A Tripartite Framework for Understanding the Multiple Dimensions of Identity

All too often, counseling and psychotherapy seem to ignore the group dimension of human existence. For example, a White counselor who works with an African American client might intentionally or unintentionally avoid acknowledging the racial or cultural background of the person by stating, "We are all the same under the skin" or "Apart from your racial background, we are all unique." We have already indicated possible reasons why this happens, but such avoidance tends to negate an intimate aspect of the client's group identity. These forms of microinvalidations will be discussed more fully in Chapter 5. As a result, the African American client might feel misunderstood and resentful toward the helping professional, hindering the effectiveness of multicultural counseling. Besides unresolved personal issues arising from the counselor, the assumptions embedded in Western forms of therapy exaggerate the chasm between therapist and minority client.

First, the concepts of counseling and psychotherapy are uniquely Euro-American in origin, as they are based on certain philosophical assumptions

and values that are strongly endorsed by Western civilizations. On the one side are beliefs that people are unique and that the psychosocial unit of operation is the individual; on the other side are beliefs that clients are the same and that the goals and techniques of counseling and therapy are equally applicable across all groups. Taken to its extreme, this latter approach nearly assumes that persons of color, for example, are White and that race and culture are insignificant variables in counseling and psychotherapy. Statements like "There is only one race, the human race" and "Apart from your racial/cultural background, you are no different from me" are indicative of the tendency to avoid acknowledging how race, culture, and other group dimensions may influence identity, values, beliefs, behaviors, and the perception of reality (Carter, 2005; Helms, 1990; D. W. Sue, 2001).

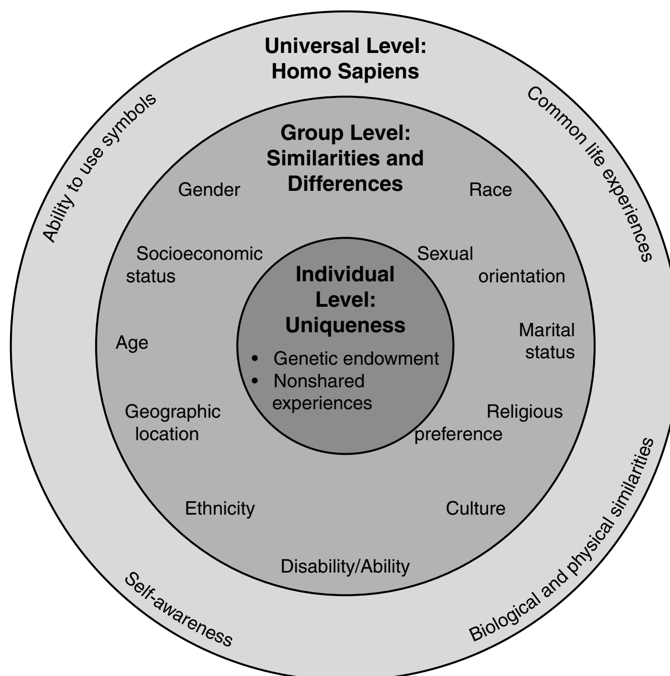
Related to the negation of race, we have indicated that a most problematic issue deals with the inclusive or exclusive nature of multiculturalism. A number of psychologists have indicated that an inclusive definition of multiculturalism (gender, ability/disability, sexual orientation, etc.) can obscure the understanding and study of race as a powerful dimension of human existence (Carter, 2005; Helms & Richardson, 1997). This stance is not intended to minimize the importance of the many cultural dimensions of human identity but rather emphasizes the greater discomfort that many psychologists experience in dealing with issues of race rather than with other sociodemographic differences. 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. We 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 (à la Dr. Murphy).

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, on the one hand, and our need to acknowledge the existence of other group identities related to social class, gender, ability/disability, age, religious affiliation, and sexual orientation, on the other (D. W. Sue, Bingham, Porche-Burke, & Vasquez, 1999).

There is an old Asian saying that goes something like this: "All individuals, in many respects, are (a) like no other individuals, (b) like some individuals, and (c) like all other individuals." While this statement might sound confusing and contradictory, Asians believe these words to have great wisdom and to be entirely true with respect to human development and identity. We have found the tripartite framework shown in Figure 2.1 (D. W. Sue, 2001) to be useful in exploring and understanding the formation of personal

Figure 2.1

Tripartite Development of Personal Identity



identity. The three concentric circles illustrated in Figure 2.1 denote individual, group, and universal levels of personal identity.

