HANDBOOK OF RACIAL-CULTURAL PSYCHOLOGY AND COUNSELING

Training and Practice

Volume Two

Edited by

ROBERT T. CARTER

John Wiley & Sons, Inc.

HANDBOOK OF RACIAL-CULTURAL PSYCHOLOGY AND COUNSELING

HANDBOOK OF RACIAL-CULTURAL PSYCHOLOGY AND COUNSELING

Training and Practice

Volume Two

Edited by

ROBERT T. CARTER

John Wiley & Sons, Inc.

This book is printed on acid-free paper. ♾

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.
Published simultaneously in Canada.

Library of Congress Cataloging-in-Publication Data:

Handbook of racial-cultural psychology and counseling : theory and research, volume 2 / edited by Robert T. Carter.
p. cm.
Includes bibliographical references.
ISBN 0-471-38628-6 (cloth : v. 1) — ISBN 0-471-38629-4 (cloth : v. 2) —
ISBN 0-471-65625-9 (set)
1. Psychiatry, Transcultural—Handbooks, manuals, etc. 2. Psychology—Cross-cultural studies—Handbooks, manuals, etc. 3. Cross-cultural counseling—Handbooks, manuals, etc.
I. Carter, Robert T., 1948–
RC455.4E8H368 2004
616.59—dc22

2004042222

Printed in the United States of America.

10 9 8 7 6 5 4 3 2 1

Contents

A Cultural-Historical Model for Understanding Racial-Cultural Competence and Confronting Dynamic Cultural Conflicts: An Introduction

As discussed in the Introduction to Volume One, Jennifer Simon, who was at Wiley at the time, was instrumental in convincing me to edit the two-volume reference *Handbook on Racial-Cultural Psychology and Counseling*. I agreed to take the project through her persistence and encouragement. She prompted me to think about what type of material would help advance the field and at the same time build on existing research and scholarship. It was also her belief that conceptual and research issues combined into one volume with training and practice would not be practical. More important, as we discussed the project, it seemed unwise to try to combine what might be a large body of scholarship into one volume. So, reluctantly, I agreed to think in terms of two volumes for the *Handbook,* one that focused on critical and core concepts and research findings and one devoted to practice and training in racial-cultural counseling and psychology. The task of editing a collection of scholarship is demanding. Yet the complexity of putting together a two-volume reference handbook was beyond what I might have imagined. The *Handbook* is a reflection of the patience and commitment of the contributors and the editorial assistants who helped keep things organized.

During my conversation with Jennifer Simon I became convinced that what was needed in the field was a collection of scholarship that met two important goals. One goal was for the material to go beyond the typical emphasis on "minorities" as the focus for cultural knowledge, mental health interventions, and training. The other goal was to use a conceptual framework for the *Handbook* that was distinctive and important.

DEFINING TERMS: WHY A RACIAL-CULTURAL FOCUS?

In the Introduction to Volume One, I explain how I came to think in terms of racial-cultural as a conceptual framework and how come I use that perspective as opposed to the conceptual framework reflected in the popular terms "multicultural"

and "cultural diversity." I contend that such broad terms are useful only if one intends to address a range of differing and distinct reference group memberships as equally important (i.e., gender, ethnicity, sexual orientation, region, social class). Because so much is included in such broad concepts and frameworks it is hard to know what the specific cultural reference is; moreover, it becomes possible to argue for greater and greater inclusiveness until the meaning and use of the term become lost and one is unable to guide training or practice. An example offered by Alderfer (2000) stands out in my mind. In a discussion on how language about race relations has been altered in organizations and political discourse, he makes an important observation about the use of the term "diversity." Noting that the term was introduced to affirm group differences, he proceeds:

> As time has passed, however, the practical meaning of [multicultural or cultural] diversity has become increasingly diffuse. It no longer stands for a variety of meaningful group memberships. It has been transformed to include virtually any dimension of human difference that someone might choose to notice. (p. 30)

Alderfer followed—his observation with an illustration of a dialogue that took place between two White men at a corporate diversity training session. One man notes that he thinks of his coworkers differently or not in a negative way now that he has been taught about diversity. In another exchange, a 40-year-old White male states:

> Now take this company. We used to be required to wear only red neckties. Now that we have a corporate policy to value diversity, we can wear blue ties as well. This corporation values diversity (Laughter again). (p. 30)

Clearly, it is important to use terms and concepts that convey more specifically the aspects of race or culture of concern and interest for training and practice. Therefore, I have introduced a typology of assumptions as a way to clarify the meaning of various terms related to racial and cultural differences. In Volume One's Introduction, I describe five assumptions that seem to underlie the various terms people use in scholarship and practice associated with cultural difference (Carter, 2000b, this *Handbook,* Volume One). In brief, the assumptions of cultural difference and their meaning could fall into the following types:

Universal: A focus on the individual and individual difference is the traditional psychological perspective.

Ubiquitous: Social identity groups are treated as equally important aspects of cultural and social group differences, also termed multicultural or culture diversity.

Traditional: One's country as culture perspective—is reflected in globalization, international, intercultural or transcultural perspectives, in psychology and counseling.

Race-based: Race, as socially constructed categories based on skin color, physical features, and language, is the basis of culture, with psychological variations within racial groups.

Pan-national: Oppressed/oppressing groups are the context for culture and differences in culture, reflecting imperial and colonial divisions of countries and the resulting meaning of culture that emerged.

What makes the typology of assumptions necessary is the confusion surrounding the use of language regarding racial-cultural differences and what appears to be a lack of attention to the historical beginning of the field of psychology and other mental health disciplines. It is imperative that we understand that only through the prism of our past can racial-cultural competence be applied effectively in training and practice. The need for racial-cultural training and practice arises because of the central and critical place in our history and current life that race, and through race culture, holds. Each citizen and immigrant learns to understand differences between groups on the basis of race (APA, 2003). In addition, other reference groups (e.g., gender, social class, sexual orientation, ethnicity, age) have meaning in the context of one's race and psychologically identified culture. I believe that a multicultural perspective is too broad, vague, and nonspecific, and that it de-emphasizes race and its meaning and ignores Whites as members of racial-cultural groups (Carter, 2000b).

Nevertheless, there is value in using terms or conceptual frameworks that are broad and inclusive. Members of the dominant racial-cultural groups feel less threat and more acceptance. The cost is that historically disenfranchised racial groups and some members of sociodemographic groups are left behind or forgotten (e.g., poor and working-class people). Moreover, the use of the terms diversity and multicultural allow people, regardless of their race or social position, the opportunity to think of themselves as a member of an oppressed "group." Last, the lens and power of the superordinate dominant cultural worldview seems to be obscured when multiculturalism is the focus of cultural competence (see Carter, 2000b; Helms & Cook, 1999).

In my own teaching, consultation, training, and clinical practice, it has become apparent that people struggle more with race than any other group membership. Also, in teaching, consultation and training, when I have not focused on or introduced race as the primary subject of the course or workshop discussion, race is brought in and used as a proxy for culture or it is ignored. Students and participants (regardless of race) often assume that only people of Color are members of racial groups or they ignore race as an aspect of difference. So it seems to me that a race-based approach to cultural understanding and building competency in counseling and psychology is essential and imperative. It is one of the things we think we know about a person on sight, and from that visible marker we make automatic assumptions about qualities, abilities, behaviors, and other reference group memberships (e.g., ethnicity, religion, social class; Carter, 2003).

To be clear about the concepts and core ideas for a racial-cultural approach to counseling and therapy for the handbook I asked contributors to adhere to the following distinctions and definitions of core ideas of race, culture, and ethnicity. My letter inviting contributions to this volume in part stated:

> The *Handbook* is intended to be one that focuses on Racial-Cultural Psychology, which in my view is a perspective on cultural difference that uses race as the context for understanding culture. However, it does not mean that one should focus on specific racial groups. Rather, the focus should be on how race and through race culture, effects psychological and social functioning. The conceptual idea of race is defined in terms of skin color, language, and physical features and its sociopolitical use. Ethnicity is defined as one's country of origin and is connected to one's heritage and family background. Culture is defined as patterns of behavior and thought learned through socialization.
>
> I ask that you work with me in an effort to achieve coherence and consistency around these important constructs. In addition, I request that you use the conceptual schema outlined above with regard to race, culture, and ethnicity and that you use the racial-cultural frame for the development of your chapter.

