● **MAJOR CONTRIBUTION**

Multidimensional Facets of Cultural Competence

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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

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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-

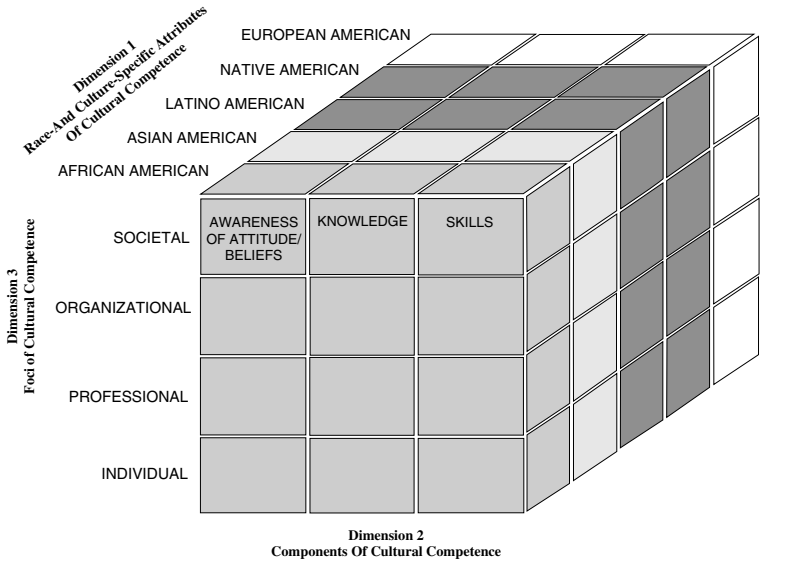

Figure 1. A multidimensional model for developing cultural competence.

tural 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

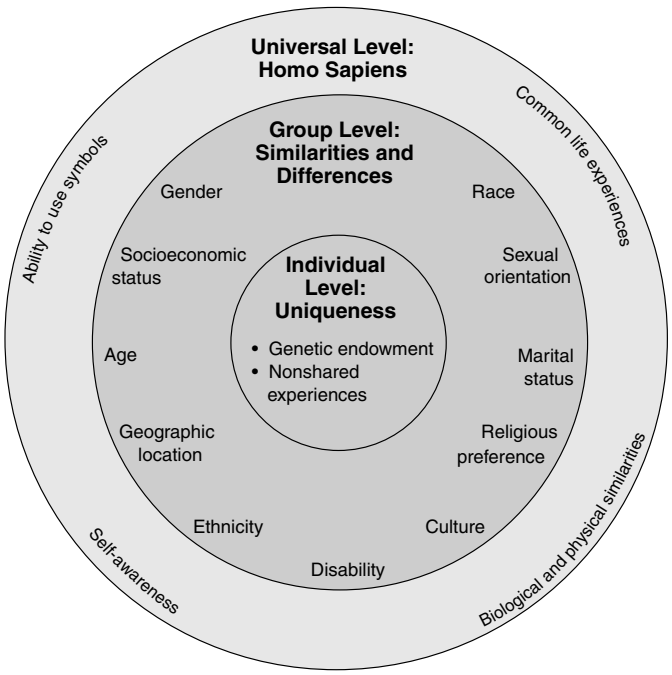

Figure 2. Tripartite framework of personal identity.

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 commonalties 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 rugged individualism, and we have traditionally valued autonomy, independence, 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 yourself" 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 homage to individual uniqueness (Samuda, 1998). Second, the universal level is consistent with the tradition and history of psychology where it has historically sought universal facts, principles, and laws in explaining human behavior. 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 disability 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 variables 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 psychologists have noted, for example, that theories of counseling and psychotherapy represent different worldviews, each with its own values, biases, and assumptions about human behavior (Ivey, Ivey, & Simek-Morgan, l997; Katz, l985; D. W. Sue & Sue, l999). 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 different 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 accepts 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

