Professional Psychology: Research and Practice
2008, Vol. 39, No. 2, 182–191

0735-7028/08/$12.00 DOI: 10.1037/0735-7028.39.2.182

Continuing Education in Cultural Competence for Community Mental Health Practitioners

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Continuing education in cultural competence is a key strategy for enhancing provider effectiveness in working with culturally diverse clients. In the mental health field, a majority of published works address training issues related to students in graduate programs. Few articles, however, discuss specific models or methods of continuing education for practitioners working in community-based settings. The authors present a case example of an interactive workshop in cultural competence for community mental health practitioners. They discuss key modules of this workshop, including (a) cultural competence and outreach principles, (b) cultural identity and worldview, (c) stereotyping and automatic thinking, (d) dynamics of difference, and (e) application exercises. Recommendations are offered for administrators, direct care staff, trainers, and researchers who may be interested in undertaking or participating in cultural competence continuing education efforts.

Keywords: cultural competence, multicultural competence, continuing education, community mental health, mental health outreach

Provision of community mental health care that appropriately addresses the cultural beliefs, values, and worldviews of those seeking services involves complex and dynamic clinical processes. Service providers in community settings are faced with the challenge of working with individuals who are economically disadvantaged, who present with multiple basic needs, and who are diverse across the full multicultural spectrum of racial or ethnic heritage, gender, age, religious orientation, and housing status, among other dimensions of cultural identity. It is critically important for providers to be able to negotiate intra- and interpersonal cultural dynamics, norms, and values to provide services that appropriately address the unique needs of all clients (American Psychological Association [APA], 2003; Sue, Arrendondo, & McDavis, 1992; Sue et al., 1998). The absence of skillful and appropriate cultural responsiveness can lead to misdiagnosis, a lack of engagement and retention, and poor clinical outcomes (Cheung & Snowden, 1990; U.S. Department of Health and Human Services, 2001).

Training in cultural competence has been cited as a strategy for enhancing provider effectiveness in working with culturally different clients (Beach et al., 2005; Brach & Fraser, 2000; Ridley, Chih, & Olivera, 2000; U.S. Department of Health and Human Services, 2001). Within the mental health field, however, little has been written about specific models or methods of continuing education in cultural competence for community-based practitioners. Instead, most published works focus on the education of students in psychology or counseling programs, addressing such areas as (a) models and approaches to multicultural graduate education (Ridley, Mendoza, & Kanitz, 1994; Speight, Thomas, Kennel, & Anderson, 1995); (b) curricular content, including strategies for implementing APA Multicultural Guidelines (2003) in psychology programs and counseling centers (Fouad, 2006; Holcomb-McCoy, 2000; McRae & Johnson, 1991; Resnik, 2006; Tomlinson-Clarke & Wang, 1999); (c) multicultural supervision (Ashby & Cheatham, 1996; D'Andrea & Daniels, 1997); and (d) the assessment of student multicultural competence (Pope-Davis, Reynolds, Dings, & Nielson, 1995; Pope-Davis, Reynolds, Dings, & Ottavi, 1994). Research suggests that multicultural training is associated with increased White racial consciousness and interracial comfort (Parker, Moore, & Neimeyer, 1998), increased ability to conceptualize a culturally diverse client's mental health issues (Constantine & Ladany, 2000), and more positive ratings of counselor competence (Steward, Morales, Bartell, Miller, & Weeks, 1998).

Although teaching principles of cultural competence to graduate students is critical for increasing the pool of providers trained to work with diverse groups of clients, continuing education oppor-

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WE THANK Raquel Andres-Hyman for her helpful editorial comments during the preparation of this article.