Many contributors applied the distinctions and some did not. It was hard for some to let go of the focus on people of Color or "minorities." I contend that such a focus is victim-oriented and does not capture the reality of how we as Americans understand racial-cultural interactions. I think we are socialized to think of cultural difference as racial difference. We also tend to be less conscious of the patterns of our dominant superordinate American cultural patterns and confuse culture, race, and ethnicity.

THE AMERICAN WORLDVIEW AND CULTURAL LEARNING

One would expect that how mental health professionals are trained and the ideas that they bring to their training and practice are central to the health and well-being of the people they seek to serve. To the extent that the values, attitudes, and beliefs that mental health professionals learn in training are congruent with the people they help, their effectiveness is greatly enhanced. To the extent that there are incongruities between the system of care, the client, and the helper's interventions, the more likely the care will be ineffective.

Training and mental health practices are shaped by several interrelated factors. One significant factor is the worldview or the cultural patterns and beliefs of the dominant group in the society. The dominant group's cultural beliefs shape the norms and structure of institutions and organizations (see Carter & Pieterse, this *Handbook,* Volume One). All institutions and organizations are linked in that they exist to serve the goals and pass on the teachings and values of the society as reflected in the worldview of the dominant racial-cultural groups (Carter, 1995, 2000a).

These institutions and organizations include schools, colleges and universities, hospitals, mental health systems, and families and communities. Families socialize their members to participate in the structure of society and teach the values, communication patterns, behaviors, attitudes, and beliefs that are congruent with the sociocultural context in which they live (see Bowser, this *Handbook,* Volume One; Yeh & Hunter, this *Handbook,* Volume One).

The North American Eurocentric view dominates theory and practice in mental health professions and in society in general. This dominance has not allowed for consideration that other cultural worldviews may exist or should be understood. The prevailing view is that mental health professionals assume that the dominant racial-cultural worldview is universal. Differing worldviews are not taught or used

in practice so that mental health professionals can be racially and culturally competent and effective (Helms & Cook, 1999; Sue & Sue, 1999, 2003).

By racial-cultural competency I do not mean being able to work primarily with non-White or immigrant group members. Racial-cultural competence as I define it is broad: It encompasses conscious knowledge of one's own racial-cultural group; it means recognizing the versatility of knowing, feeling, and behaving in particular ways due to one's reference group within one's own racial-cultural worldview (i.e., gender, ethnicity, social class, religion); and it means having knowledge about people who belong to groups other than one's own, including factual information about each group's social-political history and how that history influences the group's current status and participation in the country. To achieve racial-cultural competency, self-knowledge coupled with knowledge of one's racial-cultural group must be enhanced by individual racial-cultural self-exploration and development (Carter, 2001, 2003). One must evolve an identity that is free of bias, or in which the existence of bias is recognized and monitored. Said another way, effective and competent mental health professionals have evolved advanced racial and ethnic group identities such that they are able to facilitate growth and exploration in others as educators, advocates, policymakers, or practitioners.

Yet, unlike other scholars, I contend that the knowledge of one's reference groups comes through the lens of racial group membership and one's racial identity ego status. That is, how one understands one's ethnic or gender group membership is determined by one's racial group and one's corresponding racial identity ego status (Carter & Pieterse, this *Handbook,* Volume One).

The approach that I advocate treats all racial-cultural groups as important to understand and focus on in our teaching and practice. We should avoid the practice of describing the ills of our social system and the outcomes of exploitation and oppression by focusing on the victims of oppression. Emphasis on the victims of oppression, regardless of the group of interest, is a limited and fragmented view. The use of such a victim focus does not help us fully understand the role of racial-cultural worldviews, sociocultural norms, and institutional policies in the development of illness or in notions of abnormality and health. We must make a conscious effort to keep in the foreground the context of our racial-cultural worldview and remember how it sets and shapes our perceptions, thinking, feelings, interaction patterns, communication styles, and beliefs about what is normal and what is not. It is easier to see cultural difference in those who are immigrants to the United States, but somewhat more difficult to see the role of race and culture among people who belong to groups that have been here for many generations. Furthermore, we must always remember that skin color, physical features, and language are the primary sources of difference in our society, culture and communities, and at the same time that there are other sources of difference that also need to be understood.

CULTURE AND COMMUNITY

Many professionals accept that our cultural and social environments shape who we are and how we behave and feel in the world. Often, our culture is reflected in our neighborhoods and communities. Many racial communities have historically been

segregated; today many are still subject to external forces that maintain their social separation, while other communities may exist as distinct enclaves by choice. Nevertheless, our experiences as members of racial-cultural groups in society, as well as our personal understanding of that experience (i.e., one's racial-cultural identity), affect our mental health.

Our racial-cultural context (race, ethnic group, gender, religion, language, social class, etc.) influences how we understand health and mental well-being. Our culture also determines what is considered normal and abnormal. The circumstances we encounter in society, such as access to work, shelter, and health care, also influence our understanding of our experience and how we function in our communities and in society.

It is important to acknowledge at the outset the elements of American culture or worldview that characterize our society and dominate our belief systems, behaviors, and expectations. American culture has evolved from White ethnic upper- and middle-class values and beliefs. American cultural systems are superordinate to ethnic group values. According to Carter (1995, 2000a) and Marger (2000), White American cultural patterns include individualism, expressed through personal preferences; self-expression, reflected in a combination of conformity to social expectations and achievement of goals based on external criteria (e.g., good grades, good job); authority and power that is hierarchical; communication patterns that are verbal and normal only if standard English forms are used; a future time orientation; a Judeo-Christian religious system; belief that the nuclear family structure is ideal; and standards of music, beauty, and social traditions (holidays, monuments, etc.) based on European cultures. And a way of knowing that is practical and technical and that reduces ideas to their simplest terms (parsimony) and discusses ideas in terms of common elements (Stewart & Bennett,1991).

Thus, our way of understanding health, both physical and mental, is based on the worldview that characterizes our culture and is embedded in our professions and institutions. What do we know about cultural influences on mental health? The National Institute of Mental Health's (NIMH, 2003) Web page reports cultural differences from a traditional assumptive perspective and notes. For instance, people with schizophrenia do better in developing countries than in North America; a majority of people in Nigeria and India who are thought to have schizophrenia were better or in remission in about two years. Anthropological and cross-cultural studies have shown that cultural beliefs about mental illness affects its course and treatment. For White Americans, a person with schizophrenia is "crazy," with no hope for recovery, whereas in other countries the same people are seen as having a temporary condition that can be addressed.

Race and culture also influence diagnosis. Researchers find but cannot explain, that Black African/Americans are more often diagnosed with schizophrenia and are less often diagnosed as having affective disorders than White Americans (NIMH, 2003). Researchers argue that this reflects cultural bias on the part of clinicians (irrespective of racial-cultural group membership) who are socialized and taught during professional development to see people of Color and Blacks as more disturbed than Whites.

When participants in research studies are members of the dominant culture group, the studies' conclusions are overwhelmingly believed to apply across racial-cultural groups (i.e., are believed to be universal). Thus, the expressions of normality and illness in the majority race and culture are assumed to be true of all people irrespective of race, culture, or ethnicity. Evidence to the contrary has been mostly ignored or de-emphasized (NIMH, 2003). Yet, decades of research make it quite clear that however universal the categories (e.g., depression) of mental illness may be, the patterns of onset and duration and even the nature and clustering of specific symptoms vary widely across racial and cultural groups.