Belief/Attitude	*Knowledge*	*Skill*
1. Aware and sensitive to own heritage and valuing/respecting differences.	1. Has knowledge of own racial/cultural heritage and how it affects perceptions.	1. Seeks out educational, consultative, and multicultural training experiences.
2. Aware of own background/experiences and biases and how they influence psychological processes.	2. Possesses knowledge about racial identity development. Able to acknowledge own racist attitudes, beliefs, and feelings.	2. Seeks to understand self as racial/cultural being.
3. Recognizes limits of competencies and expertise.	3. Knowledgeable about own social impact and communication styles.	3. Familiarizes self with relevant research on racial/ethnic groups.
4. Comfortable with differences that exist between themselves and others.	4. Knowledgeable about groups one works or interacts with.	4. Involved with minority groups outside of work role: community events, celebrations, neighbors, and so forth.
5. In touch with negative emotional reactions toward racial/ethnic groups and can be nonjudgmental.	5. Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth.	5. Able to engage in a variety of verbal/nonverbal helping styles.
6. Aware of stereotypes and preconceived notions.	6. Knows about sociopolitical influences, immigration, poverty, powerlessness, and so forth.	6. Can exercise institutional intervention skills on behalf of clients.
7. Respects religious and/or spiritual beliefs of others.	7. Understands culture-bound, class-bound, and linguistic features of psychological help.	7. Can seek consultation with traditional healers.
8. Respects indigenous helping practices and community networks.	8. Knows the effects of institutional barriers.	8. Can take responsibility to provide linguistic competence for clients.
9. Values bilingualism.	9. Knows bias of assessment.	9. Has expertise in cultural aspects of assessment.
	10. Knowledgeable about minority family structures, community, and so forth.	10. Works to eliminate bias, prejudice, and discrimination.
	11. Knows how discriminatory practices operate at a community level.	11. Educates clients in the nature of one's practice.

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 a 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

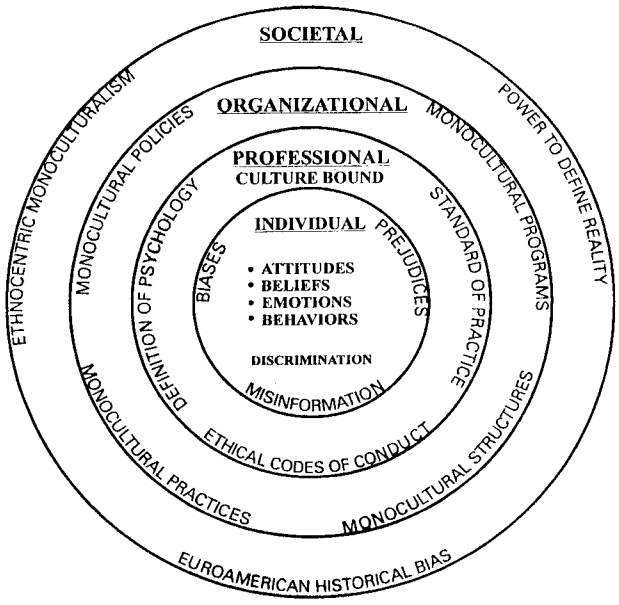

Figure 3. The foci of cultural competence: Individual, professional, organizational, and societal.

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, l985; Marsella, 1998; Parham, l993; White & Parham, l990) and is, oftentimes, inapplicable to racial/ethnic minority groups. Some African American psychologists (Parham, l993; Parham et al., l990; White & Parham, l990) 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 l800s, 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 (l993) 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 (571-447 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, l986; Foster, Cross, Jackson, & Hardiman, l988; Jackson & Holvino, l988; D. W. Sue, l991), but contributions from education (Barr & Strong, l987; D'Andrea et al., l991; Highlen, l994) and mental health agencies (Cross et al., l989) are also useful. Multicultural specialists have identified three types of organizations as they move toward multicultural implementation (Adler, l986; Barr & Strong, l987; Cross et al., l989; D'Andrea & Daniels, 1991; Foster et al., l988; Highlen, l994; D. W. Sue, l991).

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, l995; Laird & Green, l996; Ridley, l995; D. W. Sue et al., l992). 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 foci 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 foci 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 posses 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.

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