term, bicultural competence, refers to the ability to interact effectively with members of two cultures through one’s mastery of the appropriate behaviors and knowledge of the culture-based expectations of both cultures (LaFromboise & Rowe, 1983). Although there has been a
widespread assumption that living in two cultures is invariably a marginalizing experience and must involve a preference for one culture over the other (Kerwin & Ponterotto, 1995), LaFromboise et al. (1993) argued that it is possible to gain competence in a second culture without losing identification with one’s traditional culture. The key to acquiring bicultural competence and minimizing the potentially negative impact of contact with the dominant culture is maintaining a strong sense of personal identity. A component of this personal identity for members of any ethnic minority group is cultural commitment (Johnson & Lashley, 1989; Sanchez & Atkinson, 1983), which, for the purposes of the current study, is defined as a desire to adopt what an individual understands to be the values, norms, attitudes, and behavioral practices of a given culture. In this sense, cultural commitment is a necessary first step in the process of voluntary acculturation, but commitment itself does not imply that acculturation has progressed very far. Ethnic identity is

the sum total of group members’ feelings about those values, symbols, and common histories that identify them as a distinct group. . . . A person does not belong to an ethnic group by choice; rather, he or she must be born into such a group and becomes related to it through emotional and symbolic ties. (Smith, 1991, pp. 181-182)

For most individuals, cultural competency, ethnic identity, and cultural commitment all coincide in their primary cultural identification. However, for Native Americans immersed to varying degrees in contact with a second culture, they may or may not choose to make a commitment to the values, norms, and behavioral practices of the second culture. Whether they make a commitment to the second culture, they may or may not derive any portion of their ethnic identity from it. Finally, irrespective of making a cultural commitment or deriving identity, a person may or may not be competent at functioning in the second culture. An example may help to illustrate these distinctions. A young woman may move from her reservation to a large city to take a job whose duties require her to function competently in the dominant culture. Even after years of working successfully at this job, she may never come to view herself as “White” in terms of ethnic identity, and—although competent in the dominant culture—she may not make a commitment to it by adopting its values, norms, or attitudes as her own. In contrast, her sister, who moved from the reservation with her, after a few years may stop describing herself as “American Indian,” reject her traditional culture, and commit herself to adopting the norms and behaviors of the dominant culture. Thus, cultural commitment (especially for those who have made a recent commitment to a second culture) does not necessarily involve completed acculturation,
cultural competence, or ethnic identity. Although connections between acculturation, bicultural competence, and mental health will be described in this article, the specific focus of this study was the influence of cultural commitment on counselor preference and perceptions of counselors.

Research is mixed about whether acculturation influences ethnic minority clients’ help-seeking preferences. Some studies suggest that Mexican American college students prefer an ethnically similar counselor to a dissimilar counselor and perceive the similar counselor as a more credible source of help, regardless of the students’ cultural commitment (Lopez, Lopez, & Fong, 1991; Ponce & Atkinson, 1989). Other studies suggest that acculturation to the dominant culture is related to the willingness of Asian American college students to seek Western-style psychological help (Atkinson & Gim, 1989). However, still other research suggests the converse, namely, that high levels of identification with Asian culture predict willingness to see a psychologist (Atkinson, Whiteley, & Gim, 1990). Perhaps these apparent discrepancies are explained by complex interactions between acculturation, cultural identification, gender, and the nature of the hypothetical presenting problem (Gim et al., 1990). The somewhat contradictory findings in this body of research can perhaps best be summarized by concluding that although many studies suggest that ethnic minority clients prefer counselors of the same ethnicity, especially for students with low acculturation to the dominant culture (Atkinson, Jennings, & Liongson, 1990), these preferences must be considered in relation to other factors related to preference (Atkinson & Wampold, 1993). Among these moderating variables may be the nature of the hypothetical presenting problem (Gim et al., 1990), counselor cultural sensitivity (Atkinson, Casas, & Abreu, 1992; Pomales, Claiborn, & LaFromboise, 1986; Thompson, Worthington, & Atkinson, 1994), and match of counselor and client sex. Although the effect of gender on counseling process and outcome has received increased research attention, findings are inconclusive, especially when applied to multicultural counseling (Atkinson & Schein, 1986).

In research focused on Native Americans, studies suggest that college students have a strong preference for Native American counselors, men prefer male counselors regardless of presenting problem, and women appear to prefer female counselors only for personal problems (Haviland, Horswill, O’Connell, & Dynneson, 1983). Native American college students low in acculturation may have significantly less favorable attitudes toward counseling (Price & McNeill, 1992) and a strong preference for a Native American counselor, if they were to seek counseling from anyone (BigFoot-Sipes, Dauphinais, LaFromboise, Bennett, & Rowe, 1992). BigFoot-Sipes et al. (1992) also found that female Native American students had a strong preference for a female Native American counselor regardless of whether the pre-
senting problem was academic or personal. In other research, stronger commitment to Native American culture was associated with stronger preference for seeing a Native American counselor (Johnson & Lashley, 1989) and was associated with different expectations about counseling.

Research with Native American students confirms that counselor attitude and value similarity are among the most important aspects of counselor preference (Bennett & BigFoot-Sipes, 1991). Unfortunately, almost the entire body of research on counselor preferences has been conducted with college students. These findings have limited generalizability to the full population of Native Americans because many of those who most need mental health services do not attend colleges or universities. Therefore, the purpose of the present study was to investigate the association of cultural commitment in Native Americans living on a reservation to preferences for counselor characteristics and perceptions of counselors. The focus was on women because they may be most likely to seek help from outside sources for themselves or a family member. Approximately 45% of all Native American households are headed by a woman (LaFromboise, Berman, & Sohi, 1994). In keeping with contemporary theory (LaFromboise et al., 1993), we assessed cultural commitment not as a mutually exclusive dichotomy but rather in terms of orthogonal dimensions of commitment to Native American culture and the dominant culture.

Specifically, in line with the previous research on acculturation, cultural commitment, and counselor preference described above, we hypothesized that greater commitment to Native American culture and less commitment to the dominant culture would be associated with stronger preference of Native American women for (a) a female counselor, (b) a Native American counselor, (c) a counselor who was aware of Native American culture, and (d) a counselor who used a more directive counseling style. Second, we hypothesized that these preferences would be stronger for a personal counseling problem than a vocational counseling problem. We posed a specific directional hypothesis for sex preference because, although the research is somewhat mixed, most previous studies suggested a preference for female counselors, especially for personal problems. Our hypothesis about counseling style was based on previous research suggesting that Native Americans prefer a directive counseling approach to a nondirective one (Dauphinais, Dauphinais, & Rowe, 1981). We also investigated the association of cultural commitment to perceptions of four analogue counselors in a repeated-measures design that represented two levels of sensitivity to Native American culture and two types of counselor ethnicity (Native American vs. Anglo). Our third hypothesis led us to expect that cultural commitment would influence perceptions of counselors who varied in cultural sensitivity and ethnicity. Specifically, we expected that women with high commitment to only
Native American culture would form the most favorable impressions of the culturally sensitive Native American counselor. We expected women with high commitment to only Anglo culture to view the two Anglo counselors most favorably, regardless of the counselors’ sensitivity. We formed no specific hypotheses regarding the complexities of how women with high or low commitment to both cultures would perceive the counselors.

METHOD

Participants

Participants were recruited through letters mailed to a random sample of 1,600 residences on the Confederated Tribes of the Warm Spring Reservation in central Oregon. A total of 218 Native American women (age 18 or older) responded by returning surveys with useable data. The resulting sample represented a 14% response to our solicitation. Separate tribes live together on this reservation. Women identified themselves as belonging to the following tribal groups: Warm Springs (32%), Wasco (21%), Warm Springs and Wasco mixed heritage (37%), and other tribal groups (10%). The mean age of respondents was 37.93 years (SD = 12.40; range = 18-73). To provide the maximum protection of anonymity, no further demographic questions were asked.

Instruments

Cultural commitment. This measure was adapted for the present study from single-item questions used in previous research (Johnson & Lashley, 1989; Price & McNeill, 1992; Sanchez & Atkinson, 1983) that conceptualized cultural commitment in terms of two orthogonal factors of identification with the “traditional” culture (in this case Native American) and the dominant culture. Participants were asked to choose which one of the following four phrases best described them: (a) “I have a strong commitment to both Native American and Anglo-American cultures,” (b) “I have a strong commitment to Native American culture and a weak commitment to Anglo-American culture,” (c) “I have a strong commitment to Anglo-American culture and a weak commitment to Native American culture,” or (d) “I have a weak commitment to both Native American and Anglo-American cultures.” Following the example of Johnson and Lashley (1989), we included two items to corroborate validity through asking about (a) degree of participation in tribal activities and (b) proficiency in the tribal language. These items used 3-point scales (1 = not at all, 2 = somewhat, 3 = very). Because language
proficiency may depend on opportunities not completely within the respondents’ control, for this study we added two additional validity items asking about (a) opportunity to learn the tribal language and (b) degree to which respondents were encouraged to speak the tribal language at home or school. These items used 3-point scales matched specifically to each item (e.g., for learning the tribal language: 1 = no opportunity, 2 = some opportunity, 3 = a lot of opportunity). Scoring is based only on the single item asking respondents which combination of strong or weak commitment to Native American and Anglo-American cultures best describes them. In addition to face validity, evidence of concurrent validity was provided by Johnson and Lashley, who reported that language proficiency and participation in tribal activities were associated in expected ways with the four-category item measuring cultural commitment. Price and McNeill (1992) reported that commitment to Native American culture assessed by this item was associated in expected ways with previous experience living on a reservation.

**Multi-Ethnic Preferred Counselor Characteristics Inventory (MEPCCI).** This measure was developed by Wetsit (1992), based on earlier work by Bernstein, Wade, and Hofmann (1987), to assess preferences for counselor characteristics across different presenting problem scenarios common to Native American students. Wetsit’s original measure included six scenarios, but the two concerning academic difficulties for college students were deleted in the present study. Of the four scenarios retained, two scenarios involved personal problems (breakup of romantic relationship, losing temper with your child) and two involved vocational problems (fear you might lose your job, dissatisfied with current job). In the current study, preferences for four counselor characteristics were assessed: (a) gender, (b) ethnicity, (c) counseling style, and (d) cultural awareness. Respondents used a 5-point Likert-type scale (1 = not important, 5 = very important) to indicate the overall importance of a counselor characteristic for this problem and then indicated their preferences within each characteristic, for example, within ethnicity the preferences were (a) same race as me, (b) different race than me, or (c) doesn’t matter. Beyond face validity, neither Wetsit nor Bernstein et al. reported evidence of validity or reliability for their versions of this measure. To reduce the number of analyses and control inflation of Type I error, in the current study pairs of preference items for the two vocational and two personal problem scenarios were summed to form two-item scales.