There is also racial-cultural variation in how people view and understand self and personal identity (Sue & Sue, 2003). For instance, among many Asian cultures, the self is interdependent (Yeh & Hunter, this *Handbook,* Volume One); in dominant North American cultural practices, the self is primarily individual and internal. Because mental health is influenced by notions of self and personal identity, Asians' relationships with others matter a great deal to and affect their mental health. Regardless of culture, we are all humans and therefore share similarities in our physiological and neurochemical systems. Thus, some common expressions of emotion do seem to characterize human experience. However, subjective meaning associated with particular emotions and their expression vary by culture.

Members of racial-cultural groups vary in the level of identification and investment they make in their group culture. Acculturation to the dominant culture and levels of psychological identification with the racial group vary by individual, and the variation influences the meaning and significance of the group and its culture for the individual person. Socioeconomic resources, among other factors, also influence the vulnerability one has to stressors of life events. Fewer resources and lower social status seem to be associated with greater vulnerability to life event stressors. One's community and its organizations can have both positive and negative effects on mental health. Support systems and organizations that seek to reduce the effects of social, personal, and economic problems can protect people from the harm of stressors and reduce the incidence and prevalence of negative mental and physical health outcomes (NIMH, 2003).

It is easy to see differences when people speak another language, wear clothes that are different, or look physically different. It is harder to see and understand cultural differences in perception of the world, in thinking, and in interpersonal relationships when there is more perceived similarity. It is more difficult within the context of American society where many groups of Americans have been in the society for hundreds of years and acculturated but not assimilated into mainstream cultural patterns (Marger, 2000). Under these circumstances, it is difficult to discern less obvious racial-cultural variation among Americans. Moreover, the process of learning about and understanding cultural differences in training and practice conflicts with dominant American cultural patterns; what I call dynamic cultural conflicts arise and need to be acknowledged and addressed (Carter, 2004). *Dynamic cultural conflicts occur when two cultural styles are operating at the same time but in contradiction to one another.*

For example, the American cultural norm is to reduce an issue to its simplest terms. Thus, Americans attempting to understand a different culture reduce that culture to its bare essentials. But cultures are complex, not simple; understanding a different culture requires accounting for that complexity. And therein lies the conflict: We either allow complexity or we strive for simplicity. We must allow complexity to exist to learn about cultural influences, and so we must suspend our style of reducing things to simple terms. That is, we cannot reduce a racial-cultural group to general characteristics or understand a person through statistical information about the group.

We are taught as part of the culture to be professional and leave our personal beliefs out of our professional work and practice, so as individuals we fragment these parts of ourselves (Stewart & Bennett, 1991). For example, as American mental health care professionals we are taught to separate our professional and personal lives. Yet to learn about race and culture we must explore our personal experiences and beliefs; that is a violation of our cultural norms and a dynamic cultural conflict (Carter, 2004).

Usually when we are learning something new we are focused on something other than our personal selves, something that is external to us. As part of our culture, we focus on the practical and technical; that is, we learn what it is and how it works. However, learning about racial-cultural experiences, I believe, requires that we learn about ourselves, a dynamic cultural conflict in itself. We, as Americans are not accustomed to revealing ourselves or being the focal point of learning. Nevertheless, racial-cultural learning is most effective when it is grounded in self-exploration.

The more aware you are of your racial-cultural norms, values, and communication styles, the easier it is for you to grasp another racial-cultural way of seeing and experiencing the world. A fish doesn't know that it is in water and you are not. From the perspective of the fish, there is no other way to be. And it is likely that the fish does not see the world as being in water, but simply as the world. If you believe that the world is as you see it without variation and you use your worldview to understand those who seek your help, then miscommunication will occur (Carter, 2004). It will be impossible to acknowledge that another worldview exists and to see the world through another racial or cultural lens. It will be difficult to learn and understand another cultural worldview, another way to communicate, another way to behave if one is unaware that one's perceptions and ways of knowing and being are bound by one's own unexamined racial-cultural worldview.

It is hard to overcome dynamic cultural conflicts when the prevailing beliefs about the racial-cultural groups in North American society are so negative and demeaning. As part of the dynamic cultural conflict, mental health professionals must overcome the racial-cultural legacies of the past. It is necessary to fight the notion, however framed, that nondominant racial-cultural group members are inferior or culturally deprived or disadvantaged. These notions have been part of the foundation of theories of human development and personality and have dominated the way scholars and researchers have characterized and in many instances continue to characterize people who are not considered members of the mainstream or who are victims of poverty or

poor educational systems, or crime and so forth. Thus, psychotherapy has been a tool of the status quo used to control and demand compliance with dominant group behavioral norms and it has not been used to help people on their own racial-cultural terms.

OVERCOMING THE RACIAL LEGACY OF THE PAST

Carter and Pieterse (this *Handbook,* Volume One) describe the historical development of race and how it is distinct from ethnicity and culture. Culture and ethnicity are fluid and flexible; they can change over time, usually over a few generations. Race and the characteristics associated with it are considered not to be flexible but persistent; beliefs about the attributes and characteristics associated with race seldom change over time, even over centuries. Carter and Pieterse show how race has come to be the context for culture in the United States. In developing racial-cultural competency training and mental health practice it is important to understand the historical legacy of race and culture, particularly how they have been treated and taught in psychology, in related disciplines, and in mental health practice. There is a considerable history regarding race and culture that has to be overcome; some beliefs and traditions surrounding race and culture remain prominent in mental health training and practice.

Pedersen (this *Handbook,* Volume One) and Draguns (this *Handbook,* Volume One) describe the relationship between anthropology and cultural psychology. The discipline that studied culture prior to the rise of cultural or cross-cultural psychology was anthropology. Much of the science of anthropology during the late nineteenth and early twentieth centuries was comparative: Western culture was held as the standard for a mature or civilized and socially-morally advanced cultures; other cultures and worldviews were described as immature, underdeveloped and uncivilized. The primary mechanism used to distinguish a mature society was racial classification.

Carter (1995) noted that during the nineteenth century anthropologists developed racial classification systems by using measurements of skin color, hair texture, and lip thickness. Psychology during that era was a science that studied the mind by building on biology and physics. Yet psychology as a discipline adopted the racial systems used by anthropology to explain and justify differences between human groups. Thus, early in the history of the discipline the research associated with race and culture was devoted to psychological investigations that affirmed the prevalent paradigm of the times, which held that Whites were psychologically and genetically superior to non-Whites.

That leading psychological health professionals accepted this paradigm is well documented by Carter (1995). G. Stanley Hall, the first president of the American Psychological Association, wrote in a popular book on adolescence that people of Color were not civilized. Louis Terman, another highly influential psychologist who adapted intelligent tests for use in the United States, proclaimed that non-White Americans were unable to benefit from education, nor could they be productive citizens, because they did not possess normal levels of intellectual ability. Similar sentiments were restated in the mid-1960s by Arthur Jensen and also by Hernstein and

Murray in the 1990s (see Carter, 1995, pp. 31–32). Belief in racial group inferiority has been challenged and rejected by many researchers and scholars (Graves, 2001; Jones, 1997). Yet the ideas and practices based on racial-cultural differences are still present in many spheres of American life. In the mental health professions, some practices that produce disparities in access and treatment reflect to some degree the dominant and traditional belief that the poor, the working class, and people of Color cannot benefit from education, training, or treatment.

In some cases, the inferiority models were replaced by the notion of "disadvantage" or "deprivation." Carter (1995) stated, "The social activism of the 1950s and 1960s brought about a shift from the inferiority paradigm to the oppression or cultural and social deprivation paradigm" (p. 39). The new paradigm became an important mechanism for explaining the differences in people's health and mental health experiences and still is used widely today. Cultural deprivation merges the beliefs and visions of social and biological notions regarding race and, through race, culture. People from non-White racial groups, it was argued, were culturally or socially deprived of the community structures, family systems, and economic and moral-emotional resources typical of White dominant racial group members. Thus, they were "disadvantaged" and Whites were in the language of today "privileged." Many factors contribute to disadvantage, such as poverty, lack of education and learning, discrimination, and social and family disruption; these factors are believed to determine the mental and psychological functioning of non-White racial group members. In that the effects are attributed to the effort, ability, morals, or personality of the person or racial group members who have to cope with the effects of such factors in this way the victim is at fault rather than the effects of the external stressors. Thus, mental health scholars and professionals propose interventions for people of Color to address the significant levels of what is described as dysfunction in the form of low self-esteem, mental disturbance, poor impulse control, violent tendencies, and other deviations from dominant racial-cultural group norms.