Individual level: "All individuals are, in some respects, like no other individuals." There is much truth in the saying that no two individuals are identical. We are all unique biologically, and recent breakthroughs in mapping the human genome have provided some startling findings. Biologists, anthropologists, and evolutionary psychologists had looked to the Human Genome Project as potentially providing answers to comparative and evolutionary biology, to find the secrets to life. Although the project has provided valuable answers to many questions, scientists have discovered even more complex questions. For example, they had expected to find 100,000 genes in the human genome, but approximately 20,000 were initially found, with the possible existence of another 5,000—only two or three times more than are found in a fruit fly or a nematode worm. Of those 25,000 genes, only 300 unique genes distinguish us from the mouse. In other words, human and mouse genomes are about 85 percent identical! While it may be a blow to human dignity, the more important question is how so relatively few genes can account for our humanness.

Likewise, if so few genes can determine such great differences between species, what about within the species? Human inheritance almost guaran-

tees differences because no two individuals ever share the same genetic endowment. Further, no two of us share the exact same experiences in our society. Even identical twins, who theoretically share the same gene pool and are raised in the same family are exposed to both shared and nonshared experiences. Different experiences in school and with peers, as well as 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 are shared experiences (Plomin, 1989; Rutter, 1991).

Group level: "All individuals are, in some respects, like some other individuals." As mentioned earlier, each of us is born into a cultural matrix of beliefs, values, rules, and social practices (D. W. Sue, Ivey, & Pedersen, 1996). By virtue of social, cultural, and political distinctions made in our society, perceived group membership exerts a powerful influence over how society views sociodemographic groups and over how its members view themselves and others (Atkinson et al., 1998). Group markers such as race and gender are relatively stable and less subject to change. Some markers, such as education, socioeconomic status, marital status, and geographic location, are more fluid and changeable. While ethnicity is fairly stable, some argue that it can also be fluid. Likewise, debate and controversy surround the discussions about whether sexual orientation is determined at birth and whether we should be speaking of sexuality or sexualities. Nevertheless, membership in these groups may result in shared experiences and characteristics. They may serve as powerful reference groups in the formation of worldviews. On the group level of identity, Figure 2.1 reveals that people may belong to more than one cultural group (i.e., an Asian American female with a disability), that some group identities may be more salient than others (race over religious orientation), and that the salience of cultural group identity may shift from one to the other depending on the situation. For example, a gay man with a disability may find that his disability identity is more salient among the able-bodied but that his sexual orientation is more salient among those with disabilities.

Universal level: "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, etc.), (c) self-awareness, and (d) the ability to use symbols such as language. In Shakespeare's *Merchant of Venice,* Shylock attempts to acknowledge the universal nature of the human condition by asking, "When you prick us, do we not bleed?" Again, while the Human Genome Project indicates that a few genes may cause major differences between and within species, it is startling how similar the genetic material within our chromosomes is and how much we share in common.

Individual and Universal Biases in Psychology and Mental Health

Unfortunately, psychology—and mental health professionals in particular—have generally focused on either the individual or universal levels of identity, placing less importance on the group level. There are several reasons for this orientation. First, our society arose from the concept of rugged individualism, and we have traditionally valued autonomy, independence, and uniqueness. Our culture assumes 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 anyone but yourself" reflect this value. Psychology and education represent the carriers of this value, and the study of individual differences is most exemplified in the individual intelligence testing movement that pays homage to individual uniqueness (Suzuki, Kugler, & Aquiar, 2005).

Second, the universal level is consistent with the tradition and history of psychology, which 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 (Chang & S. Sue, 2005).

Third, we have historically neglected the study of identity at the group level for sociopolitical and normative reasons. As we have seen, 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 (Helms & Richardson, 1997; D. W. Sue 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). We have more to say about this in the next chapter.

Nevertheless, disciplines that hope to understand the human condition cannot neglect any level of our identity. For example, psychological explanations that acknowledge the importance of group influences such as gender, race, culture, sexual orientation, socioeconomic class, and religious affiliation lead to more accurate understanding of human psychology. Failure to acknowledge these influences may skew research findings and lead to biased conclusions about human behavior that are culture-bound, class-bound, and gender-bound.

Thus, it is possible to conclude that all people possess individual, group, and universal levels of identity. A holistic approach to understanding personal identity demands that we recognize all three levels: individual (uniqueness), group (shared cultural values and beliefs), and universal (common features of being human). Because of the historical scientific neglect of the group level of identity, this text focuses primarily on this category.