**Counselor Analogue Portrayals**

Four short counselor-client vignettes based on those used by Gim, Atkinson, and Kim (1991) were modified for use in this study. Each vignette
was presented in written form and included three speaking turns each for cli-
ent and counselor. In this study, the four vignettes depicted combinations of
counselor ethnicity (Native American or Anglo-American) and sensitivity to
Native American culture (either moderately sensitive or fairly insensitive). For example, in the vignettes depicting cultural sensitivity, the Anglo coun-
selor expresses empathy for the client’s experience of cultural isolation, and
the Native American counselor acknowledges the importance of showing
proper respect for one’s family members. In the vignettes depicting insensi-
tivity, the Anglo counselor admonishes the client for arriving late to the ses-
sion, and the Native American counselor fails to acknowledge the client’s
expressed concerns about not being respected by White coworkers. Respond-
dents were told that the client in each vignette was Native American and that
the counselor in each vignette lived near but not on the reservation. (The gen-
ders of counselor and client were deliberately left ambiguous.) A manipula-
tion check item presented after each vignette assessed perceptions of the
counselor’s “level of commitment to Native American culture” using a 10-
point unanchored scale. Three additional items asked for ratings of the coun-
selor’s competency, how comfortable the respondent would be if she or he
were to see this counselor, and how willing the respondent would be to see
this counselor. The 10-point scales for these items were anchored at the end
points with not at all competent versus very competent, not at all comfortable
versus very comfortable, and not at all willing versus very willing. These
three items were then summed to form a single index. Internal consistency
(coefficient alpha) ranged from .90 to .94 for the ratings.

Procedure

Survey packets contained cover letters that promised complete anonymity
and included a prestamped return envelope. The cover letter stated our con-
cern about so few American Indians using counseling services and described
the purpose of the study as collecting information that we hoped would lead
to better training and improved counseling services. After the initial presen-
tation of demographic questions, the survey presented elements in the fol-
lowing order: (a) cultural commitment assessment, (b) MEPCCI with prob-
lem vignettes, and (c) counselor analogue portrayals and ratings. To provide
the highest assurance that the surveys would remain completely anonymous,
no tracking-return procedure or multiple mailing of the surveys was used.
Only one letter was mailed to each randomly selected residence, with no spe-
cific directive as to which adult living in the household should complete the
survey. An address located on the reservation and telephone number were
provided for potential respondents to request additional copies of the survey.
Respondents were entered in a lottery for a $100 gift certificate for her choice
of one of several businesses located on or near the reservation. In addition, all participants received a gift certificate good for a $3 purchase at one of these cooperating businesses on or near the reservation.

RESULTS

Validity and Manipulation Checks

Women responded to the four-category measure of cultural commitment with 78 (36%) reporting a strong commitment to both cultures (“strong both”), 104 (48%) reporting a strong commitment to Native American culture and a weak commitment to Anglo culture (“strong Native American”), 24 (11%) reporting a strong commitment to Anglo culture but not Native American culture (“strong Anglo”), and 12 (6%) reporting a weak commitment to both cultures (“weak both”). To check the concurrent validity of this single-item measure, the first two and the last two groups were combined to form a high commitment to Native American culture group (n = 182) and a low commitment to Native American culture group (n = 36). Chi-square analyses indicated that these two groups differed as expected, in that the group highly committed to Native culture was more active in tribal activities, $\chi^2(2, n = 218) = 13.17, p < .01$; was more proficient in their tribal language, $\chi^2(1, n = 218) = 19.97, p < .0001$; had been more encouraged to learn the tribal language, $\chi^2(2, n = 218) = 14.90, p < .001$; and had more opportunity to learn the tribal language, $\chi^2(2, n = 206) = 30.78, p < .00001$.

Respondents’ ratings of the commitment of counselors to Native American culture depicted in the vignettes were analyzed with a one-way repeated measures analysis of variance (ANOVA) as a manipulation check for the effectiveness of the vignette portrayals. The vignettes were designed to represent four different combinations of ethnicity and cultural sensitivity: Counselor A was an Anglo-American counselor with moderate sensitivity to Native American culture, Counselor B was a Native American counselor with a low level of sensitivity to Native culture, Counselor C was a Native American counselor with a high level of sensitivity to Native culture, and Counselor D was an Anglo-American counselor with a low level of sensitivity to Native culture. Results of the ANOVA suggested that the manipulation was very effective, $F(3, 215) = 110.69, p < .0001$. $t$ tests used as follow-up analyses indicated that Counselor C was rated as more committed to Native American culture than Counselor A, $t(217) = 3.25, p < .001$; Counselor A was rated as more committed than B, $t(217) = 4.73, p < .001$; and Counselor B was rated as more committed than D, $t(218) = 11.23, p < .001$. Thus, the vignettes effectively portrayed four counselors that were perceived as distinctive in
their commitment—and we believe also in their sensitivity to Native American culture (see Note 2).

Tests of Research Hypotheses

To test our first hypothesis about preferences for counselor sex, ethnicity, cultural awareness, and counseling style, we created indices of these dependent variables by combining single items from the MEPCCI. Our intention was to create continuous measures likely to be more reliable than the single items used by Wetsit (1992). The MEPCCI preference indicators for counselor sex and ethnicity consisted of two components, a categorical choice (“same,” “different,” or “does not matter”) and a 5-point scale to indicate the strength of preference (1 = not important, 5 = very important). An index was created for each item that reflected not only the basic preference but also the importance attached to the preference. First, a valence coefficient of –1 was assigned for the choice of different, +1 for same, and 0 for does not matter. This coefficient was multiplied by the importance indicator, resulting in an index that varied from –5 (very important to have a counselor of different ethnicity or sex) to 0 (this choice does not matter) to +5 (very important to have a counselor of the same ethnicity or sex). Pairs of parallel items resulting from ratings of the two vocational problems and the two personal problems were then summed to yield an index that ranged from –10 to +10 for ratings of preference for counselor sex and ethnicity—with separate ratings for vocational and personal problems. The third MEPCCI preference item asked about counselor cultural awareness (either through the counselor belonging to the respondents’ tribal group or having knowledge of the tribal culture). This preference was scored on a 1 to 5 scale, summed across parallel items in the two vocational and two personal problems to yield indices that varied from 0 (does not matter) to 10 (cultural awareness is very important). Regarding counseling style, the choices works with me to determine options and lists options and lets me decide were both given a valence of +1 because these both described a fairly nondirective style, whereas tells me what to do was assigned a valence of –1 to indicate a more directive style. The choice does not matter was assigned a valence of 0. After multiplying the valence by the importance attached to this choice (scored on a 1-5 scale) and summed across the two vocational and two personal hypothetical problems, the resulting index could range from –10 (strong preference for a directive counseling style) to 0 (does not matter) to +10 (strong preference for a nondirective counseling style). Note that assignments of valences were done only in our statistical analyses, not in the materials presented to respondents.

Our second hypothesis stated that counseling preferences would depend on whether the hypothetical presenting problem was personal or vocational.
To test both of the first two hypotheses, the four indices described above were analyzed with a mixed model multivariate analysis of variance (MANOVA), with one between-participants factor (cultural commitment group); a within-participants factor of problem type (vocational vs. personal); and a second multivariate within-participants factor of preferences for (a) counselor sex, (b) counselor ethnicity, (c) counselor cultural awareness, and (d) counselor directive versus nondirective style. Because there were too few women who indicated a weak commitment to both cultures (n = 12), they were excluded from these analyses. Results shown in Table 1 indicate a significant main effect for the between-participants factor of cultural commitment, $F(2, 202) = 7.38, p < .001$, thus providing strong support for our first hypothesis. Results also show strong support for our second hypothesis in that there was a significant main effect for vocational versus personal problem type, $F(1, 202) = 35.07, p < .001$, and a significant Cultural Commitment × Problem Type interaction, $F(2, 202) = 9.37, p < .001$.

Univariate follow-up analysis suggested that the nature of the hypothetical problem was associated with women’s preferences for the sex, ethnicity, and cultural awareness of their counselors but not counseling style. Comparison of the means in Table 1 shown in each pair of rows suggests that for women with either a strong commitment to Native American culture or to both cultures, their general preference for a counselor of the same ethnicity and sex was stronger for a personal problem than for a vocational problem. Regarding importance placed on cultural awareness, the picture is somewhat mixed, with women in the “strong both” and “strong Anglo” groups attaching higher importance to cultural awareness for personal problems than vocational problems, whereas women in the “strong Native American” group attached somewhat more importance to cultural awareness for vocational problems. Note that because the ceiling score on this index was 10, these scores indicate that all three groups had a fairly strong preference for counselors with cultural awareness. Nevertheless, the strength of this preference did vary depending on cultural commitment groups. All respondents preferred a nondirective counseling style, and the level of this preference was not dependent on the nature of the counseling problem.

Scheffe follow-up comparisons between the three cultural commitment groups are shown in the last column of Table 1. These comparisons suggest that as hypothesized, preference for a counselor with high cultural awareness and one of the same sex and ethnicity for personal problems was significantly higher for women with high commitment to Native American culture or both cultures, compared to women with a high commitment only to Anglo culture. Interestingly, for vocational concerns there were also differences, in that women with high commitment to Native American culture had even stronger preferences for counselor cultural awareness and ethnicity than women with...
## TABLE 1: Cultural Commitment and Preference for Counselor Sex, Ethnicity, Cultural Awareness, and Counseling Style (n = 205)

<table>
<thead>
<tr>
<th>Cultural Commitment</th>
<th>A: Strong Both (n = 78)</th>
<th>B: Strong Native American (n = 103)</th>
<th>C: Strong Anglo (n = 24)</th>
<th>F</th>
<th>Group Difference Scheffe Test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preference for sex</strong>^a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>3.10 4.45</td>
<td>4.70 4.69</td>
<td>0.23 0.87</td>
<td>10.96**</td>
<td>B, A &gt; C</td>
</tr>
<tr>
<td>Vocational</td>
<td>1.89 3.32</td>
<td>1.49 2.60</td>
<td>0.96 1.43</td>
<td>1.57</td>
<td>—</td>
</tr>
<tr>
<td><strong>Preference for ethnicity</strong>^b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>3.89 3.49</td>
<td>4.11 3.77</td>
<td>0.18 0.85</td>
<td>13.86**</td>
<td>B, A &gt; C</td>
</tr>
<tr>
<td>Vocational</td>
<td>0.04 0.35</td>
<td>1.15 2.28</td>
<td>0.82 1.37</td>
<td>9.80**</td>
<td>B &gt; A</td>
</tr>
<tr>
<td><strong>Preference for cultural awareness</strong>^c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>7.73 1.61</td>
<td>7.74 1.23</td>
<td>6.64 0.95</td>
<td>7.65**</td>
<td>A, B &gt; C</td>
</tr>
<tr>
<td>Vocational</td>
<td>7.07 1.12</td>
<td>8.06 0.96</td>
<td>6.27 0.94</td>
<td>36.75**</td>
<td>B &gt; A &gt; C</td>
</tr>
<tr>
<td><strong>Preference for counseling style</strong>^d</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>8.06 2.92</td>
<td>7.30 2.33</td>
<td>8.46 2.15</td>
<td>3.28*</td>
<td></td>
</tr>
<tr>
<td>Vocational</td>
<td>8.15 1.96</td>
<td>6.47 2.44</td>
<td>8.27 1.96</td>
<td>14.50**</td>
<td>C, A &gt; B</td>
</tr>
</tbody>
</table>

NOTE: Omnibus MANOVA results: Main effect for cultural commitment, $F(2, 202) = 7.38, \ p < .001$; main effect for problem type, $F(1, 202) = 35.07, \ p < .001$; Cultural Commitment × Problem Type interaction, $F(2, 202) = 9.37, \ p < .001$.

a. Scores could range from −10 to +10, with higher scores indicating stronger preference for the same sex of counselor and increasing negative scores indicating stronger preference for a male counselor. Effect of problem type, $F(1, 202) = 9.10, \ p < .001$.

b. Scores could range from −10 to +10, with higher scores indicating stronger preference for the same ethnicity of counselor and increasing negative scores indicating stronger preference for an Anglo counselor. Effect of problem type, $F(1, 202) = 61.69, \ p < .0001$.

c. Scores could range from 0 to +10, with higher scores indicating preference for greater cultural awareness; 0 indicates does not matter. Effect of problem type, $F(1, 202) = 4.47, \ p < .05$.

d. Scores could range from −10 to +10, with higher scores indicating preference for less directive counseling style; 0 indicates does not matter, and increasing negative scores indicate preference for more directive style. Effect of problem type, $F(1, 202) = 1.72, \ p = ns$.