Researchers and scholars observed that the norm used to assess or determine "cultural deprivation" was White middle-class society and argued that people of Color—Blacks, Asians, Native Americans, and Hispanics/Latinos—were not deprived of culture, but were culturally different. The claim of cultural difference began what has become the multicultural movement. To me, it seems more accurate to refer to the movement as one that argued for changes in race relations and an end to racial oppression with acceptance of racial-cultural differences. The position in the beginning of the cultural difference movement was essentially that Americans from historically disenfranchised groups identified on the basis of racial characteristics (i.e., skin color) had retained distinct aspects of their culture of origin because they were segregated and isolated from mainstream American society. Due to racial separation, over the course of generations, and for some groups centuries, people were able to retain cultural traditions, values, and behaviors from their respective countries and cultures of origin. As immigrants of Color came to the country, they too were often isolated and segregated, while White immigrants over time were able to overcome the initial resistance to their assimilation in the mainstream society (Carter & Pieterse, this *Handbook,* Volume One).

Racial-cultural difference was slowly being replaced or at least used as an alternative to the inferiority and cultural deprivation paradigms. It is unfortunate that all paradigms (inferiority, deprivation, and difference) continue to exist in the twenty-first century, though perhaps in slightly different forms but with the same message and assumptions. Nevertheless, the focus on racial-cultural differences has also shifted to some extent into multicultural or cultural diversity, an approach that is promoted as inclusive, yet for some is no more than another term for individual differences. I and my colleagues, as well as many contributors to this *Handbook,* contend that race as a socially constructed category is used to establish the sociopolitical-economic structure of our society. Though racial categories have no scientific basis, those in power and those who wish to share power and authority believe that race, based on skin color, determines a person's ability, morality, intelligence, and emotional state, not to mention access and opportunity.

I have pointed out (see Carter, 1995) that race and identity, both personal and social, are intertwined and interrelated. As such, race and racial identity (psychological orientation to race) are central aspects of development and mental health practice and training: "To understand racial influences in psychotherapy, one must first understand how race is integrated into personality" (p. 76). The importance of these ideas for training and practice lies in the reality that our present is shaped by our past and that each person who is training to be a mental health professional or educator is socialized in a society where race is an integral part of our daily lives in substantial ways:

> Because race is an aspect of American culture, it is reasonable to conclude that, in early intellectual and social development, a child will internalize the respective psycho-social meanings assigned to his or her racial group. For instance, racial groups vary in terms of family structure and the values attached to particular activities (e.g., cognitive versus interpersonal skills) and to forms of language (e.g., standard English, Black English, traditional Native American Indian, Korean, Chinese and Japanese language, Spanish and spanglish). These variations are also influenced by social customs and stereotypes regarding members of each racial/ethnic group. (p. 78)

Just as gender identity is learned, so are people socialized to adopt race-appropriate roles and behaviors throughout the life span process of development (Carter, 1995; Thompson & Carter, 1997). So the effort to infuse mental health training, practice, and service delivery with people and systems that are racially-culturally competent requires overcoming the legacy of cultural oppression and racism as well as the messages regarding race and culture communicated through each person's socialization in North American society.

A recently issued report that supplemented *Mental Health: A Report of the Surgeon General* for the U.S. Department of Health and Human Services (2001) titled *Mental Health: Culture, Race, and Ethnicity* addressed the striking disparities in mental health access and care provided to American "minority" groups. The report noted:

> Racial and ethnic minorities (i.e., Blacks, Hispanics, Asians, and Native Americans, historically disenfranchised Americans), have less access to mental health services than do

> whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality. (p. 3)

The authors of the report also observed:

> Additional barriers include clinicians' lack of awareness of cultural issues, bias, or inability to speak the client's language, and the client's fear and mistrust of treatment. More broadly, disparities also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. (p. 4)

Overt discrimination and prejudice is contrary to our legal codes and for some does not exist in the daily life experiences of people of Color. Yet research shows that racial-cultural discrimination is still a factor in the lives of people of Color and that racial discrimination increases their levels of stress and contributes to psychological symptoms. Discrimination occurs in education, employment opportunities, housing and health care (NIMH, 2003).

So the legacy of the past still is with us; people of Color are treated as if they have less value as citizens in our nation. To overcome the past we must recognize the problem of dynamic cultural conflicts in training and practice and we must recognize the variation within each racial-cultural group regarding both psychological identification and reference group memberships (gender, ethnicity, etc.). We also must embrace complexity and resist the cultural pattern of wanting to make the issues simple or to focus on how we are similar. As a profession we need to accept the reality that our lives and society are bounded by our cultural worldviews and that the tradition of racism and segregation has created distinct racial-cultural worldviews. The contributions to Volume Two of the *Handbook of Racial-Cultural Psychology and Counseling* illustrate many of the points raised here and in many instances go further. They all provide a way to grasp, understand, and use the complexity of racial-cultural psychology in mental health training and practice.

OVERVIEW AND OUTLINE

The volume is composed of two parts: training and practice. Derald Wing Sue and Gina C. Torino lay a strong foundation for Volume Two by outlining concrete manifestations of racial-cultural impositions by dominant group members and systems in their discussion of the mental health profession, training, and service provision. Moreover, Sue and Torino note the limits of cognitive-based racial-cultural education and how programs isolate the training to one course. They also point to the role of systemic influences in learning about racial-cultural issues; it is not just the program that teaches racial-cultural competency, but the institution as a whole.

Joseph G. Ponterotto and Richard Austin describe various approaches used to train for cultural competence. They include training for U.S. groups as well as international initiatives. They describe best practices in various programs across the country that have been used to teach mental health professionals racial-cultural competence.

Robert T. Carter follows the overview presented by Ponterotto and Austin and provides a description of the racial-cultural counseling laboratory course, identified by the previous authors as an example of a best training practice, and the curriculum context in which it is taught at Teachers College, Columbia University.

Like Carter, Charleen Alderfer describes a course that has a critical and central role in the training of family and marriage therapists. She describes the course in detail and highlights a combination of immersion and group interaction experiences as vehicles for raising awareness of racial-cultural issues. She illustrates the power of race and the cultural context for learning about differences in the family and in her course as well as the experiences that students have in the course that illuminate the importance of not losing sight of race in mental health training programs.

Vivan Ota Wang argues for the use of racial identity theory and its application in helping professionals from many disciplines learn "to be." She proposes that critical race theory, racial identity, and Bronfenbrenner's ecological model be used together to help professionals see the role of power and oppression in the lives of U.S. citizens.

Barbara C. Wallace describes an approach for racial-cultural skill acquisition. She builds on the extant literature by offering a model that seeks to teach professionals and students about the integration of affect, thought, and action. Like Ota Wang, Wallace contends that personal racial-cultural identity must be integrated into the training of mental health professionals to foster skill development. She presents specific and concrete guidelines on how to assess and acquire racial-cultural helping skills.

Marie Faubert and Don C. Locke address an extremely important issue that receives less attention in the racial-cultural literature: language diversity. They describe how American society is not receptive to multiple languages by illustrating the role of language in therapy and training. These authors do a good job of showing the relevance of language for U.S. citizens as well as for immigrants and refugees.

Mary B. McRae and Ellen L. Short discuss the important topic of racial-cultural mental health interventions for work with therapy and support groups. They provide an overview of what is known about group work and how race and culture influence interactions in groups. They propose the use of a group relations model for understanding how race and culture operate in groups and organizational settings.