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tunities for providers in professional settings are critically needed as well (Parham & Whitten, 2003). Such educational opportunities are particularly important for professionals trained in programs with minimal or no required multicultural coursework and are consistent with APA ethical principles, which prohibit providing care to those whom one has not been trained to treat (APA, 2002). Although there is little in current literature that addresses continuing education models for community-based mental health practitioners, related research demonstrates the benefits of multicultural continuing education. For example, Wheaton and Granellor (1998) found that rehabilitation counselors who attended a greater number of multicultural workshops received significantly higher scores on the full scale and knowledge, skills, and awareness subscales of the Multicultural Counseling Inventory. Similarly, within nursing and medicine, cultural competence education and training have been found to increase the cultural knowledge, skills, and awareness of professionals in practice (Beach et al., 2005). Given these findings, continuing education appears to be a viable avenue for enhancing the cultural competence of service providers working in public sector mental health settings.

For this discussion, we define *cultural competence* as knowledge and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programs that match the cultural experiences and traditions of clients and that increase both the quality and appropriateness of health care services and health outcomes (Davis, 1998). We present an introductory workshop model that uses experiential learning techniques to instruct community mental health and outreach workers in specific knowledge, skills, and awareness domains outlined in the Multicultural Counseling Competencies (MCCs; Arredondo et al., 1996; Sue et al., 1992). We begin with a brief presentation of the MCCs, which serve as the theoretical framework guiding the development of our workshop. Following this, we present a case example of a workshop model carried out with community mental health and homeless outreach workers, and we conclude with a summary and recommendations for those interested in undertaking or participating in cultural competence continuing education efforts.

Multicultural Counseling Competencies as a Guiding Framework

The MCCs were first developed in 1992 as a set of competency guidelines for enhancing service delivery with racial and ethnic populations (Sue et al., 1992). Expanded from the landmark tripartite model of multicultural competence that identified knowledge, skills, and awareness as key dimensions of multicultural competence (Sue et al., 1982), the MCCs are organized in a 3 × 3 framework in which characteristics of a culturally skilled counselor are cross-classified with primary domains of multicultural competence to create a total of nine competency areas. Culturally skilled counselor characteristics include (a) counselor awareness of his or her assumptions, values, and biases; (b) counselor understanding of the worldview of the culturally different client; and the (c) development of culturally appropriate intervention strategies and techniques. Cultural competency domains include (a) attitudes and beliefs, (b) knowledge, and (c) skills. Furthermore, for each of the nine cultural competency areas, a number of specific explanatory guidelines are presented, creating a total of 31 recommended guidelines for the delivery of culturally competent care to populations of color.

Originally published as a work in progress, the MCCs were later conceptually expanded to allow for greater applicability across traditionally marginalized and oppressed groups. As part of the expansion of the original guidelines, the Dimensions of Personal Identity model was introduced. This model outlines key identity dimensions, in addition to race and ethnicity, that "contribute to an individual's sense of identity and worldview within a sociopolitical and historical context" (Arredondo, 1999, p. 105) and that must be taken into consideration when translating the MCCs into practice. Components of the Dimensions of Personal Identity model include Dimension A, including such social identity attributes as age, culture, ethnicity, gender, language, physical and mental well-being, race, sexual orientation, and social class; Dimension B, including educational background, geographical location, hobbies, military experience, relationship status, religion and spirituality, and health care practices and beliefs; and Dimension C, representing historical moments and eras (Arredondo, 1999). An additional feature of the expanded MCCs model was the inclusion of explanatory statements that operationalize competency areas of the original guidelines. In a later update of the model, three competency areas related to organizational cultural competence were added (Sue et al., 1998), thus creating a total of 34 multicultural competency areas (for a full listing of the MCCs and explanatory statements, see Arredondo et al., 1996).

Undoubtedly, the development of the MCCs contributed to advancing the multicultural competency movement in the field of psychology. For instance, in 2002, the American Counseling Association endorsed MCCs put forth by the Association of Multicultural Counseling and Development. Also in 2002, the APA built on the MCCs in developing its *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists*. The guidelines were published as policy in the *American Psychologist* in 2003, and provide a blueprint for multicultural development and change at the individual and organizational levels (Arredondo & Perez, 2006). Interestingly, despite the presence of the MCCs and the APA guidelines, one recent study found a discrepancy between professional psychologists' beliefs in the importance of multicultural competencies and their actual practices when working with diverse groups. This finding suggests the need for greater attention to skills building and continuing education efforts for professional psychologists (Hansen et al., 2006).