* $p < .05$. ** $p < .01$. 

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^a Preference for sex a

^b Preference for ethnicity b

^c Preference for cultural awareness c

^d Preference for counseling style d
a strong commitment to both cultures. Although all women generally preferred a nondirective counseling style, women in the two groups with high commitment to Anglo culture (i.e., “strong both” or “strong Anglo”), compared to the “strong Native American” group, had a significantly higher preference for a nondirective style when working with vocational problems.

Our hypothesis predicted differences in perceptions of the analogue counselors depending on the cultural commitment of women who read the vignettes. Specifically, we expected that women with high commitment to only Native American culture would form the most favorable impressions of the culturally sensitive Native American counselor. Furthermore, we expected women with high commitment to only Anglo culture to view the two Anglo counselors most favorably, regardless of the counselors’ sensitivity. Each participant rated each counselor for (a) competence, (b) comfort with the counselor, and (c) willingness to see the counselor. These three items were summed to produce a single rating for each counselor. The four portrayed counselors represented combinations of ethnicity (Anglo vs. Native American) and two levels of cultural sensitivity (moderately sensitive vs. fairly insensitive). However, because the high and low sensitivity vignettes were not identical, data were analyzed for the variable of counselor as a single factor with four levels, instead of a 2 × 2 (Ethnicity × Sensitivity) design. Thus, the mixed model MANOVA used to test the third hypothesis had one between-participants factor (cultural commitment group) and only one within-participants repeated measure (counselor) with four levels. Once again, the small number of women in the “weak both” cultural commitment category was excluded from these analyses. Results suggested a significant main effect for cultural commitment, \( F(2, 203) = 21.36, p < .001 \); a significant main effect for counselor, \( F(3, 201) = 140.14, p < .0001 \); and a significant Cultural Commitment × Counselor Interaction, \( F(6, 404) = 10.78, p < .001 \).

Support for our hypothesis is evident in the final column of Table 2, which reports results of planned comparisons in the form of repeated measures (paired samples) \( t \) tests between ratings of each adjacent counselor, presented separately for each cultural commitment group. For example, the first row shows that women with a strong commitment to both Anglo and Native American cultures rated the culturally sensitive Native American counselor (Counselor C) significantly more favorably than either Counselors A or B, who, in turn, they rated as both more favorable than Counselor D. The second row shows that unlike the “strong both” women, the “Native American” women did make a significant distinction between Counselors A and B. These women who were strongly committed only to Native American culture gave significantly more favorable ratings to Counselor A (the Anglo sensitive counselor) than to Counselor B (the Native American insensitive counselor). Finally, women who were committed strongly only to Anglo culture did not
<table>
<thead>
<tr>
<th>Cultural Commitment Group</th>
<th>Counselor A (Anglo, sensitive)</th>
<th>Counselor B (Native American, low sensitivity)</th>
<th>Counselor C (Native American, sensitive)</th>
<th>Counselor D (Anglo, low sensitivity)</th>
<th>Repeated Measures</th>
<th>t Test Planned Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both</td>
<td>18.68 ± 7.02</td>
<td>19.27 ± 6.13</td>
<td>22.44 ± 4.15</td>
<td>14.82 ± 6.71</td>
<td></td>
<td>C &gt; A, B &gt; D</td>
</tr>
<tr>
<td>Native American</td>
<td>18.64 ± 3.17</td>
<td>16.62 ± 5.80</td>
<td>20.60 ± 4.22</td>
<td>7.51 ± 3.98</td>
<td></td>
<td>C &gt; A &gt; B &gt; D</td>
</tr>
<tr>
<td>Anglo</td>
<td>22.00 ± 4.66</td>
<td>22.17 ± 4.36</td>
<td>20.67 ± 2.46</td>
<td>10.25 ± 5.57</td>
<td></td>
<td>B, A, C &gt; D</td>
</tr>
</tbody>
</table>

NOTE: Both = strong commitment to both cultures (n = 78); Native American = strong commitment to Native American culture, weak commitment to Anglo culture (n = 104); Anglo = strong commitment to Anglo culture, weak commitment to Native American culture (n = 24). Omnibus repeated-measures MANOVA results: Main effect for cultural commitment, F(2, 203) = 21.36, p < .001; main effect for counselor, F(3, 201) = 140.14, p < .0001; Cultural Commitment × Counselor Interaction, F(6, 404) = 10.51, p < .0001.
distinguish between Counselors A, B, or C—although they rated all three more favorably than Counselor D. In these rather complex findings, four generalizations are evident: (a) The insensitive Anglo counselor (Counselor D) was rated lowest by every group of women; (b) the Native American sensitive counselor (Counselor C) was rated more favorably than any of the other three counselors by women in the two cultural commitment groups committed to Native American culture; (c) women with a high commitment only to Native American culture were the only group to distinguish between Counselors A and B, and they clearly preferred the culturally sensitive Anglo counselor (Counselor A) to the culturally insensitive Native American counselor (Counselor B); and (d) women in the two groups with commitment to Anglo culture showed no consistent preference between Counselors A and B, who differed in both ethnicity and cultural sensitivity.

**DISCUSSION**

This study explored, among Native American women who differed in commitment to Native American and Anglo culture, several aspects of their preferences for counseling and their perceptions of counselors who systematically differed in cultural sensitivity and ethnicity. We hoped to identify factors that would encourage Native American women to seek help from counselors who represented “Anglo” culture (i.e., the dominant culture outside the reservation) and to continue in counseling rather than dropping out. Specifically, we explored the hypothesis that women with a strong commitment to Native American culture would express significantly stronger preferences than other women for seeing a female Native American counselor who used a fairly directive counseling style. Second, we hypothesized that these expressed preferences would be stronger for personal problems than for vocational problems.

Our hypotheses regarding counselor sex, ethnicity, cultural awareness, and problem type were supported. However, contrary to expectations based on previous studies (e.g., Dauphinais et al., 1981), all groups in our study preferred a generally nondirective counseling style. Perhaps the difference in our findings was due to differences in our method of describing the counseling styles (i.e., “tells me what to do” is a fairly stark description of the directive style). In partial support of our hypothesis, women with a strong commitment to Native American culture expressed the lowest level of preference for a nondirective style. Although there were differences between groups and problem type that generally supported our first two hypotheses, it must be noted that, overall, all groups preferred a counselor of the same sex and ethnicity, one who was culturally sensitive, and one who used a style character-
ized by “works with me to determine options” or “lists options and lets me decide” versus “tells me what to do.” Recall that the 0 point of the scales measuring preference for sex and ethnicity shown in Table 1 represents the point of makes no difference, with +10 representing the strongest possible preference for similar sex or ethnicity and −10 representing the strongest possible preference for opposite sex or different ethnicity. Thus, because their scores for counselor sex and ethnicity were close to the 0 point, it appears that women identified only with Anglo culture did not have strong preferences in these areas. (Small standard deviations indicate that their near 0 scores did not result from approximately equal numbers of high and low scores.) The preferences of the two groups of women identified with Native American culture (i.e., “strong both” and “strong Native American”) for vocational problems were only a bit stronger but still not very high (i.e., >0 but <+2). However, the means in Table 1 show that for personal problems, women committed to Native American culture had much higher preferences for female counselors of the same ethnicity, compared to their preferences if the problem was vocational or the preferences of women identified with Anglo culture for either type of problem.

These findings are consistent with studies of college students (Haviland et al., 1983; Wetsit, 1992) that also found female Native American students generally preferred female counselors but only for problems of a personal nature. Our findings are also consistent with other research that found that higher levels of commitment to Native American culture are associated with even stronger preferences for a counselor of the same sex (Wetsit, 1992) and ethnicity (Johnson & Lashley, 1989). Our results for women living on a reservation also match studies of Native American college students that found an overall preference for counselors of the same ethnicity (BigFoot-Sipes et al., 1992; Haviland et al., 1983). However, Bennett and BigFoot-Sipes (1991) found that female students had no strong preference for counselor sex or ethnicity match, regardless of problem type or cultural commitment. These conflicting results may be due to the specific problem vignettes used in each study or, alternatively, due to the different geographical locations of the participants studied. Respondents in both the Wetsit (1992) and Haviland et al. (1983) studies were from Montana, whereas participants in the Bennett and BigFoot-Sipes study were from Oklahoma. It may be that cultural constraints on Native American women of the Warm Springs Reservation in Oregon make sharing personal information with a man inappropriate, especially if that man is not a spouse or a close family member. Further research is needed to determine which specific variables play a role in gender and ethnicity preference.

To our knowledge, ours is the only study to date that examined preferences for counselor style among potential Native American clients living on a res-
ervation. The mean scores on this scale, which could range from –10 to +10, indicated a strong preference for a nondirective style. Interestingly, women in the two groups with a strong commitment to Anglo culture had the strongest preference for a nondirective style. Perhaps, women with strong identification only to Native American culture are accepting of a slightly less nondirective style if it is combined with the nurturance, authority, and expertise expected of a tribal elder (Johnson & Lashley, 1989).

Recall that the scale measuring preference for cultural awareness ranged from 0 (does not matter) to 10 (strong preference). Means shown in Table 1 for women who identified with Native American culture were all greater than 7 on this scale, indicating that cultural awareness is a very important issue for them. Unlike preferences for sex and ethnicity, preferences for a culturally aware counselor were equally high for vocational as well as personal problems. These findings suggest that cultural awareness and cultural issues are important in vocational problems as well as in personal problems, particularly for women with a strong identification with Native American culture.

It is interesting to speculate about why the preferences for counselor sex and ethnicity were apparently stronger for personal problems than vocational problems. Helms (1995) has argued that an ethnic minority individual’s ethnic identity “status” can vary depending on context and environmental influences. For example, the social contexts of work, school, and family life involve differing demands to which a person responds with different sets of culturally relevant attitudes and behaviors. Perhaps participants in our study believed that a Native American, female, culturally aware counselor would have the best chance of helping them with the ethnic identity status they assume in relating to their families. For women in our sample, vocational life may require competence in, and identification with, the dominant culture to a far greater extent than family life. Thus, some women may feel that a representative of the dominant culture may have special expertise for providing help with vocational problems. Our findings suggest that cultural awareness is still important for women seeking help with a vocational problem but that cultural awareness is even more important when the problem is personal.