It is clear that language diversity and group interactions are important components when people seek and receive mental health services. Lack of knowledge and skill with groups and language can limit the therapist's or trainer's grasp of the client's communication and culture. Trainers, educators, and practitioners also need to recognize what William Ming Liu and Donald B. Pope-Davis define as therapy ruptures and impasses. These contributors observe that racial-cultural scholars and practitioners have paid more attention to the therapist and patient matching and descriptions of client culture's and less attention to psychotherapy process issues. In particular, they present research evidence of cultural misapplications by therapists and trainees that can result in a rupture or impasse in therapy interactions. More important, they contend that cultural ruptures and impasses can lead to client termination of therapy, particularly when a therapist introduces racial-cultural issues into treatment at a time or in a manner that does not fit with or is not consistent with the

client's presenting issues or level of development. The authors provide guidelines for clinicians as well as for trainers and supervisors in how to recognize and cope with cultural impasses and ruptures in mental health service delivery.

A cornerstone of training in the mental health profession is supervised instruction, observation, and feedback. Almost all mental health disciplines use the model of a supervisor who is established or has acquired the requisite credentials (i.e., degree, license, experience) to observe and provide feedback to a trainee and evaluate his or her interactions with patients/clients. Eric C. Chen's chapter is focused on the clinical supervisor and enhancing the supervisor's understanding and skill in racial-cultural supervision. Of particular importance, Chen focuses on the various roles a clinical supervisor assumes and illustrates the central role of supervision in mental health training. The strength of his unique approach is that it offers a structured, practical, and specific framework that can be used to integrate racial-cultural training into the work of supervisors and educators.

As was noted earlier, supervision is a mechanism we use as mental health professionals to teach, learn, and correct our work. Amy L. Reynolds illustrates issues that arise in racial-cultural supervision dyads. She provides excellent guidance for how supervision can be improved.

Charles R. Ridley and Debra Mollen conclude the training part of the *Handbook* by presenting a model for postdoctoral racial-cultural competence. They propose several features of a postdoctoral program that would build racial-cultural competence beyond predoctoral training, such as regular evaluations, learning objectives, links to practice, leader support, and preevaluation of trainees. The authors call for the development of systematic and standardized postdoctoral training programs and practices.

Part II of Volume Two focuses on practice issues associated with racial-cultural counseling and psychology. Chalmer E. Thompson's chapter on theory and practice discusses how race and culture are interdependent aspects of a person's life. She points out how psychological theory and practice can be elevated to include a more holistic view of people such that aspects of race and culture will no longer be treated as fragments of identity that belong only to nondominant group members. She adeptly integrates racial identity ego status development into a model that promotes racially-culturally effective theory and practice.

Alvin N. Alvarez and Ralph E. Piper's chapter goes a bit further and lays out a framework for how practitioners can use racial-cultural theory in practice. They show how racial-cultural theory (models of racial identity, acculturation, etc.) can be integrated into assessment, diagnosis, and intervention and used for particular outcomes. The authors fill a void in the existing literature by including ways to integrate racial-cultural models effectively into day-to-day practice.

Kevin Cokley provides a brief review of how the constructs of race and ethnicity have typically been used in the psychotherapy literature. He does this by offering an outline of methods to incorporate race, ethnicity, and related constructs in clinical work. He presents transcripts of clients to demonstrate how knowledge of race and ethnicity were incorporated and applied in his clinical work.

The chapter by Cokley is followed by one that deals with career counseling and how racial-cultural factors influence our understanding and practice in helping people move between school and work. Kris Ihle-Helledy, Nadya A. Fouad, Paula W. Gibson, Caroline G. Henry, Elizabeth Harris-Hodge, Matthew D. Jandrisevits, Edgar X. Jordan III, and A. J. Metz analyze current theory and research to illustrate what we know about the career counseling process and they test a model of culturally oriented career counseling. In general, these authors report that culture and race play important roles in the career counseling process.

Tamara Buckley and Deidre Franklin address the complex issue of racial-cultural factors in diagnosis. Diagnosis is a core feature of our mental health service delivery system: It is used to determine client competence, personality, and basic mental health and third-party payments. These authors discuss the absence of consideration of racial-cultural context in mainstream notions of normality and abnormality as well as how racial-cultural factors influence the expression of emotions and behaviors. They call for greater consideration of the role of racial-cultural factors in our understanding of mental health.

The focus on diagnosis sets the stage for three chapters that examine aspects of assessment and testing, also important tools used by mental health professionals to determine a person's psychological and emotion functioning. Lisa A. Suzuki, John F. Kugler, and Lyndon J. Aguiar provide readers with an understanding of the psychometric flaws of many tests and assessment instruments used often with little consideration of their limits. They provide guidance for practitioners in how to determine if a test or assessment procedure is appropriate for particular racial-cultural group members. For the most part, while some measures attend to racial-cultural issues, most tests (cognitive ability, personality) use universal assumptions and do not adequately incorporate racial-cultural variation into their development and construction.

Curtis W. Branch also discusses issues of clinical assessment, yet he reviews unexamined assumptions and the research evidence regarding use of traditional assessment procedures, including interviews. He asks clinicians to examine their assumptions and calls on psychological and mental health professionals to be aware of the limits of trusted assessments. Branch asks clinicians and researchers to use race- and culture-specific measures to accurately assess members of nondominant racial-cultural groups.

Tina Q. Richardson and Eric E. Frey's chapter rounds out the section on assessment. They describe a projective strategy for assessing White racial identity ego statuses and show its utility with a case example.

Donna E. Hurdle presents a chapter on working with groups using a racial-cultural perspective. Of particular value is her guidance on how to integrate traditional healing methods into group work.

Anita Jones Thomas focuses on how family therapists can use racial-cultural factors in treatment with families. She provides valuable conceptual models and case examples for work with families. She describes how racial-cultural factors influence family dynamics, socialization, and child rearing. Of particular value is her

guidance on how to assess for racial-cultural factors as well as how such knowledge informs the therapist about appropriate intervention strategies.

Dennis Miehls highlights cultural and racial identity themes that are important to assess when working with couples. It is important for the clinician to be aware of his or her own cultural biases and attitudes, or to be self-aware, to enhance working relationships when conducting racial-cultural therapy.

Patrica Arredondo examines clinical practice with immigrant populations. She offers a psychohistorical framework for effective racial-cultural competent practice that sets the context for how immigrants are treated in the current sociocultural environment. The author discusses the various stressors experienced by the new wave of immigrants, who are primarily people of Color. They face considerable stress due to their race and culture, information vital to mental health service providers.

Shawn O. Utsey, Rheeda L. Walker, Nancy Dessources, and Maria Bartolomeo present Black Americans' unique racial-cultural experiences. Their focus is on a specific racial group because, the authors suggest, Blacks' bicultural experience is distinct from that of other groups. They argue further that current theory about bicultural or acculturative processes does not capture the experience of people of African descent.

James E. Dobbins and Judith H. Skillings offer a clinical diagnosis and treatment model for individual White racism and its manifestations. They argue that there are parallels between being socialized to hold racist attitudes and beliefs and substance abuse or abuse of personal/social power.

Robert T. Carter, Jessica M. Forsyth, Slivia L. Mazzula, and Bryant Williams introduce the topic of race-based stress and offer evidence from an exploratory study of how racism is experienced by people of Color. They call for new legal standards and definitions, organizational policies and clinical standards to adequately address the psychological, physical and emotional effect of the experience of racism.

Elizabeth M. Vera, Larisa Buhin, Gloria Montgomery, and Richard Shin discuss how mental health professionals can expand how they deliver services and conceptualize their roles. They argue that racially-culturally competent mental health service should include outreach, advocacy, and prevention, activities typically outside the boundaries of traditional service delivery and practice.