Workshop Background and Design Considerations

The case description that follows is generalized from introductory cultural competency workshops we conducted with community mental health outreach workers in four midwestern and eastern U.S. states. Although we describe a case example of this workshop model with community mental health outreach workers specifically, we have conducted this workshop, with modifications, over 30 times, in 1- or 2-day programs, with an array of health care providers and with university residence hall counselors. We attribute the broad applicability of the workshop to the comprehensive nature of the MCCs model and its strength in capturing necessary cultural competence areas for meeting client needs within various helping professions.

In designing the initial workshop model and its adapted versions, our overarching goal was to create a dynamic interactive experience that would allow participants to explore principles of cultural competence and to discuss the relevance of these principles in community mental health practice, including potentially sensitive areas of culture pertaining to race, sexuality, stereotyping, and privilege. Throughout the workshop, experiential learning techniques are used as a key teaching strategy through the use of film clips, interactive exercises, and small-and large-group discussions. The research literature suggests that experiential learning may be particularly useful in facilitating personal reflection, cultural empathy, and increased awareness of one's own worldview and cultural expectancies (Arthur & Achenbach, 2002; Kim & Lyons, 2003). In addition, we find that experiential and interactive activities can lessen the sense of an imposed and separate body of knowledge that people will understand or fail to understand. In our workshops, we draw on the collective wisdom of participants through activities that elicit examples of cultural competence principles and guidelines in their day-to-day work. Such real-life examples are powerful teaching tools and help to make cultural competence accessible and concrete for participants. To maximize participation, we limit enrollment to 25 people.

The Community Mental Health Cultural Competence Workshop: A Case Example

From a curriculum design and conceptual perspective, the practice of assertive mental health outreach represents a "good fit" for an introductory training in the principles of cultural competence for two quite different reasons. On the one hand, the person- and strengths-focused philosophy and theory of assertive mental health outreach provide fertile ground for incorporating the philosophy and theory of cultural competence, which emphasize understanding and making contact with the whole person as well as the client or patient (Rowe, 1999). On the other hand, there is a surprising lack of attention to issues of cultural competence in the outreach literature. Thus, drawing on the MCCs model (Arredondo et al., 1996; Sue et al., 1992), a key focus of the workshop is to raise participants' awareness and knowledge of the role of culture in the outreach process and to explore the manner in which awareness of multicultural issues can be translated into specific skills in engaging homeless persons.

The workshop comprises five content areas drawing primarily from the MCCs' counselor characteristic domains of counselor awareness of personal assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques. Specific workshop content areas include (a) cultural competence and outreach principles, (b) cultural identity and worldview, (c) stereotyping and automatic thinking, (d) dynamics of difference, and (e) application exercises. Below we present a typical workshop addressing these content areas and include themes that frequently emerge during participant discussions throughout the training.

Introductions

With participants and facilitators standing in a circle, one facilitator holds a ball of yarn and instructs participants to introduce themselves, stating their name, where they work, and where they would go if they were given an all-expense-paid vacation. We model this for participants, and then throw the ball to a participant. The exercise continues until all have introduced themselves. This activity creates a visual much like a spider's web or a net in the center of the circle. On completion of the activity, still standing in the circle and holding the yarn, we ask participants about the relevance of this exercise. The discussion that follows begins the process of thinking about culture, diversity, cultural competence, and mental health outreach work. Participants typically offer observations that the "web" or "net" symbolizes the interconnectedness of participants as well as the similarities and differences across them, as represented in the multiple vacation sites they chose. If not already noted by participants, we point out that this activity brings up ideas of community and helping, such as when a participant misses the tossed ball of yarn or the ball rolls out of the circle and other participants retrieve it and give it to the intended recipient.