Before closing this portion of our discussion, however, we would like to add a caution. While the concentric circles in Figure 2.1 might unintentionally suggest a clear boundary, each level of identity must be viewed as permeable and ever-changing in salience. In counseling and psychotherapy, for example, a client might view his or her uniqueness as important at one point in the session and stress commonalities of the human condition at another. Even within the group 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 impact our lives. Being an elderly, gay, Latino male, for example, represents four potential reference groups operating on the person. The culturally competent helping professional must be willing and able to touch all dimensions of human existence without negating any of the others.

The Impact of Group Identities on Counseling and Psychotherapy

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 (Fraga, Atkinson, & Wampold, 2002; D. W. Sue, 2001). 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 (Katz, 1985). Given that schools of counseling and psychotherapy arise from Western European contexts, the worldview that 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 distinct interpretation of reality and offer a different perspective on the nature of people, the origin of disorders, standards for judging normality and abnormality, and therapeutic approaches.

Among many Asian Americans, for example, a "self orientation" is considered undesirable while 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, while unhealthy development is thinking only of oneself. Likewise, relative to their Euro-American counterparts, many African Americans value the emotive and affective quality of interpersonal interactions as qualities of sincerity and authenticity (Parham, 1997; Parham et al., 1999). Euro-Americans often view the passionate expression of affect as irrational, lacking objectivity, impulsive, and immature on the part of the communicator. Thus, the autonomy-oriented goal of counseling and psycho-

therapy and the objective focus of the therapeutic process might prove antagonistic to the worldviews of Asian Americans and African Americans, respectively.

It is therefore highly probable that different racial/ethnic minority groups perceive the competence of the helping professional differently than do mainstream client groups. Further, if race/ethnicity affects perception, what about other group differences, such as gender and sexual orientation? If that is the case, minority clients may see a clinician who exhibits therapeutic skills that are associated primarily with mainstream therapies as having lower credibility. The important question to ask is, "Do groups such as racial/ethnic minorities define cultural competence differently than do 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 (Constantine, 2007; Fraga et al., 2002; McGoldrick, Giordano, & Garcia-Preto, 2005; Nwachuku & Ivey, 1991; D. W. Sue & Sue, 1999; Wehrly, 1995).

What Is Multicultural Counseling/Therapy?

In light of the previous analysis, let us define *multicultural counseling/therapy* (*MCT*) as it relates to the therapy process and the roles of the mental health practitioner:

> *Multicultural counseling and therapy can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems. (D. W. Sue & Torino, 2005)*

This definition often contrasts markedly with traditional definitions of counseling and psychotherapy. A more thorough analysis of these characteristics is described in Chapter 4. For now, let us extract implications for counseling practice from the definition just given.

1. *Helping role and process.* MCT involves broadening the roles that counselors play and expands the repertoire of therapy skills considered helpful and appropriate in counseling. The more passive and objective stance taken by therapists in clinical work is seen as only one method of helping. Likewise, teaching, consulting, and advocacy can supplement the conventional counselor or therapist role.

2. *Consistent with life experiences and cultural values.* Effective MCT means using modalities and defining goals for culturally diverse clients that are consistent with their racial, cultural, ethnic, gender, and sexual orientation backgrounds. Advice and suggestions, for example, may be effectively used for some client populations.
3. *Individual, group, and universal dimensions of existence.* As we have already seen, MCT acknowledges that our existence and identity are composed of individual (uniqueness), group, and universal dimensions. Any form of helping that fails to recognize the totality of these dimensions negates important aspects of a person's identity.
4. *Universal and culturespecific strategies.* Related to the second point, MCT believes that different racial/ethnic minority groups might respond best to culture-specific strategies of helping. For example, research seems to support the belief that Asian Americans are more responsive to directive/active approaches and that African Americans appreciate helpers who are authentic in their self-disclosures. Likewise, it is clear that common features in helping relationships cut across cultures and societies as well.
5. *Individualism and collectivism.* MCT broadens the perspective of the helping relationship by balancing the individualistic approach with a collectivistic reality that acknowledges our embeddedness in families, significant others, communities, and cultures. A client is perceived not just as an individual, but as an individual who is a product of his or her social and cultural context.
6. *Client and client systems.* MCT assumes a dual role in helping clients. In many cases, for example, it is important to focus on the individual clients and encourage them to achieve insights and learn new behaviors. However, when problems of clients of color reside in prejudice, discrimination, and racism of employers, educators, and neighbors, or in organizational policies or practices in schools, mental health agencies, government, business, and society, the traditional therapeutic role appears ineffective and inappropriate. The focus for change must shift to altering client systems rather than individual clients.