Arthur C. Evans Jr., Miriam Delphin, Reginald Simmons, Gihan Omar, and Jacob Tebes describe in detail the elements of creating and maintaining a system of care that is racially-culturally competent. The authors share some of the complexity involved in establishing a racially-culturally competent statewide system of mental health care. Yet they also show that it is possible if multilevel and multifaceted policies, procedures, and programs are used to make racial-cultural competency an integral part of mental health care. I think the model described represents an advance, designed to reduce health disparities and at the same time require racially-culturally competent mental health practice and service delivery.

Leon D. Caldwell and Dolores D. Tarver reflect on the impact of the American Psychological Association's Ethical Code on racially-culturally competent practice. They effectively point to contradictions and conflicts in the premises of the

Ethnical Code that limit racial-cultural practice. They extend the thinking of Farah Ibrahim and Susan Chavez Cameron (this *Handbook,* Volume One), who raised similar issues about ethics in research in Volume I of the *Handbook*. The value of Caldwell and Tarver's contribution is the way the authors use case examples to illustrate the cultural limits of the Ethical Code.

Robert T. Carter, PhD
Professor of Psychology and Education
Department of Counseling and Clinical Psychology
Teachers College, Columbia University

REFERENCES

Alderfer, C. P. (2000). National culture and the new corporate language for race *relations.* In R. T. Carter (Ed.), *Addressing cultural issues in organizations: Beyond the corporate context* (pp. 19–34). Thousand Oaks, CA: Sage.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologists, 58*(5), 377–402.

Bowser, B. P. (in press). The role of socialization in cultural learning: What does the research say? In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 184–206). Hoboken, NJ: Wiley.

Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy.* New York: Wiley.

Carter, R. T. (Ed.). (2000a). *Addressing cultural issues in organizations: Beyond the corporate context.* Thousand Oaks, CA: Sage.

Carter, R. T. (2000b). Reimagining race in education: A new paradigm from psychology. *Teachers College Record, 102*(5), 864–896.

Carter, R. T. (2001). Back to the future in cultural competence training. *The Counseling Psychologist, 29,* 787–789.

Carter, R. T. (2003). Becoming racially and culturally competent: The racial-cultural counseling laboratory. *Journal of Multicultural Counseling, 31*(1), 20–30.

Carter, R. T. (2004). *Disaster response to communities of Color: Cultural responsive intervention.* Technical report for the Connecticut Department of Mental Health and Addiction Services (DMHAS). Available from http://www.dmhas.state.ct.us.

Carter, R. T. (in press). Uprooting inequity and disparities in counseling and psychology: An Introduction. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1). Hoboken, NJ: Wiley.

Carter, R. T., & Pieterse, A. (in press). Race: A social and psychological analysis of the terms and its meaning. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 41–63). Hoboken, N J: Wiley.

Draguns, J. G. (in press). Cultural psychology: Its early roots and present status. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 163–183). Hoboken, NJ: Wiley.

Graves, J. L., Jr. (2001). *The emperor's new clothes: Biological theories of race at the millennium.* New Brunswick, NJ: Rutgers University Press.

Helms, J., & Cook, D. (1999). *Using race and culture in counseling and psychotherapy.* Boston: Allyn & Bacon.

Ibrahim, F. A., & Cameron, S. C. (in press). Racial-cultural ethical issues in research. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 391–413). Hoboken, NJ: Wiley.

Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.

Marger, M. (2000). *Race and ethnic relations: American and global perspectives* (5th ed.). Belmont, CA: Wadsworth.

National Institute of Mental Health. (2003). *Sociocultural and environmental process.* Retrieved February 13, 2003 from www.nimh.nih.gov.publicat/basechap7.

Pedersen, P. (in press). The importance of "cultural psychology" theory for multicultural counselors. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 3–16). Hoboken, NJ: Wiley.

Stewart, E. C., & Bennett, A. (1991). *American cultural patterns: A cross-cultural perspective* (2nd ed.). Yarthmouth, ME: Intercultural Press.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.

Thompson, C. E., & Carter, R. T. (Eds.). (1997). *Racial identity development theory: Applications to individual, group and organizations.* Hillsdale, NJ: Erlbaum.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to Mental health: A report of the surgeon general.* Rockville, MD: U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Yeh, C. J., & Hunter, C. D. (in press). The socialization of self: Understanding shifting and multiple selves across cultures. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Theory and research* (Vol. 1, pp. 78–93). Hoboken, NJ: Wiley.

Contributors

Lyndon J. Aguiar, MS
New York University
New York, New York

Charleen Alderfer, EdD, NCC, LMFT
The College of New Jersey
Ewing, New Jersey

Alvin N. Alvarez, PhD
San Francisco State University
San Francisco, California

Patrica Arredondo, EdD
Arizona State University
Tempe, Arizona

Richard Austin, MSEd
Fordham University
New York, New York

Maria Bartolomeo, MA
Seton Hall University
South Orange, New Jersey

Curtis W. Branch, PhD
College of Physicians and Surgeons
Columbia University
New York, New York

Tamara R. Buckley, PhD
Hunter College, City University of New York
New York, New York

Larisa Buhin, PhD
Loyola University–Chicago
Chicago, Illinois

Leon D. Caldwell, PhD
University of Nebraska
Lincoln, Nebraska

Robert T. Carter, PhD
Teachers College, Columbia University
New York, New York

Eric C. Chen, PhD
Fordham University
New York, New York

Kevin Cokley, PhD
University of Missouri at Columbia
Columbia, Missouri

Miriam Delphin, PhD
Yale University School of Medicine
New Haven, Connecticut

Nancy Dessources, MA
Seton Hall University
South Orange, New Jersey

James E. Dobbins, PhD, ABPP
Wright State University
Dayton, Ohio

Arthur C. Evans Jr., PhD
Connecticut Department of Mental Health & Addiction Services
Hartford, Connecticut
Yale University School of Medicine
New Haven, Connecticut

Marie Faubert, CSJ, EdD
University of Saint Thomas
Houston, Texas

Jessica M. Forsyth, EdM
Teachers College, Columbia University
New York, New York

Nadya A. Fouad, PhD
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Deidre Cheryl Franklin-Jackson, PhD
Harlem Educational Activities Fund, Inc.
New York, New York

Eric E. Frey
Lehigh University
Bethlehem, Pennsylvania

Paula W. Gibson, PhD
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Elizabeth Harris-Hodge, MS
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Caroline G. Henry, MS
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Kris Ihle-Helledy, PhD
Northwestern University Career Services
Evanston, Illinois

Donna E. Hurdle, PhD
University of North Carolina–Wilmington
Wilmington, North Carolina

Matthew D. Jandrisevits, MA
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Edgar X. Jordan III, MSE
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

John F. Kugler, PhD
New York University
New York, New York

William Ming Liu, PhD
University of Iowa
Iowa City, Iowa

Don C. Locke, EdD
North Carolina State University
Raleigh, North Carolina

Silvia L. Mazzula, MA
Teachers College, Columbia University
New York, New York

Mary B. McRae, PhD
New York University
New York, New York

A. J. Metz, MS
University of Wisconsin–Milwaukee
Milwaukee, Wisconsin

Dennis Miehls, PhD, LICSW
Smith College School for Social Work
Northampton, Massachusetts

Debra Mollen, PhD
Texas Women's University
Denton, Texas

Gloria Montgomery, MA
Loyola University–Chicago
Chicago, Illinois

Gihan Omar, PhD
Yale University School of Medicine
New Haven, Connecticut

Alex Pieterse, MA
Teachers College, Columbia University
New York, New York

Ralph E. Piper, PhD
Princeton University
Princeton, New Jersey

Joseph G. Ponterotto, PhD
Fordham University
New York, New York

Donald B. Pope-Davis, PhD
University of Iowa
Iowa City, Iowa

Amy L. Reynolds, PhD
Buffalo State College
Buffalo, New York

Tina Q. Richardson, PhD
Lehigh University
Bethlehem, Pennsylvania

Charles R. Ridley, PhD
Indiana University
Bloomington, Indiana

Richard Shin, MA
Loyola University–Chicago
Chicago, Illinois

Ellen L. Short, PhD
New York University
New York, New York

Reginald Simmons, PhD
Connecticut Department of Children and Families
Hartford, Connecticut