Cultural Competence and Outreach Principles

Following this introductory exercise, we establish ground rules for the day, present the workshop agenda, and then review cultural competence and outreach principles with participants. To do this, we have found it useful to pass around two separate sheets, each listing one set of principles. Participants are asked to read a principle and pass the sheet to the person next to them until all principles are read. The principles of cultural competence we use are (a) working with clients is inevitably a cross-cultural enterprise (APA, 2003; Arredondo, 1999); (b) becoming culturally competent is a process, not an end point (APA, 2003; Campinha-Bacote, 2002); (c) a central part of working effectively across cultures is becoming aware of our own personal cultural filters (APA, 2003; Arredondo et al., 1996; Sue et al., 1998); (d) "to do" and "how to" approaches to cultural competency workshops can promote stereotyping (Gregg & Saha, 2006); and (e) stereotyping is a natural part of the human perception process, but is one we need to be aware of and challenge (Allport, 1954; APA, 2003; Arredondo et al., 1996; Hamilton, 1979). Principles of assertive mental health outreach include (a) start where people are both "physically"—on the streets, etc.—and "existentially"—what they see as their needs (Cohen & Marcus, 1992; Lamb, Bachrach, Goldfinger, & Kass, 1992); (b) respect the survival strengths of homeless people (Chafetz, 1992; Martin, 1990); (c) build trust by engaging with the person, not the patient (Brickner, 1992; Susser, Goldfinger, & White, 1990); (d) provide a range of services—housing, help with entitlements and work, social needs, and others—not just mental health treatment (Dennis, Buckner, Lipton, & Levine, 1991; Rowe, 1999); and (e) don't make promises you can't keep, and keep the promises you make (Rowe, 1999).

After reading these principles, we allow time for discussion and offer "devil's advocate" questions such as, "What's wrong with having 'to do' or 'how to' approaches to cultural competence?" (Possible answer: It contradicts the unique person-centered principle of cultural competence and may promote stereotyping.) In discussing the principles, participants frequently note their overlap and suggest that each set of principles helps to support the other. For instance, becoming aware of our own personal cultural filters helps one begin where people are physically and existentially. Similarly, becoming aware of and challenging stereotypes and

automatic thinking help one engage with the unique person rather than, for example, an abstract "homeless person with mental illness." We conclude this discussion by letting participants know that the principles presented are not comprehensive but rather are central tenets around which the workshop is designed.

Cultural Identity and Worldview

Our next exercise helps participants think about how the concept of cultural identity and worldview applies to their own lives and their work with clients. It is adapted from an activity in *The ASTD Trainer's Sourcebook, Diversity*: *Create Your Own Training Programs* (Rasmussen, 1996). Specific competency areas or explanatory statements addressed by completion and discussion of this activity include, but are not limited to, that culturally skilled counselors (a) "have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality and abnormality and the process of counseling" (Sue et al., 1992, p. 482); (b) "can recognize the influence of other personal dimensions of identity (PDI) and their role in cultural self-awareness" (Arredondo et al., 1996, p. 50); and (c) "can describe the A and B Dimensions of Identity with which they most strongly identify" (Arredondo et al., 1996, p. 52).

We begin by giving the participants a handout and asking each of them to complete two tasks. The first is to list all of the social or cultural identity groups to which the individual belongs (e.g., sister, woman, parent, middle class, African American, Catholic, etc.). The second task is to choose the three or four groups that each person deems as most central to who they are and to create a pie chart, dividing the pie according to the principal three or four personal or social identity dimensions that are most important to their view of themselves. Participants then discuss the exercise in pairs and are led through a facilitated full-group discussion that addresses their experience of completing the activity.

Discussions address the notion of similarities and differences between people, particularly along social identity dimensions that may not be immediately apparent. Also discussed is the idea that identity group salience is context and time dependent. Participants frequently note that the groups most central to their identity change over time as they take on different roles (i.e., student, health care provider, parent, grandparent, etc.). For some, certain identity groups are particularly salient and remain fairly stable over time. These include ethnic group membership and religious orientation. We review with participants the notion of worldview and how salient identity groups shape one's belief systems, assumptions, and modes of problem solving, decision making, and conflict resolution (Ibrahim, 1991). We also discuss with participants how worldview affects client help-seeking patterns, client and provider health and illness beliefs, and client and provider perceptions of normative behavior.