What Is Cultural Competence?

Consistent with this definition of MCT, it becomes clear that a culturally competent healer is working toward several primary goals (D. W. Sue et al., 1982; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1998). First, a culturally competent helping professional is one who is actively in the process of becoming aware of his or her own assumptions about human behavior,

values, biases, preconceived notions, personal limitations, and so forth. Second, a culturally competent helping professional is one who actively attempts to understand the worldview of his or her culturally different client. In other words, what are the client's values and assumptions about human behavior, biases, and so on? Third, a culturally competent helping professional is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different client. These three goals make it clear that cultural competence is an active, developmental, and ongoing process and that it is aspirational rather than achieved. Let us more carefully explore these attributes of cultural competence.

Competency One: Therapist Awareness of One's Own Assumptions, Values, and Biases

In almost all human service programs, counselors, therapists, and social workers are familiar with the phrase, "Counselor, know thyself." Programs stress the importance of not allowing our own biases, values, or hang-ups to interfere with our ability to work with clients. In most cases, such a warning stays primarily on an intellectual level, and very little training is directed at having trainees get in touch with their own values and biases about human behavior. In other words, it appears to be easier to deal with trainees' cognitive understanding about their own cultural heritage, the values they hold about human behavior, their standards for judging normality and abnormality, and the culture-bound goals toward which they strive.

What makes examination of the self difficult is the emotional impact of attitudes, beliefs, and feelings associated with cultural differences such as racism, sexism, heterosexism, able-body-ism, and ageism. For example, as a member of a White Euro-American group, what responsibility do you hold for the racist, oppressive, and discriminating manner by which you personally and professionally deal with persons of color? This is a threatening question for many White people. However, to be effective in MCT means that one has adequately dealt with this question and worked through the biases, feelings, fears, and guilt associated with it.

Competency Two: Understanding the Worldview of Culturally Diverse Clients

It is crucial that counselors and therapists understand and can share the worldview of their culturally diverse clients. This statement does not mean that providers must hold these worldviews as their own, but rather that they can see and accept other worldviews in a nonjudgmental manner. Some have

referred to the process as cultural role taking: The therapist acknowledges that he or she has not lived a lifetime as an Asian American, African American, American Indian, or Hispanic American person. It is almost impossible for the therapist to think, feel, and react as a racial minority individual. Nonetheless, cognitive empathy, as distinct from affective empathy, may be possible. In cultural role taking the therapist acquires practical knowledge concerning the scope and nature of the client's cultural background, daily living experience, hopes, fears, and aspirations. Inherent in cognitive empathy is the understanding of how therapy relates to the wider sociopolitical system with which minorities contend every day of their lives.

Competency Three: Developing Appropriate Intervention Strategies and Techniques

Effectiveness is most likely enhanced when the therapist uses therapeutic modalities and defines goals that are consistent with the life experiences and cultural values of the client. This basic premise will be emphasized throughout future chapters. Studies have consistently revealed that (1) economically and educationally marginalized clients may not be oriented toward "talk therapy"; (2) self-disclosure may be incompatible with the cultural values of Asian Americans, Hispanic Americans, and American Indians; (3) the sociopolitical atmosphere may dictate against self-disclosure from racial minorities and gays and lesbians; (4) the ambiguous nature of counseling may be antagonistic to life values of certain diverse groups; and (5) many minority clients prefer an active/directive approach to an inactive/nondirective one in treatment. Therapy has too long assumed that clients share a similar background and cultural heritage and that the same approaches are equally effective with all clients. This erroneous assumption needs to be buried.