Judith H. Skillings, PsyD
Private Practice
Amherst, Massachusetts

Derald Wing Sue, PhD
Teachers College, Columbia University
New York, New York

Lisa A. Suzuki, PhD
New York University
New York, New York

Dolores D. Tarver, EdM
University of Nebraska
Lincoln, Nebraska

Jacob Tebes, PhD
Yale School of Medicine
New Haven, Connecticut

Anita Jones Thomas, PhD
Northeastern Illinois University
Chicago, Illinois

Chalmer E. Thompson, PhD
Indiana University
Bloomington, Indiana

Gina C. Torino, EdM
Teachers College, Columbia University
New York, New York

Shawn O. Utsey, PhD
Virginia Commonwealth University
Richmond, Virginia

Elizabeth M. Vera, PhD
Loyola University–Chicago
Chicago, Illinois

Rheeda L. Walker, PhD
University of South Carolina
Columbia, South Carolina

Barbara C. Wallace, PhD
Teachers College, Columbia University
New York, New York

Vivan Ota Wang, PhD
National Human Genome Institute
Bethesda, Maryland

Bryant Williams, MA
Teachers College, Columbia University
New York, New York

PART I

Training for Racial-Cultural Competence

CHAPTER 1

Racial-Cultural Competence: Awareness, Knowledge, and Skills

Derald Wing Sue and Gina C. Torino

In the United States, the population of people of Color has grown dramatically in recent years and is expected to continue to increase (Sue & Sue, 2003). According to the U.S. census (2000), most of the population increase between 1990 and 2000 was composed of visible racial ethnic groups. For example, the Latino population increased by almost 58%, the Asian American/Pacific Islander population by over 50%, the African American population by 16%, and American Indian/Alaska Native population by 15.5%; however, the White population increased by only 7.3% (Sue & Sue, 2003). It is projected that people of Color will become a numerical majority in the United States between 2030 and 2050 (Sue et al., 1998), yet there is no such trend in the field of counseling psychology. Whites still compose the majority of counselors and trainees in the United States (Sue & Sue, 2003). With an increasingly diverse population and a comparatively homogeneous counseling profession, the importance of racial-cultural counseling competence will become crucial.

Thus, many counseling psychology programs and professional organizations, such as the American Psychological Association (APA), have shifted their foci to train counselors to work competently with various racial/ethnic groups. For example, Ponterotto (1997) found that 89% of APA- and non-APA-accredited counseling psychology programs had at least one multicultural training course, and 58% of the respondents stated that multicultural issues are integrated into all course work. In addition, the APA has recently endorsed the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (American Psychological Association [APA], 2003). The goals for these guidelines are to provide psychologists with (1) the rationale and need for addressing racial and ethnic issues in education, training, research, practice, and organizational change; (2) basic information, relevant terminology, and current empirical research from psychology and related disciplines; (3) references to enhance ongoing education, training, research, practice, and organizational change methodologies; and (4) paradigms that broaden the purview of psychology as a profession (APA, 2002).

Why do we believe that the aforementioned changes in the field of counseling psychology and in psychology in general are so important? In this chapter, we explore

the limitations of the Eurocentric approach to counseling and therapy and demonstrate how this approach can cause harm to individuals from various racial/ethnic groups. Next, we define multicultural therapy and show how it expands on traditional definitions of counseling and therapy in several important ways. We define cultural competence and elaborate on the three components of awareness, knowledge, and skills. We conclude this chapter with a discussion of the implications of racial-cultural competence for education and training.

LIMITATIONS OF EUROCENTRIC APPROACHES TO COUNSELING AND THERAPY

All forms of healing and helping originate from a specific cultural context and, as such, strongly reflect the cultural values and assumptions of the particular society (Carter, 1995; Harner, 1990; Highlen, 1994; Sue, 1999, 2001). The concepts "counseling" and "psychotherapy" are uniquely Euro-American in origin and are based on certain philosophical assumptions and values strongly endorsed by Western civilizations: (1) a belief that the individual is the psychosocial unit of operation, (2) mind-body dualism: the separation of physical and mental functioning, (3) rational cause-effect orientation to understanding the world, (4) mastery and control over people and the environment, (5) a future orientation, and (6) a strong belief in equal access and opportunity (Highlen, 1996; Katz, 1985; Kluckhohn & Strodtbeck, 1961; Stewart, 1971; Sue & Sue, 1999; Wehrly, 1995). These cultural assumptions are not often shared by persons of Color, whose worldviews and life experiences are quite different from those of their White counterparts. As a result, the imposition of these cultural beliefs and values on clients of Color may result in cultural oppression (Sue & Sue, 1999). For example, the belief in equality of opportunity has strong sociopolitical connotations, which have adversely affected the diagnosis and treatment of many marginalized groups in the United States.

As a result, Western forms of psychotherapy operate from a worldview that is individualistic and emphasizes the uniqueness, independence, and self-reliance of people. Success is believed to be due to one's own efforts, and lack of success is attributed to one's shortcomings or inadequacies. The effects of sociopolitical or systemic forces are minimized in favor of the belief that everyone, regardless of race, gender, or social class, has an equal opportunity to succeed in life. Statistics indicating that persons of Color have higher unemployment rates and are more likely to have less education and to live in communities with higher poverty and crime are often seen as evidence of negative personal attributes (laziness, lower intelligence, and poor impulse control) among racial/ethnic groups. The belief that everyone can succeed if they work hard enough may unintentionally blame the victim for his or her current life situation.

The Euro-American worldview, which emphasizes individuality, independence, and self-reliance, assumes universality: All clients are the same, and the goals and techniques of counseling and therapy are equally applicable across all groups. Taken to its extreme, the approach assumes that persons of Color should be like their White counterparts and that race and culture are insignificant variables in counseling and psychotherapy. Statements like "We are all the same under the skin" and "Apart from

your racial/cultural background, you are no different from me" are indicative of the tendency to avoid acknowledging how race and culture may influence identity, values, beliefs, behaviors, and the perception of reality (Carter, 1995; Helms, 1990; Sue, 2001, 2003). The failure to recognize the importance of race and culture in counseling may lead to visible racial/ethnic group members underutilizing mental health services and terminating therapy earlier than their White counterparts (Atkinson, Morten, & Sue, 1998), making clients of Color feel that they are at fault because of the failure to consider systemic factors (bias and discrimination) as contributing to their problems (Sue & Sue, 1999), and being denied needed mental health services because these are structured in such a manner as to meet only the needs of White people.

Many psychologists who believe that issues of race and culture affect the lives of our clients and the therapeutic relationship in significant ways have concluded that the theories of counseling and psychotherapy, the standards used to judge normality and abnormality, the definitions of what is appropriate professional therapeutic behavior, and the codes of ethics are not only culture-bound but culturally biased (Highlen, 1996; Katz, 1985; Pedersen, 1994; Ridley, 1995). As such, theories of counseling and psychotherapy may potentially clash with racial/ethnic groups whose worldview may differ from that of their White counterparts. Others have pointed out that clinical practice with African Americans, Asian Americans, Hispanic Americans, and Native Americans may result in cultural oppression (Paniagua, 1998; Parham, White, & Ajamu, 1999; Sue & Sue, 1999), that the profession must begin to develop racial-cultural competencies that recognize the racial diversity of the clientele (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982), and that *cultural competence* must become a defining feature of the mental health profession's standards of practice (Sue, Bingham, Porche-Burke, & Vasquez, 1999). The term "cultural competence" is defined later in this chapter.