Our third hypothesis involved predictions about how differing commitment to Native American and Anglo culture would be associated with perceptions of counselors who varied in cultural sensitivity and ethnicity. We expected that women with high commitment to only Native American culture would form the most favorable impressions of the culturally sensitive Native American counselor (i.e., Counselor C). We expected women with high commitment to only Anglo culture to view the two Anglo counselors (Counselors A and D) most favorably, regardless of the counselors’ sensitivity. Results partially supported our hypotheses. Perhaps, not surprisingly, the Anglo counselor who demonstrated cultural insensitivity (i.e., Counselor D)
was rated lowest of all counselors by all three groups. Perhaps, also not surprisingly, the Native American counselor who demonstrated cultural sensitivity (Counselor C) was rated highest by all “both” groups with commitment to Native American culture. However, comparison of Counselor A, the culturally sensitive Anglo counselor, with Counselor B, the culturally insensitive Native American counselor, is among the most interesting in this study and has significant implications for counselor training and practice. Women with a strong commitment to Anglo culture did not distinguish between these two counselors. However, women with a strong commitment to Native American culture (and not to Anglo culture) preferred the Anglo culturally sensitive counselor to the Native American culturally insensitive counselor. These findings underscore the importance of cultural sensitivity in counseling practice and suggest that especially for women who strongly value their tribal culture, seeing a counselor who is sensitive to that culture is more important to them than seeing a counselor who is a member of the culture but does not appear to be sensitive to its values.

These findings are consistent with other studies that found both counselor ethnicity and cultural sensitivity are important factors and interact with one another as well as client characteristics in determining which counselor potential clients prefer to see (Bennett & BigFoot-Sipes, 1991; BigFoot-Sipes et al., 1992; LaFromboise et al., 1990). Perhaps women in our study with high commitment to Native American culture, based on previous experience, did not expect much sensitivity from an Anglo counselor. Thus, Counselor A who was Anglo and sensitive may have created a positive dissonance that enhanced favorable ratings, whereas Counselor B who was Native American and insensitive may have created negative dissonance by disappointing expectations. The influence of positively or negatively confirmed expectations on the counseling process might be a fruitful area for further research.

LaFromboise et al. (1990) developed a five-level model of acculturation for Native Americans based on varying degrees of cultural commitment and assimilation. In this model, the traditional level is similar to the “strong Native American” group in this study, with low commitment to the dominant culture and strong commitment to Native American culture. The marginal level corresponds to our “weak both” group, with low commitment to both cultures. The bicultural level corresponds to our “strong both” group, with a high commitment to both cultures. The assimilated level corresponds to our “strong Anglo” group, with low commitment to Native American culture and strong commitment to Anglo culture. The fifth level, pantraditional, is composed of persons formerly at the assimilated level who seek out their traditional roots and embrace their tribal heritage. Thus, our “strong both” group contained women that, according to the LaFromboise et al. model, could be
labeled as either *bicultural or pantraditional*, depending on the developmental trajectory they followed to arrive at their commitment to both cultures. The bicultural versus pantraditional trajectories—as well as the other three acculturation levels—may have important consequences for counselor preference that should be investigated in future research.

There are a number of important methodological limitations that should be noted. Our sample was limited to women on a single reservation, making generalizability to men or to women on other reservations uncertain. The self-selected sample was undoubtedly not representative of all women on this reservation. For example, it is certainly conceivable that those with the strongest negative attitudes toward Anglo culture did not return surveys. However, this sample may represent women who have at least some favorable disposition to seek counseling, and it provides a better basis for generalization to Native Americans living on reservations than previous studies that used college students as samples of convenience. In addition, all measures were susceptible to the potential biases of self-report instruments. A threat to construct validity was introduced by the single-item forced-choice method of designating cultural commitment groups. Although checks supported the validity of the indicator item, because cultural commitment is a complex construct, this single item provided at best only a rough assessment.

Finally, limitations are introduced by the written counseling vignettes. The brief exchanges depicted did not provide a very powerful or realistic portrayal of actual counseling. On the other hand, they did have the advantage of not introducing confounds based on the physical attractiveness or vocal response tone of actors presented on videotape. The written exchanges were not free of confounds, however, because pairs of vignettes differed in ways other than cultural sensitivity and ethnicity. For example, Counselor D was the only counselor depicted confronting a client (about being late), and Counselor C was the only counselor to speak empathically about family relationships. Because social desirability bias may be a particular problem in studies of ethnic minority counselor preferences (Abreu & Gabarain, 2000; Coleman, Wampold, & Casali, 1995), we chose to present four different vignettes instead of two pairs of identical vignettes (that varied only by counselor ethnicity) to better mask our research purpose. Although some type of confound is therefore unavoidable, it is important to note that the differences in rating counselors in this study may have been due to differences in the vignettes that were not related to cultural sensitivity or ethnicity.

The advantage of our study is that it is one of the few investigations of counseling preferences of Native American women living on a reservation and the only such study we are aware of to assess perceptions of analogue counselors. Of course, more research of all types is needed to improve counseling services for Native Americans. However, studies of reservation life are
especially needed. The task is particularly difficult, in part, because of the negative history that many Native Americans have experienced with research results and government policies that were used to exploit and repress them (Garrett & Pichette, 2000). The understandable resulting distrust of researchers must be overcome, as the first author in this study attempted, through many hours of patient contacts with tribal leaders, by becoming well-known in the reservation community, and by making a commitment to be of benefit to the people instead of only extracting information from them and then leaving—never to be seen again.

If the results of this study are extended and replicated in future research, further evidence could be marshaled to support conclusions that must remain tentative for now. It appears that Native American women living on the reservation we studied, like many Native American college students, prefer female counselors—especially for personal problems. Although they prefer a counselor matched to their ethnicity, cultural sensitivity appears to be an overriding factor. Some of our results suggest that counselors representing the dominant culture may be regarded as competent and may engender willingness of Native American women to see them, if they can demonstrate their cultural awareness and sensitivity. Interestingly, the acceptability of a culturally sensitive Anglo counselor appears to be highest for women with a strong singular identification to Native American culture.

We believe it is important not to overgeneralize these findings to Native American women who do not live on reservations. One of the many differences between these groups of women is that information about Anglo culture is conveyed much more exclusively through media portrayals and through contact with human resource workers who come to the reservation for the women we studied, whereas women who live off the reservation have much more extensive direct contact with Anglo culture. Conversely, the sources of information about one’s traditional culture are necessarily more limited for women living off the reservation. Each group experiences unique stresses and coping advantages (LaFromboise et al., 1994). It remains uncertain how these differences might influence the counseling preferences and perceptions of Native American women who live off the reservation.

Our findings suggest that for Native American women who do live on reservations to receive adequate counseling services, it is essential that counselors have competence in dealing with these individuals. In our study, the Anglo counselor who evidenced cultural insensitivity was rated far more negatively than any of the other three counselors. The results of this study support the need for counselors to receive thorough training about Native American cultural issues and values to provide competent and ethically appropriate counseling to this underserved population. Many writers believe that non–Native American counselors can and should be trained to work
more effectively with Native American clients (e.g., Atkinson, 1994; LaFromboise & Foster, 1992; LaFromboise & Howard-Pitney, 1995; Sabnani, Ponterotto, & Borodovsky, 1991). Further research concerning the type of training necessary will be very important in providing guidance for counselors who wish to work with this population.

NOTES

1. Because we used a repeated-measures design in which every participant was exposed to every vignette, we deliberately chose not to present a pair of identical vignettes with moderate cultural sensitivity and a pair of identical low sensitivity vignettes that varied only with regard to counselor ethnicity. Of course, the advantage of doing so would have been to create a $2 \times 2$ factorial design with added control for confounds. However, we felt this advantage was outweighed by the disadvantages of (a) added fatigue and lessened attention as participants read through pairs of obviously identical transcripts and (b) increased transparency about our research purposes and the resulting greater social desirability bias if respondents saw, quite evidently, that the only variation in a pair of vignettes was counselor ethnicity.

2. Note that although the vignettes were intended to portray counselors of varying cultural sensitivity, through an inadvertent error the manipulation check item asked participants to rate a counselor’s “commitment to Native American culture.” Thus, validity of the manipulation check depends on participants’ view that cultural sensitivity must necessarily be a component of cultural commitment.

REFERENCES


Revitalizing the Division:
The Reorganization of Division 17

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Kathleen L. Davis
University of Tennessee

Between 1992 and 1996, Division 17 of the American Psychological Association (APA) was reorganized to respond to Executive Board- and member-perceived need for more active and effective participation in APA and the field of psychology, enhanced member involvement, and greater responsiveness on matters of concern to counseling psychologists. This article describes the process of the reorganization, including both documented historical events and interviews with key participants. It is intended to capture the historical record and provide insight into the process of the restructuring as well as the division’s governance and activities.

In the years 1996 to 1997, the American Psychological Association (APA) celebrated the Golden Anniversary of Divisions. To add to the celebration, each division was asked to contribute a description of its founding and historical development. Naomi Meara and Roger Myers authored an excellent chapter tracing the societal, political, and economic forces that have influenced counseling psychology and the division since its beginning in 1946 (Meara & Myers, 1999). In addition, the 50th anniversary of the Division of Counseling Psychology (Division 17) was marked by a major reorganization of the divisional structure, which was begun when President Bruce Fretz called a special 3-day Executive Board meeting in May 1992 at Solomons Island, Maryland.

This article describes the process of the reorganization and includes material drawn from interviews with key participants as well as a record of historical events. The interviews give a range of insights and perspectives into the deliberations and into what the process was like for various leaders who took part in it. The interviews also provide an in-depth and thorough look at reasons for the reorganization that are often difficult to capture by simply recounting events. It is hoped that in relating events and participants’ perspectives on these events, we can capture the historical record and provide members with a better understanding of how the division works and how it
can be helpful to them in their professional lives. We hope that such an understanding will prompt individuals to become more involved in divisional governance and activities.

The reorganization of the divisional structure was intended to encourage more individual members to become active participants in Division 17 and to enable more effective governance of the division by redistributing many responsibilities and some authority. It was designed to permit greater responsiveness to member needs, to the APA, and to the broader field of psychology and thus enhance the ability of Division 17 to take a proactive (rather than reactive) stance on matters that are of concern to counseling psychologists. The specifics of the reorganized structure are presented in the section titled “Establishment and Refinement of a Concept” and in Appendix A.

PROLOGUE

The Division of Counseling Psychology (originally the Division of Personnel and Guidance) was officially organized in 1946, when the divisional structure was established within the APA. Its early years reflected its roots in personnel and guidance and in vocational psychology. At that time, counseling psychology was primarily centered in academic departments, in college and university counseling center practice, and in the education and training of those who would pursue similar careers. There was also early interest in the training of school counselors. The focus was on applications that were educational, developmental, and preventive (Gelso & Fretz, 1992; Whiteley, 1980). Over time, however, particularly with the expansion of psychology into the community and the burgeoning employment opportunities in the private sector for psychotherapists in the 1970s, the boundaries of counseling psychology began to incorporate wider ranges of applied activities. Those changes created a need for licensure of psychologists who wanted to be providers of psychological services. With the APA’s urging, state laws began to demand certifiable credentials for both individual psychologists and the doctoral programs that trained them (APA, 1987; Wellner, 1978). Thus, counseling psychology was expanding in size, scope, and focus, as the number of accredited training programs grew and counseling psychology graduates who wanted to be practitioners also increased. The number of graduates was greater than the number of jobs in counseling centers and training programs, and many of the students were interested in various practice settings in the community (Cameron, Galassi, Birk, & Waggener, 1989). At the same time, again at the APA’s urging, insurance reimbursement for psychological services was increasing, providing opportunities for psychologists in independent practice.
The leaders of Division 17 through the 1970s and 1980s were employed primarily by universities, and they were concerned that many counseling psychologists who entered nonacademic practice settings might not be joining or renewing their membership in the division (Huebner & Corazzini, 1984) or might be finding professional homes in other APA divisions (APA Membership Services, personal communication, August 1994). However, because counseling psychology reflects a distinctive perspective (Gelso & Fretz, 1992), many of the counseling psychologists who identified with other groups also continued to identify with the specialty (APA Membership Services, personal communication, August 1994).