This exercise highlights the need to take a total-person approach to care and to consider the full cultural identity spectrum in working with individuals. This approach may be particularly important in assisting individuals who are homeless to connect with past aspects of themselves and their lives that may have held particular importance prior to becoming homeless. We conclude this exercise by distributing a handout of cultural dimensions to consider in working with clients. Adapted from Rasmussen (1996), this handout addresses intraindividual diversity through its delineation of dimensions of culture that are primary (e.g., race, ethnicity, gender, age, etc.) and secondary (e.g., housing status, economic class, geography, employment status, etc.). These dimensions parallel the A and B dimensions of the Personal Dimensions of Identity model in the revised MCCs (Arredondo et al., 1996). We note for participants that primary dimensions are those we are born into and are generally less malleable, and that secondary dimensions represent contextually based dimensions of one's identity (Arredondo, 1999; Arredondo et al., 1996; Rasmussen, 1996) that may change over time or be modified with conscious effort. Furthermore, as a transition to the next module addressing stereotyping and automatic thinking, we discuss with participants how many primary dimensions of diversity are visibly apparent and note that stereotyping, bias, and discrimination often occur on the basis of one's membership in one or more of these primary or secondary dimensions of identity.

Stereotyping and Automatic Thinking

The activities in this module provide participants with the opportunity to explore the automatic nature of personal and societal biases and the impact these can have on the mental health outreach and treatment process. Examples of guidelines or explanatory statements from the expanded MCCs framework addressed in this module are that culturally skilled counselors (a) "are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups" (Sue et al., 1992, p. 482); (b) "are aware of negative emotional reactions toward other racial and ethnic groups that may prove detrimental to their clients in counseling" (Sue et al., 1992, p. 482); and (c) "consciously attend to examples that contradict stereotypes" (Arredondo et al., 1996, p. 55). It is worth noting that, although examples (a) and (b) of these competency guidelines were written in terms of racial and ethnic stereotyping, the activities in this section are designed to address stereotyping in terms of any relevant cultural or personal identity dimensions.

We begin this section by showing a brief film titled *The Lunch Date*, in which the main character, an older White woman, has an encounter with an African American man in the film and learns that her initial impressions of the man are incorrect (Davidson, 1990). The film illustrates the automatic nature of stereotyping and challenges viewers' assumptions regarding the individuals depicted in various encounters in the movie.

In discussing the film and its relevance to homeless outreach work, we look at the importance of challenging automatic impressions and stereotypes that arise in our work with clients as well as in our day-to-day interactions. Drawing on the social cognitive stereotyping literature, we review findings that support the automatic and persistent nature of stereotyping and discuss strategies for reducing the biasing effects of automatic thinking (Hamilton, Stroessner, & Driscoll, 1994; Johnston & Macrae, 1994). For instance, we point out the need to gather as much individuating information about clients as possible in the time permitting as a means of countering stereotypic ideas a clinician may have when interacting with a client (Fiske & Neuberg, 1990). We highlight the primary and secondary dimensions of diversity, reviewed in the previous exercise, as cultural identity dimensions around which specific information about a person can be gathered as a means of

obtaining a more accurate and holistic understanding of his or her life space. Similarly, we discuss alternative hypothesis testing and information seeking to discount something believed to be true of a client as additional strategies that can help in reducing bias (Berardi-Coletta, Buyer, Dominowski, & Rellinger, 1995; Turk & Salovey, 1986). We conclude this exercise by discussing with participants any of these strategies that they have used, or wish they had used, in their work.