As a point of clarification, several psychologists have noted that the term "multicultural" or "multiculturalism" obscures the concept of race by including gender, ability/disability, sexual orientation, social class, and religion in the definition (Carter, 1995, this *Handbook,* Volume One; Carter & Qureshi, 1995; Helms, 1995, 2001; Helms & Richardson, 1997). In this chapter, we use the term "racial-cultural" to emphasize the importance of race but not to the exclusion of other important cultural variables (e.g., gender, social class) in the lives of our clients.

To define racial-cultural counseling competence, we must first define the more general concept of multicultural counseling and therapy (MCT). Understanding the basic premises and concepts of MCT will lay the groundwork for understanding the acquisition of racial-cultural competence by counselors and other mental health professionals.

MULTICULTURAL COUNSELING AND THERAPY

Helms and Richardson (1997) state that MCT

> 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)

Sue, Ivey, and Pedersen (1996) define MCT on a conceptual level as a "metatheory (i.e., a theory about theories) in that it offers an organizational framework for understanding the numerous helping approaches that humankind has developed" (p. 13). Such a definition includes the importance and legitimacy of non-Western indigenous healing systems. Therefore, MCT can be defined in the following manner:

> Multicultural counseling and therapy is both a helping role and a process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, utilizes universal and culture-specific helping strategies and roles, recognizes client identities to include individual, group, and universal dimensions, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of the client and client systems.

More traditional definitions of counseling and therapy tend to ignore issues of culture in the therapeutic process. For example, counseling and therapy have been described as conversations with a therapeutic purpose (Korchin, 1976); development of a therapeutic alliance for the purpose of catharsis and/or the opportunity to develop or change behaviors, attitudes, insights, or feelings (Grencavage & Norcross, 1990); using techniques based on scientifically grounded psychological principles (Reisman, 1971); and even as "the talking cure" or the "purchase of friendship" (Schofield, 1964). These traditional definitions reveal certain common characteristics related to the process and goal of counseling. First, counseling is seen as centered in the counselor-client relationship primarily on a one-to-one basis. Second, the primary mode of providing help is through talking or verbal behavior. Third, the goal is to change behaviors, feelings, and attitudes and to develop insights. Fourth, mental health professionals emphasize the importance of basing therapeutic interventions on well-grounded scientifically determined psychological principles. In addition, depending on the theoretical orientation, counselors may seek to modify primarily thoughts or behaviors (cognitive-behavioral), social-familial relationships (family systems), or feelings and expectancies (existential); to facilitate the client's self-insight and rational control of his or her own life (psychodynamic); or to enhance mental health or self-actualization (humanistic).

MCT accepts many of these basic premises, but broadens and expands the traditional definitions of counseling and therapy in the following manner (Sue et al., 1996):

1. MCT broadens the perspective of the helping relationship. Rather than a singular focus on the individual, it takes a self-in-relation orientation. The individualistic approach is balanced with the collectivistic reality that we are embedded in our families, significant others, communities, and culture. The client is perceived not solely as an individual, but as an individual who is a product of his or her social and cultural context. As a result, systemic influences are seen as equally important as individual ones. Further, theories of counseling and psychotherapy are notorious for their one-dimensional nature. There are theories that can be described as primarily focusing on the feeling self (existential-humanistic), behaving self (behavioral), thinking self (cognitive), social self (interpersonal and family systems), or

historical self (psychodynamic). In many respects, these theories of counseling and psychotherapy fail to see the whole person. MCT conceptualizes people as more than thinking, feeling, or behaving beings; it also recognizes people as racial, cultural, spiritual, and political beings. Any theory that fails to acknowledge these other dimensions views only a limited portion of the human condition.

2. MCT expands the repertoire of helping responses. In translating the assumptions of counseling and mental health into practice, it becomes clear that certain specific guidelines for counselor behavior are considered "therapeutic." These are best explicated by what can be called therapeutic taboos derived from current and previous codes of ethics of the American Psychological Association (1995, 2002), American Counseling Association (1995), and American Association for Marriage and Family Therapy (1998): (1) Counselors do not give advice and suggestions (doing so may foster dependency); (2) counselors do not self-disclose personal thoughts and feelings (doing so is not professional); (3) counselors do not serve dual role relationships (doing so represents a conflict of interest); (4) counselors do not accept gifts from clients (doing so means a loss of objectivity); and (5) counselors do not barter (there is potential abuse of power). However, the American Psychological Association's (2002) code of ethics has revised some of their codes to allow multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm to the client, and to allow bartering only if it is not clinically contraindicated and if the resulting arrangement relationship is not exploitative. In spite of these changes to the APA's ethics code, the role of the counselor is primarily to maintain objectivity, to place responsibility for change on the client, and to use relatively passive attending and listening. Yet, many multicultural psychologists have pointed out that "helping" as perceived by many people of Color involves the helper engaging in these taboo behaviors (Berman, 1979; Herring, 1999; L. C. Lee & Zane, 1998; Nwachuku & Ivey, 1991; Parham et al., 1999).

3. MCT advocates for alternative helping roles. As indicated earlier, the traditional counselor/therapist role is usually confined to a one-to-one, verbal-oriented process in the office that places the burden for change primarily on the client. The assumption is often that the problem resides within the client and, consequently, change must occur in the person. Even when problems are attributed to external conditions (an abusive spouse, an overbearing boss, or job discrimination), clients are encouraged to deal with the situation on their own. Seldom would it be considered appropriate for the counselor to actively intervene in the social system. MCT acknowledges the importance of the traditional counselor/therapist role, but believes that it is much too narrow and limiting, especially in working with racial/ethnic communities and clients. When, for example, the problems of clients of Color reside in prejudice, discrimination, and racism of employers, educators, neighbors, and/or organizational policies or practices in schools, mental health agencies, government, business, and our society, the traditional therapeutic role appears ineffective and inappropriate (Parham et al., 1999; Sue, 2001; Sue et al., 1996).

To provide adequate MCT, it is imperative that counselors become culturally competent. Briefly, becoming a culturally competent counselor involves a general

transformation of one's own attitudes/beliefs, knowledge, and skills before MCT can be implemented on a professional level.

CULTURAL COMPETENCE

Consistent with the definition of MCT, culturally competent counselors and therapists exhibit expertise in their ability to aid racial/ethnic clients at both the individual/personal level and the organizational/societal level:

> Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of the client and client systems. Multicultural counseling competence is achieved by 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.

Such a definition assumes that equal treatment in counseling and psychotherapy may represent biased or discriminatory treatment if the racial/cultural backgrounds of clients are ignored. Likewise, differential therapeutic treatment based on an understanding of different life experiences is not necessarily discriminatory. The goal of cultural competence is equal access and opportunity, which may dictate differential treatment (i.e., process, outcome, and roles).

One of the earliest attempts to define multicultural counseling competencies came from the work of the APA Division of Counseling Psychology (17) (now the Society of Counseling Psychology) committee in which multicultural competencies were conceptualized in a tripartite division: awareness, knowledge, and skills related to working effectively with racial/ethnic populations (Sue et al., 1982). Another group further refined these three divisions into 31 competencies (Sue et al., 1992) that formed the foundation for measures of multicultural counseling competencies (D'Andrea, Daniels, & Heck, 1991; LaFromboise, Coleman, & Hernandez, 1991; Ponterotto, Sanchez, & Magids, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994) and models for multicultural training (Carney & Kahn, 1984; Pedersen, 1994; Sabnani, Ponterotto, & Borodovsky, 1991).

Multicultural counseling competence is multidimensional and multifaceted, and its many properties have been described in greater detail elsewhere (Constantine & Ladany, 2001; Ridley, Baker, & Hill, 2000; Sue, 2001; Sue et al., 1992). Readers interested in a more detailed description should go to the original sources. Using the divisions of awareness, knowledge, and skills and concentrating primarily on racial-cultural competence in counseling, the following attributes must be present in mental health practitioners and systems of mental health delivery.

Racial-Cultural Awareness

According to the competency standards, becoming aware of one's own values, assumptions, and biases as they relate to issues of race and race relations is paramount