Division 17 responded to the expansion of members’ interests by developing a proliferation of committees (e.g., Committee on Women, Committee on Ethnic and Racial Diversity, Committee on Independent Practice) and numerous special interest groups (SIGs). At the same time, the division maintained the established traditional committees (e.g., Education and Training, Fellowship, Membership, Professional Affairs, Program, Scientific Affairs) that reflected divisional and APA interests. By 1990, there were 13 committees and 20 SIGs, with the president monitoring these many groups and their activities while simultaneously attempting to follow (and, in some cases, provide leadership for) developments at the national level. The president made all committee appointments. The activities of the committees varied according to the chairperson, and the involvement of members beyond the chair largely depended on the effectiveness of the chair, who was usually in that position for only 1 year.

The governance of the division had become sprawling and unwieldy, and the ability of the division to be both attentive and responsive to the needs of members and to issues of the association and the field was severely hampered. Presidents of the division, burdened as they were by the organizational structure and the demand to know about and attend to a tremendous range of issues, continued to raise concerns about this structure, about the division’s goals and responsibilities, and about how possible changes in the organization might allow for more rapid and effective responding.

Concerned about the proliferation of committees, the need to increase member involvement, and the need to move out of provincialism (e.g., focus on counseling psychology identity issues), Presidents Naomi Meara (1988-1989) and Michael Patton (1990-1991) engaged in a process of exploration and consideration of mechanisms for improving the functioning of the division. But, the roots of such exploration began much earlier, with President Don Blocher’s appointment in 1981 of Tom Magoon, Lyle Schmidt, and Naomi Meara to an ad hoc Committee on Structure and Function.
Naomi Meara (president, 1988-1989) recalls,

Don [Blocher] was concerned that there were a number of issues, particularly practice issues, on which we were not current because our style was laid back, if not somewhat disorganized, and he thought we could benefit if we looked at how things operated. We quickly became aware of several systemic factors—we were a volunteer organization with no central office, all of our workers were dispersed, and we had high turnover in leadership positions. We thought we needed to look at better internal organization and we needed to recognize our members and highlight their contributions. We made a list of suggestions, and at Don’s invitation we went to the 1981 midyear meeting. Our report led to the development of a handbook, containing the bylaws, which described each officer’s and committee chair’s responsibilities and other matters pertaining to the structure and function of the division. In addition, we suggested having an agenda book in advance of each meeting, an awards ceremony at the business meeting, and so forth. These changes enabled the Executive Board to have more organization and focus at its meetings.

Naomi Meara continues,

When I became president-elect in 1987, I began to revise the Division 17 procedural handbook. It had not been revised since Mary Sue Richardson organized it during Don Blocher’s term. In updating this document, I was struck by the fact that whenever there was an issue, the division appointed a committee, and often it was an ad hoc committee that turned into a standing committee. It became apparent to me that we had three kinds of groups functioning like committees [those associated with annual events (e.g., Awards, Convention Program, Fellowship, Nominations), special groups (e.g., Cultural and Ethnic Diversity, New Professionals, Private Practice, Special Interest Groups, Women), and traditional activities (Education and Training, Professional Affairs, Scientific Affairs) of the division] . . . and it seemed to me at that time that we needed a structure that would better reflect those functions. The other thing I noticed was that everything went through the president! As the organization became larger and more complex and we kept adding more committees, not only did we not have room on the letterhead, no one person could keep track of it, particularly since we were volunteers. So, I felt that we should have an organization with more people on the Executive Committee who knew in depth what these committees and special interest groups were doing.

So, I formed a planning committee, which was a subset of the Executive Committee. We came in early to the 1988 midyear meeting and talked about the different structure and functions of different kinds of committees. It so happened at that midyear meeting, which was held in Washington, DC, that Bruce Fretz, then editor of The Counseling Psychologist (TCP), came to a number of our sessions, and one of the things he said he wanted to attend was the discussion on structure and function. He felt that reorganization was very important, and he made it a high priority when he was president (1991-1992).
Several years before Bruce Fretz’s presidency, the Organizational and Political Issues Group at the Third National Conference for Counseling Psychology (a.k.a., Georgia Conference) recommended establishing “a reorganizational task force to examine structured, representational, and management problems of the division” (Brammer et al., 1988, p. 414). The group also discussed several alternatives to increase the participation of underrepresented and underserved groups in the divisional structure.


> I was beginning to worry about the vibrancy of the division during the time that I was president. My presidential initiative of the regional conferences was an attempt to address some of the same issues that the reorganization targeted. What I saw was that there was only modest opportunity for involvement in the division, mostly along interest lines.

Jim Hurst, who was also a participant at Solomons Island, continues,

> What were the factors that motivated those of us to want to take a look at restructuring? They were the lack of member involvement, the lack of opportunities for involvement, the lack of shared and decentralized responsibility, and the centralization of too much responsibility in the president. I think that the organization that existed 10 years ago was not serving the profession and discipline of counseling psychology like it needed to be. These factors were an impetus for what led to the Solomons Island retreat and the return to a set of values—that was like going back to bedrock.

**FOCUS ON THE ORGANIZATION**

Under President Bruce Fretz (1991-1992), the attention to divisional structure and the challenge to be responsive to the changing needs of counseling psychologists became explicit and focused. Bruce’s midyear meeting began with a brainstorming session to identify themes for the division and its members, action goals to address those themes, potential divisional structures that would allow those goals to be accomplished, and obstacles to effective implementation. He asked the Executive Board members to think about the future, specifically, “What would counseling psychology be like in the next century?” Each person listed three “visions,” which were then taped to the walls of the room. Linda Brooks, at that time a member-at-large, remembers a lot of newsprint around the room, the result of a very productive group looking at its own future. The visions then were grouped and classified. The
themes identified by the board included (a) active involvement in training; (b) definition and implementation of the scientist-practitioner model; (c) attention to diversified roles and diversity among members; (d) professional development; (e) structure and functions of Division 17; and (f) proactive, political, and collegial relations (APA Division 17, 1993, p. 174). According to the minutes of the 1992 midyear meeting,

Many of our desires for the future pertain to being active, intentional, and proactive. . . . As in the past, our history has reflected growth and development. The changing times may necessitate additional strategic planning and goal setting. . . . Finally the discussion touched on power and the ability to control one’s future and destiny. (APA Division 17, 1993, p. 174)

Although this exploration generated energy and enthusiasm for the division’s potential, it also highlighted the frustration and roadblocks each president and board had faced.

As the board moved to a discussion of the implementation phase of long-range planning, it was clear that the most central issues were the structure and function of Division 17, the need for strategic planning, the development of both long-range and action goals, and the establishment of a mission statement. The board concluded that “the action goals may or may not include establishing a different divisional structure to reach those goals” (APA Division 17, 1993, p. 174).

There were various options considered for addressing these issues. These options included an ad hoc committee composed of past division leaders, a committee representing various sectors of the membership, or a subcommittee of the board. Finally, it was decided that these matters were of sufficient import and magnitude that the members of the Executive Board should be the ones responsible for conducting an in-depth evaluation of the future of the division. Consequently, a planning retreat of the entire Executive Board was scheduled for May 1992, at Solomons Island in Maryland. Puncky Heppner and Jean Carter were appointed to serve as the agenda-planning team for the retreat, with Jan Birk (president-elect) carrying the administrative responsibility. This planning retreat began a complicated process that involved extensive work on the part of a number of subsequent presidents and their Executive Boards who shared the responsibility for the implementation of the reorganization plan.

**PLANNING THE RETREAT**

Jean Carter (member-at-large, 1991-1994) recalls,
Puncky and I agreed to undertake the planning of the agenda, and very soon it dawned on us that we had accepted a huge job, as the success of the retreat would depend on the agenda. We began a series of regular phone consultations and, in mid-April, agreed to combine an agenda-planning meeting with the PIPS [Project to Integrate Practice and Science] meeting that was already scheduled for Madison, Wisconsin. We met in the airport in St. Louis and began working even on the plane to Madison. We allowed an extra day for the agenda planning and used every minute of it. We took full advantage of the face-to-face meeting time and spent a full day working, thinking, and talking. While talking through the issues, we realized that the structure would need to change and that it would help the board in its retreat to have something to react to, rather than having to start from scratch. So, we began designing structures, organized in different ways to address different problems. The ideas came quickly, but as we tried to draw the organizational structures—the way the different parts would relate to each other—too often it could not be done. And we knew that if we could not draw it, it would not work so those ideas were discarded.

Following the Madison meeting, many hours were spent developing drafts of potential structures and other materials for the Executive Board’s reactions. Our goals were to provide written materials and other supplies (e.g., portable copy machine) that would enhance productivity.

As Puncky Heppner (secretary, 1990-1993) remembers,

I remember as Jean and I began talking and preparing the agenda for the retreat, it hit us how significant and complex the problems were and subsequently the complexity of planning the retreat. After considerable discussion, it occurred to us that we would have to structure the retreat so as to facilitate discussion of all of the issues within the group, as well as promote creative problem solving to address the complexity and interrelationships within the issues. As we progressed in our planning, it also become clear to us that the problems facing the division could not be handled with minor changes. In contrast, it seemed to us that a major reorganization of the division was needed, but we did not know whether others would agree with what seemed like our radical conclusion. In retrospect, it is kind of funny for the two of us who were barely 40 to even contemplate a reorganization of the magnitude we envisioned as necessary. We were so lucky to have the board we had at that time . . . knowledgeable of the division, cooperative, good-spirited, supportive, and forward looking with a strong desire to make things better, which included a willingness to take some risks. It was a good thing we did not have an outside consultant (as was originally suggested), as the board members really knew the issues, the needs, the problems, history, and the personalities.

CORNERSTONE OF A VISION

In May 1992, the members of the Executive Board (Bruce Fretz, president; Jan Birk, president-elect; Mike Patton, past-president; Puncky Heppner, sec-
retary; Kathy Davis, treasurer; Jo-Ida Hansen, Jim Hurst, and Helen Roehlke, APA council representatives; and Linda Brooks, Jean Carter, and Chris Courtois, members-at-large) arrived at Solomons Island to begin long-range planning for the division. Everything was open to question, and new ideas were to be proposed regarding the structure, function, and operation of the division. A retreat provided the Executive Board with the opportunity to be creative and the time to address issues in depth, a luxury rarely experienced during the annual, regularly scheduled midyear or the APA convention meetings. New and bold ideas were encouraged to be the norm rather than the exception.