Following this activity, we lead participants through an exercise that illustrates the role stereotyping plays in mental health treatment from the perspectives of both persons receiving and persons providing services. We ask participants to join one of two groups—the minority group, on one side of the room, if they identify more with the minority perspective; and the majority group, on the other side of the room, if they identify more with the majority perspective. We give no further instructions regarding what we mean by the terms *minority* and *majority*. We then ask each group to generate a list of stereotypes that they believe the other group holds of them. From these lists, we instruct each group to select the eight most prominent stereotypes that they believe the other group believes of their group. Still working in their group, participants are each given a marker and asked to place an "I" next to the stereotypes that they believe to be the most inaccurate, a "U" next to those that they deem the most understandable, and a "P" next to the three stereotypes they consider to be the most painful. Each group then reports the tallies of Ps, Is, and Us and briefly discusses their experience of completing the exercise. This is followed by a large-group discussion addressing the process of completing the activity, including such specific prompts from the facilitators as, "On what basis did you choose to join your group?" "Did you learn anything new in completing the exercise?" and "What relevance does this exercise have to outreach work?"

A common theme in discussing this activity is the participants' surprise over the variability in minority and majority group identifications. Some state that they automatically interpreted the instructions in terms of race, whereas others say they chose their group identification in terms of economic status, gender, or political orientation. Often, we discuss worldview at this point, noting that identity group salience can contribute to how an individual interprets the instructions. Individuals for whom race is a central part of their identity, for example, are likely to interpret *minority* and *majority* in racial terms. Participants also report surprise at how quickly they were able to generate lists of stereotypes they believed the other group had of them and how liberating it was to be able to say publicly that certain stereotypes were inaccurate or painful to them. We note the ways in which awareness of mutual perceptions for both "minority" and "majority" groups can lead to enhanced cultural sensitivity and competence. In discussing the relevance of this activity for work with clients, we note the destructive nature of unchallenged and internalized stereotypes and the healing nature of providing clients with the opportunity to talk about ways that they have been discriminated against or treated differently on the basis of their cultural identity.

Dynamics of Difference Activities

Following lunch, which we recommend be served for the group as a whole to give participants time to relate to each other casually, we review the principles of cultural competence and assertive mental health outreach to "reground" the group in the conceptual foundation of the training. We then facilitate two activities that together illustrate the manner in which privilege and resources can affect interpersonal interactions, stereotyping, and help-seeking behavior. We call this section the "dynamics of difference" module, as each of its activities illustrates processes that can occur in the presence of both differences and similarities in social identity dimensions across various groups. Multicultural competency guidelines or explanatory statements addressed are that culturally skilled counselors (a) "can identify, name and discuss privileges that they personally receive in society due to their race, socioeconomic background, gender, physical abilities, sexual orientation, and so on" (Arredondo et al., 1996, p. 52); (b) "can identify implications of concepts such as internalized oppression, institutional racism, privilege, and the historical and current political climate regarding immigration, poverty and welfare (public assistance)" (Arredondo et al., 1996, p. 56); and (c) "should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served" (Arredondo et al., 1996, p. 59).

Structured inequality exercise. For the first activity in this module, we divide participants into four groups and give each group a packet containing different resource materials (scissors, glue, construction paper of various colors, paper clips, ruler, instructions, etc.). Each group has the same task to complete and, although each group has relatively more or fewer resources to complete the task, no group has all the materials necessary to complete the activity. We instruct the groups that they may barter with each other for resources, and the first group to complete the activity "wins." We then observe the ensuing process of negotiation and comment only when a participant asks a specific question, offering no further help than to repeat the initial instructions. At the end of the activity, typically marked by intense competition and trading or sharing of resources, we facilitate a group discussion on what it was like for members to have more or fewer resources, what the interactions among the groups were like, and the parallels between the exercise and the real-life experiences of their clients.

Overall, we stress that the activity quickly creates a microcosm of the various ways in which individuals negotiate having or not having resources in society, framing our comments around the manner in which the four groups related to one another. Occasionally, we see participants in the four groups quickly join as one group, share the resources, and complete the task together so that they win together as one large group. Just as often, however, as a result of unyielding competition, no group wins, and after allowing the activity to run beyond its roughly scheduled time of 45 min, we stop the exercise to allow time for discussion. In some cases, the group with the fewest resources finds creative ways to bargain with the other groups. At other times, this group simply gives up and refuses even to attempt the task. Participants in groups with many resources often remain at their table, oblivious to the scarcity of resources of the other groups, until approached by the others with requests to barter or borrow. If not approached, at the conclusion of the activity, those with greater resources often report a complete lack of awareness that the resources were inequitably distributed ("You mean everybody didn't have yellow paper, scissors, and glue?"). Recall that it is impossible to win the task without bargaining or forming collaborative relationships with

other groups, so in these instances the group would lose the activity.