Because groups and individuals differ from one another, the blind application of techniques to all situations and all populations seems ludicrous. The interpersonal transactions between the counselor and client require differential approaches that are consistent with the person's life experiences (Sue et al., 1996). In this particular case, and as mentioned earlier, it is ironic that equal treatment in therapy may be discriminatory treatment! Therapists need to understand this. As a means to prove discriminatory mental health practices, racial/ethnic minority groups have in the past pointed to studies revealing that minority clients are given less preferential forms of treatment (medication, electroconvulsive therapy, etc.). Somewhere, confusion has occurred, and it was believed that to be treated differently is akin to discrimination. The confusion centered on the distinction between equal access and opportunities versus equal treatment. Racial/ethnic minority groups may not be asking for equal treatment so much as they are asking for equal access and opportunities. This dictates a differential approach that is truly nondiscrimi-

natory. Thus, to be an effective multicultural helper requires cultural competence. In light of the previous analysis, we define it in the following manner:

> *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 a organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (D. W. Sue & Torino, 2005)*

This definition of cultural competence in the helping professions makes it clear that the conventional one-to-one, in-the-office, objective form of treatment aimed at remediation of existing problems may be at odds with the sociopolitical and cultural experiences of their clients. Like the complementary definition of MCT, it addresses not only clients (individuals, families, and groups) but also client systems (institutions, policies, and practices that may be unhealthy or problematic for healthy development). This is especially true if problems reside outside rather than inside the client. For example, prejudice and discrimination such as racism, sexism, and homophobia may impede the healthy functioning of individuals and groups in our society.

Second, cultural competence can be seen as residing in three major domains: (a) attitudes/beliefs component—an understanding of one's own cultural conditioning that affects the personal beliefs, values, and attitudes of a culturally diverse population; (b) knowledge component—understanding and knowledge of the worldviews of culturally diverse individuals and groups; and (c) skills component—an ability to determine and use culturally appropriate intervention strategies when working with different groups in our society. Table 2.1 provides an outline of cultural competencies related to these three domains.

Third, in a broad sense, this definition is directed toward two levels of cultural competence: the person/individual and the organizational/system levels. 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 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 (Lewis, Lewis, Daniels, & D'Andrea, 1998; D. W. Sue, 2001). We suggest that it does little good to train culturally com-

Table 2.1 Multicultural Counseling Competencies

I. Cultural Competence: Awareness

1. Moved from being culturally unaware to being aware and sensitive to own cultural heritage and to valuing and respecting differences.
2. Aware of own values and biases and of how they may affect diverse clients.
3. Comfortable with differences that exist between themselves and their clients in terms of race, gender, sexual orientation, and other sociodemographic variables. Differences are not seen as deviant.
4. Sensitive to circumstances (personal biases; stage of racial, gender, and sexual orientation identity; sociopolitical influences, etc.) that may dictate referral of clients to members of their own sociodemographic group or to different therapists in general.
5. Aware of their own racist, sexist, heterosexist, or other detrimental attitudes, beliefs, and feelings.

II. Cultural Competence: Knowledge

1. Knowledgeable and informed on a number of culturally diverse groups, especially groups therapists work with.
2. Knowledgeable about the sociopolitical system's operation in the United States with respect to its treatment of marginalized groups in society.
3. Possess specific knowledge and understanding of the generic characteristics of counseling and therapy.
4. Knowledgeable of institutional barriers that prevent some diverse clients from using mental health services.

III. Cultural Competence: Skills

1. Able to generate a wide variety of verbal and nonverbal helping responses.
2. Able to communicate (send and receive both verbal and nonverbal messages) accurately and appropriately.
3. Able to exercise institutional intervention skills on behalf of their client when appropriate.
4. Able to anticipate impact of their helping styles, and limitations they possess on culturally diverse clients.
5. Able to play helping roles characterized by an active systemic focus, which leads to environmental interventions. Not restricted by the conventional counselor/therapist mode of operation.

Source: D.W. Sue et al. (1992) and D. W. Sue et al. (1998). Readers are encouraged to review the original 34 multicultural competencies, which are fully elaborated in both publications.

petent 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 become involved in impacting systemic and societal levels as well.

Last, our definition of cultural competence speaks strongly to the development of alternative helping roles. Much of this comes from recasting healing as involving more than one-to-one therapy. If part of cultural competence involves systemic intervention, then roles such as a consultant, change agent, teacher, and advocate supplement the conventional role of therapy. In contrast to this role, alternatives are characterized by the following:

- Having a more active helping style
- Working outside the office (home, institution, or community)
- Being focused on changing environmental conditions as opposed to changing the client
- Viewing the client as encountering problems rather than having a problem
- Being oriented toward prevention rather than remediation
- Shouldering increased responsibility for determining the course and outcome of the helping process

It is clear that these alternative roles and their underlying assumptions and practices have not been perceived as activities consistent with counseling and psychotherapy.