Board members started the retreat with different ideas about what was to occur and what the outcome might be. Chris Courtois remembers having been frustrated with the general conservatism of the Executive Board for a number of years, but she felt these board members realized things needed to change. The recognition and acceptance of divisional reorganization as the outcome occurred at different times for each participant. Jim Hurst was looking for a paradigm shift and admitted to sometimes feeling impatient with the slow progress. Mike Patton recalls originally thinking that the focus of the retreat was to be on strategic planning but realizing, by the 2nd day, that the agenda had become a reorganization of the whole division. Jo-Ida Hansen, who frequently admits to disliking change, was worried that the elimination of numerous committees would result in fewer opportunities for members to contribute their energies to the division. As a result, she questioned how some of the more radical changes would be implemented and the impact the changes would have on the membership-at-large. Even Bruce Fretz, whose ideas began this process, did not fully realize the extent of what had been accomplished until after returning home. So, what happened at Solomons Island that fostered such sweeping changes?

After gathering on Saturday afternoon, the hard work began with a discussion of the definition of counseling psychology, work on a mission statement for the division, the problems and needs of members, and the functions implied by the mission statement and member needs. Several major themes emerged: (a) how to generate more interest in the division and opportunities for involvement by people from various work settings and ethnic, gender, and racial groups; (b) how to enhance the division’s ability to be more responsive and more proactive in the field, profession, and in APA; and (c) how to facilitate the organization’s administrative functioning. The group quickly realized that the current organization of the division did not provide an effective structure and by Sunday morning was already prepared to move into small groups to develop potential structures for the division.

The openness and willingness of all members to explore alternatives and engage in constructive criticism led to a cohesiveness that would be difficult
to emulate. One thing that stands out for Helen Roehlke was the working spirit of the group; it was “a shared venture...a meeting of the minds.” However, that does not mean there was agreement on everything. For example, Linda Brooks remembers being disgruntled that the board was spending so much time on the details of reorganization and had not specifically identified the goals or mission. Although the agreed upon values were reflected in the reorganization plans, there was no clear picture of where we were going in the whole process. To contribute collaboratively and reduce her concerns, Linda volunteered to take the major responsibility for summarizing the themes, issues, and goals and for writing a mission statement.

As Jim Hurst remembers,

I cannot remember anyone there who was casting cold water on ideas that emerged.... Steps were taken to release ourselves from the burden of our past structures...to free ourselves from how we had done things for so many years and to envision what we wanted to happen in the future. I think that Bruce set the parameters that way, and then, very frankly, the group worked together superbly. There was a combination of thinkers there, ranging from those who were able to articulate the vision, those who were able to restate and summarize these visions, and those who were able to provide a foundation of reality. ... My own view is that there was an excellent chemistry that emerged. The membership of the division deserves credit for selecting those who provided leadership for these transitions.

All 11 people present at the Solomons Island retreat shared the essential values and goals for the division; however, several concerns were raised. One was that officers in the division needed support for professional services, such as copying, typing, and mailing. Individuals in independent practice were typically disadvantaged in this regard, and in addition, such support was becoming increasingly limited for those in academic and other organizational settings. Thus, to facilitate the involvement by a wider range of members, the board considered the need to provide secretarial assistance for officers. Engaging a professional executive office to perform a variety of necessary functions for the division was one of the options explored.

Another concern focused on how to enable the division to become more proactive in policy development both in the profession and in APA. One option discussed was to expand the responsibilities and duties of the members-at-large. Although assigned by the president to significant projects from time to time, and often consulted about matters of policy, the duties of the members-at-large were not as well-defined as those of the other Executive Board members. This sometimes led to differences in expectations about responsibilities and contributions to the functioning of the division. Another hindrance to proactive policy development and communication was that
committee chairs were appointed to their positions for 1 year, so there was an annual turnover in Division 17 representation and communication with the major APA boards and committees (e.g., Education and Training Board, Board of Scientific Affairs, Board of Professional Affairs) and thus a lack of continuity in divisional plans and projects in these important areas. So, the members-at-large who could provide continuity were not involved in a hands-on manner in important activities, and those who were involved (i.e., the committee chairs) served for a short time and often were not present during Executive Board deliberations. Thus, it became clear that the organization of the division at that time did not provide a structure that was conducive to long-range planning, coherent leadership, or a proactive agenda.

After the 1st day, Jean Carter and Puncky Heppner evaluated what had happened and what was decided and established a structure for the 2nd day. In midmorning, the board members were asked to break into three work groups identified by Puncky and Jean. Each group was charged with developing a tentative organizational mode—including a written organizational plan and the underlying assumptions or values that were used to develop the proposed structure to facilitate attaining the goals that had been discussed.

Each group came back to the meeting room with different, but not entirely dissimilar, plans for restructuring the division. Each plan was presented and discussed; then the board broke for lunch with an assignment: “Think about the implications of each group’s proposal. Use this time to reflect and feel; try to see proposals from different perspectives.”

Questions were raised about each of the proposals; most of the questions reflected concerns about how the goals that had been identified earlier in the process would be met within a specific structure or entity in the reorganization plan. For example, a recurrent value was the importance of having greater opportunity for suggestions and actions generated from the members, as well as enhanced ability for the Executive Board to initiate action. There was concern that the division had been merely responding in a reactive and top-down manner to the initiatives of APA instead of representing the membership and implementing what they would like to have happen. To ensure that both top-down and bottom-up strategies were included in division governance, Mike Patton suggested semiautonomous sections for the division (see Appendix B).

The creation of four vice presidents, corresponding to the directorates in APA, was an attempt to reduce the workload for the president and empower more individuals to initiate actions relevant to the promotion of the counseling psychology agenda. These vice presidents, with their expertise in one of the four areas (professional practice, science, education and training, public interest and diversity), would be in a better position to evaluate proposals and
make recommendations about policies and procedures. Their activities would enhance the proactive involvement of counseling psychology. The domain titles of the vice presidents were thought through very carefully, with an eye toward creating positions that would adequately capture the spirit of counseling psychology. Thus, it was important to the board to include the notion of both public interest and diversity, to embrace both education and training, and to not limit practice to independent practice but to include the entire professional practice arena.

The goals of open participation and shared governance, as well as the capacity of the division to engage in significant action on behalf of counseling psychology in a targeted and timely way, received careful attention and consumed a great deal of the board’s time and energy. The result of this effort was a mixture of board-initiated and member-initiated groups, with varying degrees of autonomy, responsibility, and “shelf life.” The combination of member groups (i.e., sections and SIGs) and board-appointed groups (i.e., special task groups [STGs], advisory councils, and administrative committees) was intended to provide flexibility in the division’s capacity to respond and initiate. The final reorganizational chart reflects these intentions (see Appendix A).

The board left Solomons Island with a concept and an outline of a new structure for the division. Chris Courtois remembers, there was also “a strong consensus that we would go about restructuring in a very systematic way and that we would do quite a bit to keep the entire membership informed as to our rationale, plan, timetable, et cetera.” The next steps would entail having the membership review the proposed structure, suggest necessary changes, support the final consensus, and then engage in the process of implementing it. The board members were hopeful that the rest of the membership would come to the same conclusions that they had: Things had to change within the division for it to remain a vital and contributing organization within the profession of psychology in general and within counseling psychology in particular.

ESTABLISHMENT AND REFINEMENT OF A CONCEPT

The results of the June 1992 Executive Board elections ensured some continuity and some “new blood.” Linda Brooks and Jo-Ida Hansen returned to the Executive Board as the newly elected treasurer and president-elect, respectively. Lucia Gilbert, council representative, and Jim Spivack, member-at-large, added different perspectives that were independent of those discussed at Solomons Island.
In the fall, a special mailing describing the reorganization plan was sent to the members. President Jan Birk asked for and received comments and reactions to the proposed plan from approximately 50 members. Jan remembers that most were positive and supportive of the Executive Board’s work. Other members asked penetrating questions and offered suggestions. This feedback from the members was used to revise the original proposal during the midyear meeting. To provide the time necessary to adequately address the multitude of issues presented by the proposed reorganization before taking it to the membership for a vote, President Birk extended the midyear meeting by 1 day.

Looking back, Jan Birk (president, 1992-1993) recalls that the process of putting the plan to paper required an incredible amount of time and work by the members of the Executive Board(s) and they went through the process admirably—in a style marked by utmost collaboration and equanimity. When you consider the stress we were under to develop the plan, solicit members’ input, fine tune the plan, and then effect approval of the relevant bylaw changes, it was to everyone’s credit that our friendships not only endured but solidified.

The following mission statement was printed in the Spring 1993 issue of the Division 17 Newsletter. The points in the Statement reflect the values shared at Solomons Island that gave form to the reorganization plan.

**MISSION STATEMENT OF DIVISION 17**

The Division of Counseling Psychology (17) of the American Psychological Association is an organization that promotes the science and practice of counseling psychology through a broad array of professional goals and activities. Specifically, the mission of the Division is to:

- Continue to define and promote the specialty of counseling psychology as the science and profession of psychology evolve and social issues change.
- Bring together psychologists who specialize and/or have an interest in counseling psychology.
- Advocate for counseling psychology within the field of psychology and in the public sphere, and provide leadership in all issues pertaining to the well-being and growth of counseling psychology.
- Support, encourage, and promote diversity of member characteristics, work settings, roles and activities.
- Promote the integration of science and practice and further evaluative, scientific, and applied activities in counseling psychology.
- Define, promote, and support the education and training of counseling psychologists throughout the professional life span.
- Establish and maintain standards of professional service offered by counseling psychologists.
- Promote the application of counseling psychology in the public interest. ("Mission Statement," 1993, p. 1)

In addition, the newsletter ("Position Descriptions," 1993) contained position descriptions for the newly created vice presidents; definitions and guidelines for sections, SIGs, and STGs; and the proposed changes to the bylaws. The bylaws were to be voted on at the division’s business meeting during the next APA convention. In May 1993, a subcommittee of the Executive Board (Jan Birk, Jean Carter, Bruce Fretz, Jim Spivack, and Jo-Ida Hansen) met in Washington, D.C., to craft the proposal, which would be voted on at the annual business meeting in Toronto. In addition, the subcommittee discussed possible scenarios of the transition process if the membership voted to go forward with the reorganization. All committee chairs and chair-designates were contacted for their assessment of the future of their committees, including timelines for completion of tasks and sunsetting for transformation into sections. Some committee chairs were uncertain as to how the new structure would affect their committee and naturally were reluctant to commit to such a drastic and unpredictable change. It took a lot of time and effort on the part of President-elect Jo-Ida Hansen to persuade some committee chairs or chair-designates to develop a preparatory plan if reorganization were approved; however, as usual, in the end, everyone engaged in the difficult work at hand. A number of committees thought they could transfer their functions very quickly, whereas others thought it would take 2 years to make the transition.

To facilitate understanding among the members attending the division’s business meeting at the 1993 APA convention in Toronto, the Executive Board held an open meeting at which a few of the board members made short presentations about the reorganization and answered questions. This meeting was well attended, and excellent questions were posed and answered. Many concerns were related to how the new structure would respond to the issues identified by the Executive Board: more inclusiveness and involvement of counseling psychologists, greater receptivity and implementation of members’ views and ideas, and more promotion of a proactive agenda.

At the business meeting, the proposed bylaw changes necessary to begin the transition to the new structure received almost unanimous approval by the membership. The lone negative voter stated that she voted against the new structure, not because she had any strong objections, but because she did not think anything this important should be passed unanimously.
TRANSITION FOR CHANGE

The Executive Board now had the mandate to begin the arduous work of implementing the new structure. Not many on the board realized the amount of time, planning, and creative problem solving such a transition would require. The new president, Jo-Ida Hansen, was ideal for the job, as she is a very organized and detailed-oriented person—exactly what was needed at this stage.

She recalls, “The huge task of implementation was very difficult, and it matched what I expected. At the same time, I really appreciated the members’ ability to transcend personal agendas and compromise for the good of the division.”

As Jo-Ida wrote in her fall President’s column (Hansen, 1993), “The two most dramatic changes, perhaps, include (a) the expansion of our member-at-large positions from three to four and their conversion to vice presidents, and (b) the creation of Sections for the Division” (p. 1). Fortunately, in the 1991, 1992, and 1993 elections, the membership, in its wisdom, had elected three members-at-large who had definite interests and expertise in three of the four vice presidential areas: Rosie Bingham became vice president for diversity and public interest; Jean Carter, vice president for professional practice; and Jim Spivack, vice president for education and training. What to do about the fourth vice president?

Because the necessary bylaw changes for the reorganization had not been approved by the membership prior to the election of new officers (which occurs routinely in the late spring), no slate for vice president for science had been presented to the members. As a result, there was no one elected to assume this key position after the reorganization plan was approved in August 1993. At the same time, many scientists were feeling disenfranchised and ignored by APA and had diverted their energies and professional affiliations to the American Psychology Society. The Executive Board thought it was crucial that the division retain its scientific base if we were to maintain our identity as a scientist-practitioner specialty. A number of members who had made numerous scholarly contributions were identified, and it was decided that Jo-Ida Hansen would first ask Mike Patton to be the vice president for scientific affairs. He agreed to serve, but there was a conflict with the Division’s Bylaws, which allow past presidents only to be elected and serve as a representative to APA Council. After consulting with the APA legal counsel, it was decided that Mike would be able to act in the capacity of vice president for scientific affairs if he were called coordinator of the science vice presidency. An election for the newly created position of vice president for
scientific affairs would occur the following spring; however, it was critical to have someone in the position during this 1st year of transition.

Using the new structure, Jo-Ida Hansen created 13 STGs, usually composed of three members of the Executive Board. These STGs were to help address the transition and promote the underlying values in the mission statement. Examples of the STGs were the Finance Committee Proposal STG (to consider a new committee in the structure), the Membership Categories Proposal STG (to examine the possibility of including people as division members who are not members of APA), the Fellowship Criteria Proposal STG (to develop new criteria that were more inclusive of the membership, not only the scientists who published), and a number of STGs labeled Section-Formation Working Groups. These latter STGs included, but were not limited to, Section Finances, Section Membership, Section Organizational/Governance Structure, Section Division Support/Privileges, and Section Project Autonomy. Every board member was on at least 2 STGs, and some members were on more.

In accordance with the new structure and the goal to have more involvement by members in the functions of the division, each of the vice presidents was to have an advisory council. So, the new vice presidents, including the coordinator of the science vice presidency, were asked to submit names for the three positions on their advisory councils.

In January 1994, four agenda books arrived at every board member’s office or home along with a very detailed timeline for the 4 days (half days on Thursday and Sunday) of the midyear meeting in Tampa. Everyone there remembers certain highlights of the meeting, including the long hours for meetings, the unbelievable amount of work accomplished, the imperative break in the middle of the day for recuperation, Jo-Ida Hansen losing her voice, the late dinners, and Jean Carter’s cookies. Others recall extensive discussions about specific issues. The two biggest organizational changes—vice presidents and sections—required the most discussion, planning, and problem solving. And not surprisingly, the issues were autonomy, responsibility, and accountability.

There was considerable intense debate about the vice presidents’ roles and the extent to which they should operate autonomously in their areas of expertise versus having the president or board sign off on their activities. Related to this debate was a potential change in budgeting; should or could the vice presidents be given discretionary budgets to better enable them to provide a strong voice for counseling psychology and to respond rapidly in initiating projects or attending important meetings or conferences? It was decided to provide each vice president a budget. However, issues related to autonomy continued to develop and to be debated.
There was a long discussion about section autonomy. Most board members wanted to give the sections as much autonomy as possible, whereas some voiced the fear that without sufficient restrictions and accountability, the sections could cause legal difficulties for the division. The results of these discussions and the STG reports and decisions related to sections were compiled by Linda Forrest and Mike Patton and presented as “Guidelines for the Governance and Operation of Sections” (also known as Section Guidelines) at the next Executive Board meeting at the APA convention. By the 1994 convention, 6 months later, the board had the fifth draft of these guidelines. After Mike Patton’s 1-year term as the science coordinator ended, Linda Forrest was given major responsibility for compiling the Section Guidelines. Little did anyone know that there would be seven additional drafts before the guidelines were sent to the APA legal counsel for review in April 1995. Some of the impetus for the multiple drafts arose out of a need for very detailed information on how to form a section or SIG, how a section or SIG would govern itself, and how each would relate to the division. Although the general guidelines in the newsletter (“President’s Column,” 1993) were followed, each revision of the Section Guidelines raised a number of questions or issues that then had to be clarified and made consistent with other parts of the guidelines. The Section Guidelines were finally renamed “Rules and Procedures for the Formation, Governance, and Operation of Sections” following the advice of APA legal counsel in 1995.

Also at the 1994 midyear meeting, a discussion ensued that led to a minor change from the original reorganization plan; rather than selecting one of the four vice presidents for administrative reporting and information exchange purposes, sections would report to the Executive Board. This change came as a response to concerns raised by the groups that were asking to become sections. To them, reporting to only one vice president implied that they “belonged” in that area, and many viewed their roles and goals to be congruent with more than one vice president’s area. Although the intent had been an administrative line only, a change was needed. This, of course, required yet another change in the Section Guidelines.

Some of the standing committees were to be sunsetted at the 1994 APA convention in August, 1 year after passage of the reorganization plan, and they were eager to become sections or at least operate as sections-in-formation during the following year. Already, as of February 1994 at the midyear meeting, three groups had their petitions approved to become sections-in-formation. Two (Lesbian, Gay and Bisexual Awareness and Women) had been standing committees, and one (Health) was a newly developed group. Two others (Independent Practice, a former standing committee, and Vocational Behavior and Career Development, a former SIG) were granted status
as sections-in-formation at the convention meeting. At the following midyear meeting in January 1995, another standing committee, Ethnic and Racial Diversity, was granted section-in-formation status.

Despite the initial apparent success, there were many complex issues and details to address as both the board and the members attempted to work with the new structure. There were misunderstandings. One committee thought it was to be sunned in 2 years rather than 1. One section-in-formation realized that it was going to take the board a very long time to develop the Section Guidelines and decided to wait until the final version was approved before continuing its progress toward “sectionhood.” Another section-in-formation submitted bylaws that had to be revised a number of times to reflect each new change in the Section Guidelines. Some SIGs under the old structure were uncertain as to whether to remain a SIG or become a section (see Appendix B for a description of sections and SIGs). The advantages and differences in functions were not clearly understood or consistent; complete and definitive information was difficult to obtain. It was a learning and, at times, a frustrating process for many people in the division.

The Guidelines for Special Interest Groups were similar to the Section Guidelines and were developed primarily after the multiple revisions of the Section Guidelines. Many of the SIGs in the old structure wished to remain SIGs in the new.

Sections and SIGs also could have conventions or workshops to increase members’ awareness of new developments or emerging issues in the field. The procedures and guidelines for the development and promotion of conferences and workshops were described in yet another document, Guidelines for Regional Workshops and Conferences.

At the August 1995 outgoing meeting of the Executive Board, the May 19, 1995 version of the Rules and Procedures for the Formation, Governance, and Operation of Sections was approved. At the same meeting, the Guidelines for Division 17 Conferences and Regional Workshops (dated February 1995) were approved. The Rules and Procedures for the Formation, Operation, and Governance of Special Interest Groups were approved at the 1996 midyear meeting the following February.

In addition to creating various rules and procedure documents, the Division 17 bylaws needed to be revised to reflect all the changes associated with reorganization and other changes directed toward having more members involved in contributing to the functioning of the division. Not only did the board need to be aware of the major changes needed to accurately describe changes in procedures and positions (officers, committees and their chairs, etc.), but the bylaws had to be in compliance with the Association’s Bylaws and Rules. During 1993 to 1995, as the board was working on changes in the
division’s bylaws, the APA was proposing changes in the Association’s Bylaws, many of which affected divisions. Although divisions were being given more autonomy, they were required to be more accountable for compliance with APA Bylaws, Association Rules, and current policies (e.g., DeLeon, 1996).

THE NEW STRUCTURE TAKES OFF

In August 1994, Jean Carter (professional practice) and Jim Lichtenberg (scientific affairs) became the first two counseling psychologists officially elected as vice presidents in Division 17. Consistent with all terms of office for the Executive Board, each vice president would serve for 3 years. Jim Spivack and Rosie Bingham, originally elected members-at-large, remained as vice presidents of education and training and diversity and public interest, respectively. By now, the president was relying on the vice presidents for their expertise and knowledge of issues that potentially could affect counseling psychologists. The vice presidents initiated projects and responded to requests from the president as well as the APA Directorates. In addition, the vice presidents were working together on issues that crossed areas (e.g., postdoctoral accreditation, specialization, prescription privileges, and violence in society). The division was able to respond more appropriately and quickly to issues and requests from a number of organizations, including APA.

The Executive Board that met for the 1995 midyear meeting had four members who had been at Solomons Island (Kathy Davis, president; Jo-Ida Hansen, past president; Linda Brooks, treasurer; and Jean Carter, vice president for professional practice), six members who had been working on the details of reorganization for 18 months or more (Linda Forrest, secretary; Rosie Bingham, vice president for diversity and public interest; Jim Spivack, vice president for education and training; John Alcorn, Lucia Gilbert, and Melba Vasquez, APA council representatives), and two who were propelled into the process at the 1994 convention (Dorothy Nevill, president-elect, and Jim Lichtenberg, vice president for scientific affairs). Although committed to completing the reorganization, the details involved in doing so were formidable and time consuming. Because reorganization had consumed the lives of many board members for a long time, most members were eager to address other issues affecting the specialty.

Kathy Davis began the midyear meeting with yet another strategic planning session; this time the purpose was to (a) identify the opportunities and threats the division needed to address in the next decade, (b) determine if and how the reorganization was helping the division attain its goals and purposes,
and (c) reinvigorate the group and regain some energy for the final push while reminding the board of the initial reasons for reorganization. The bylaws were to be revised, sent to APA legal counsel for review, and voted on by the membership at the annual business meeting during the 1995 APA convention.

In addition to the changes associated with reorganization, a new membership category, “Professional Affiliate,” was being proposed for those who identified themselves as counseling psychologists or were affiliated with the specialty but who were not members of APA. There were differing views on the potential benefits and losses associated with this new membership category. Some expressed the concern that if a large number of current members chose to drop their APA memberships and become Professional Affiliates, it could affect the division’s representation in the APA Council, as only APA members are mailed ballots to allocate seats on the Council of Representatives. Others thought that some distinguished members were considering dropping or had dropped their APA memberships and the Professional Affiliate category would provide a means to keep these people and others involved in the division. The new membership category was included in the proposed changes to the bylaws that would require a vote of the membership at the 1995 annual convention.

Six groups had been recognized as sections-in-formation. Their bylaws had to be reviewed for consistency with the division’s Rules and Procedures for the Formation, Governance, and Operation of Sections and then given section status by the board members.

At the 1995 Executive Board meetings at the APA convention in New York, bylaws from three sections-in-formation (Health; Lesbian, Gay and Bisexual Awareness; and Women) were approved. In addition, the Section on Women became the first section in the division. After 3 years, the division finally had one of the new structures for greater member involvement that was conceived and conceptualized at Solomons Island.

Another momentous occasion at that convention was the passage of the new Division 17 bylaws. After the years of work, members of the Executive Board were apprehensive that there were so many changes in the bylaws that the membership would not accept all of the changes at once. Contingency plans had been developed. People in the audience attending the business meeting said a collective expression of relief and disbelief crossed the faces of all the officers on the podium when the revisions were approved without dissent or comment.

The reorganization of Division 17 was in place, and all phases were being implemented. Sarah Jordan of the APA Division Services Office is reputed to have said that Division 17 was a model in how to implement the restructuring
of a division in APA, and several other divisions have studied our process and outcome as they consider reorganization.

Kathy Davis (1994-1995 president) said,

The things that impressed me the most were the hard work and amount of time and energy expended as well as the dedication and commitment to the project.

The number of people involved in the reorganization was huge. Not only were the Executive Board members during four or five administrations involved, but there were all the members of the section steering committees who wrote their bylaws and coordinated the elections of officers, the SIG coordinators who verified names on petitions or proposed membership lists, APA legal counsel who reviewed division and section guidelines and bylaws, and so on. We involved a lot of people!

INTO THE FUTURE

Although the reorganization did not, and will not, prevent or solve all issues in Division 17, we think the membership and its leaders are addressing and meeting most of the goals identified at Solomons Island. We believe there now exist a structure and means for those who wish to become involved in Division 17 to do so. The importance of having an active and involved membership cannot be overstated. Counseling psychologists need an organization that will attempt to represent all facets and the vast majority of the members of the profession. As a profession, counseling psychologists cannot afford to be fractionated on the bases of work settings, activities, or interests; the total membership provides the direction and driving force of the new professional and its organization, Division 17.


At the Executive Board meeting in Toronto [1996], I sat there and watched Dorothy Nevill and then Jerry Stone, and I thought, “Holy Toledo!”—the luxury of their being able to turn to a vice president for a report and the productivity that emerged under the vice-president’s leadership was marvelous. The new structure may not be perfect, but given my perspective from 1988, the reorganization is as an enormous improvement in all of the ways that we hoped—with involvement, with attention in various areas, the scientist-practitioner model, diversity, and the involvement along each of those lines, and the sections, STGs, and the SIGs. There is no way that the reorganization has solved all the problems, but it is taking us in the direction to solve them. It provides us with a structure, a vehicle by which we can address them more effectively. When counseling psychologists get together, we are far more inclined to work together cooperatively and productively.
After the 1997 APA convention in Chicago, Helen Roehlke (1991-1994 council representative) reported,

I think that we were no longer waiting to see the fruits of our labor; we were actually beginning to see things happen. I felt really excited because it seemed that we were able to determine that we had, in fact, addressed the issues that concerned us at Solomons Island. The thing that was the most exciting aspect for me, in addition to doing a much better job of recognizing and attending to the needs of the various subpopulations in the division, was that we were actually providing opportunities for people to become involved in the division governance at a much earlier point in their careers. Now there seem to be many more people to share the responsibilities and the work [of the division]. The other thing that has resulted, even though I am not sure we necessarily foresaw that this would be such an important outcome, is our becoming involved and forming liaisons with so many different relevant groups. I think that we have made huge strides in terms of where and how our influence is felt.

As Division 17 embarks on its second 50 years as a division of the APA, its organization, its leadership, and its members have just engaged in a process that reflects what counseling psychology symbolizes. The essence of counseling psychology is to strive for the health of its organization, its members, and the specialty; to address appropriately issues related to the development of the organization and the specialty; to attend to the diversity and the changes in the needs of the many individuals and groups that constitute the division; and to address proactively the interaction between the specialty and the field of psychology, the APA, and society.
APPENDIX A
1995 Organizational Structure of the Division of Counseling Psychology (17)

APPENDIX B
Sections and Special Interest Groups

Definitions and purpose of sections and relationship of special interest groups to Division 17 as stated in the Division 17 bylaws found in the Division 17 Officers Handbook, revised 1996.

Sections

*Definitions and purpose.* Sections may be established by the Executive Board provided that (a) they represent an active and functionally unitary interest of a large group of members (at least 50 voting members of the division); (b) their proposed purposes and objectives are consistent with the purposes and objectives of the division and American Psychological Association (APA); (c) they are formed with administrative structures subject to Executive Board oversight and control; (d) they operate in a manner consistent with applicable APA Bylaws and Rules and Division 17 Bylaws and Rules and Procedures; and (e) the establishment of any new section is not inimical to the welfare of APA, the division, or any division section already established. Sections are organized to represent and further the educational, scientific, professional, and public interest goals of division members. The division’s Executive Board may dissolve or issue sanctions against a section for cause by a two thirds vote following an appropriate hearing. Procedures governing division sections are established by division Executive Board.

Special Interest Groups (SIGs)

*Relationships of SIGs to Division 17.* The basic purpose of SIGs is to promote and maintain forums for open, regular communication among professionals sharing an interest in a particular area of relevance to the field of counseling psychology. Groups are created and dissolved as particular interests increase or decrease in importance to the membership of the division, in keeping with the larger mission of the division and the interests of the members.
APPENDIX C
Significant Events in Reorganizing the Division

The Prelude: Presidential Initiatives

August 1980  Don Blocher appoints the ad hoc Committee on Structure and Function
Fall 1984  Lyle Schmidt reappoints ad hoc Committee on Structure and Function
April 1987  George Gazda’s presidential project, Third National Conference for Counseling Psychology (the Georgia Conference)
1987-1988  Jim Hurst organizes Division 17 Regional Conferences
January 1989  Naomi Meara develops proposal for structure and function of committees
January 1991  Mike Patton appoints subcommittee to study structure of committees

The Reorganization: Formal Actions

January 1992  Bruce Fretz proposes an Executive Board retreat to discuss long-range planning and possible changes in the structure and function of the division
May 1992  Solomons Island Retreat—Executive Board develops a formal proposal for reorganization
October 1992  Jan Birk presents Solomons Island proposal in Division 17 Newsletter and asks for reactions and suggestions from members
January 1993  Midyear Executive Board meeting and revision of Solomons Island proposal
May 1993  Subcommittee of Executive Board meets to develop reorganization proposal with accompanying bylaw changes
August 1993  Divisional membership approves proposed structure and bylaw changes
February 1994  Jo-Ida Hansen’s midyear meeting with 13 special task groups and five petitions for sections-in-formation
August 1994  First vice president of professional practice and vice president for scientific affairs are elected
February 1995  Section Guidelines are revised and new bylaw changes are discussed
August 1995  Bylaw changes are approved by the membership, the first section (Women) is recognized, and the first vice president for education and training is elected to that office
February 1996  Two sections (Health and Lesbian, Gay and Bisexual Awareness) are recognized
August 1996  First vice president for diversity and public interest is elected to the office, and six sections give annual reports

REFERENCES


President’s column. (1993, Spring). *Division 17 Newsletter, 14*.


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gration of psychology and theology; and therapeutic change. He is author of a book titled *Overcoming Unintentional Racism in Counseling and Therapy: A Practitioner’s Guide to Intentional Intervention* (Sage, 1995).

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**Derald Wing Sue** is professor of psychology and education at Teachers College, Columbia University. He was the cofounder and first president of the Asian American Psychological Association and has served as president of the Society for the Psychological Study of Ethnic Minority Issues (Division 45 of the American Psychological Association). His work in the development of multicultural counseling competencies has had widespread influence on the counseling and mental health professions. In addition to numerous publications in journals, he has coauthored three widely used texts in the field: *Counseling the Culturally Different: Theory and Practice* (1999) (3rd ed.), *Counseling American Minorities: A Cross Cultural Perspective* (1998) (5th ed.), and *Multicultural Counseling Competencies: Individual and Organizational Development* (1998). His most recent project, *You Are a Racist: The Painful Journey to Understanding and Combating Racism*, is a new book on the deconstruction of Whiteness.

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Division 17 Membership Chair
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For further information about the Student Affiliate Group (SAG), contact:

SAG
5100 Rockhill Road
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University of Missouri-Kansas City
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(816) 235-2494 or sagjumk.edu
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MISSION

Counseling Psychology as a psychological specialty facilitates personal and interpersonal functioning across the life span with a focus on emotional, social, vocational, educational, health-related, developmental, and organizational concerns.

The specialty focuses on typical, atypical, and dysfunctional development, encompassing individual, family, group systems, and organizational perspectives.

By integrating theory, research, and practice, and with the awareness and skills to work with diverse populations, this specialty includes a broad range of practices that help people improve their well-being, alleviate distress and maladjustment, resolve crises, and increase their ability to function productively.

Counseling psychology uniquely encompasses normal developmental issues and problems associated with physical, emotional, and mental disorders.

PURPOSE

Division 17 brings together psychologists, students, and professional affiliates who are dedicated to promoting education and training, scientific investigation, ethics, diversity, and public interest in professional psychology.

We support, encourage, and promote our members and celebrate our diversity. Division 17 strives to meet the interests of its members through Sections and Special Interest Groups (SIGs).

Sections (formal groups):
- Independent Practice
- Advancement of Women
- Society for Vocational Psychology
- Lesbian, Gay, and Bisexual Awareness
- Racial and Ethnic Diversity
- Prevention

SIGs (informal groups):
- Aging and Adult Development
- Children and Adolescents
- College Counseling Centers
- Supervision and Training
- Couples and Families
- Hypnosis
- Impaired Psychologists
- Group Counseling
- Men, Masculinity, and Men’s Studies
- Organizational Counseling Psychology
- Teaching and Research in Qualitative Methods

BENEFITS

- Six issues annually of The Counseling Psychologist covering important theoretical, scientific, and professional issues, and the business proceedings of Division 17.
- Three issues of the Division 17 Newsletter with information about Division activities.
- Participation in the Division 17 program, hospitality suite, and social hours at the annual APA convention.
- Collaboration with others interested in Counseling Psychology.
- Access to the Division 17 listserv to exchange information and ideas.
- Involvement in Sections or SIGs.
- Advocacy efforts for Counseling Psychology within the field of psychology and the public sector.
- Division committee service.
- Division awards.

MEMBERSHIP

Membership is open to anyone whose interests and activities support the scientific or professional advancement of Counseling Psychology and who meets at least one of the following requirements:

- Members and Associates must hold comparable APA membership.
- Professional Affiliates (PAs) are psychologists or professionals in related disciplines who are not APA members. PAs may not vote or hold office in the Division but may belong to Sections and SIGs.
- Student Affiliates (SAs) must be enrolled in a counseling psychology program. SAs may not vote on Division-wide issues or hold Division offices but may belong to Sections and SIGs. SAs also receive three issues of the Student Affiliate Group (SAG) Newsletter and may participate fully in SAG governance.

For further information, check: www.div17.org