In drawing links between this exercise and homeless outreach work, participants in the group that had some resources (paper, scissors, glue, etc.) but whose packet lacked instructions liken this situation to homeless persons who want treatment but have little knowledge of where to get help or how to navigate the mental health system. Participants note that this may be particularly true for recent immigrants or for monolingual individuals. Participants also may note that they have to "swallow their pride" to go to another group to ask for a particular resource or note the humiliation or anger they feel when they are turned away. They sometimes extrapolate this experience to that of homeless persons who are reluctant to ask for help because of past negative experiences with mental health treatment and the expectation of being rebuffed or mistreated if they ask for help again. At those times when no group wins and all lose, participants often note the similarity of this result to competition and duplication of resources within and between agencies that strain resources and inhibit their capacity to create or maintain creative programs that meet the ethnic and cultural needs of their client populations.

Walk through privilege. The last activity in this module illustrates interpersonal and societal ripple effects of stereotyping by addressing the unearned benefits of membership in a privileged group. Because this activity is higher risk than others, we dedicate a full hour or more to discuss the experience with participants and its relevance to working with clients. To begin the activity, participants line up shoulder to shoulder in the center of the room. We instruct them that we will read a series of statements and request that they take one step forward if the statement applies to them or to follow the instructions included at the end of the statement. The series of statements are examples of specific ways that stereotyping leads to bias and discrimination. Many of the statements are based on the classic Peggy McIntosh (1989) article *White Privilege: Unpacking the Invisible Knapsack*, which addresses privilege and stereotyping specifically related to race. We also include additional statements related to socioeconomic status, education, religion, sexual orientation, and other social identity groups to underscore the effects of stereotyping and privilege on other dimensions of cultural identity. Some examples of the statements we use follow:

1. I can be sure that if I need legal or medical help my race will not work against me.
2. I do not have to educate my children to be aware of systemic racism for their own protection.
3. If one of your parents was ever laid off, unemployed, or underemployed not by choice, take one step backward.
4. I have never been asked when and how I decided my sexual orientation.
5. I can browse in a store pretty well assured that I will not be followed or harassed.
6. My gender is not a consideration where salary is concerned.
7. If you ever skipped a meal or went away from a meal hungry because there wasn't enough money to buy food in your family, take a step backward.
8. Whether I use checks, credit cards, or cash, I can count on my skin color not to work against the appearance of financial reliability.

On completing this activity, we ask participants to look at other participants dispersed throughout the room. Typically, White men are in the front of the room, White women are next behind them, and persons of color are in the middle to the back of the room. Participants frequently report being surprised at the spread of individuals throughout the room, saying that, although they were aware of racism and discrimination, they had not expected to see such dispersion among them as a group, given their similarities in economic status and employment. Participants of color frequently report frustration at not being able to advance (i.e., step forward) while others advance, and many White Americans report frustration (and guilt) at having advanced, particularly because of having not felt privileged in their own lives. Participants often state that the exercise reminded them of the many ways that clients may be marginalized and how this, in turn, can negatively affect their willingness to engage in mainstream behavioral health services.

Application Exercises

The final two activities in this workshop are designed to encourage participants to integrate the material covered during the day into their thinking and, ultimately, their practice. In addition to addressing all of the MCCs covered to this point, this section of the workshop focuses on the third domain of the MCCs model (developing appropriate intervention strategies; Arredondo et al., 1996) and draws on the collective wisdom of the group through the sharing of stories. The research literature suggests that storytelling can be an effective teaching tool for promoting affective learning (Calman, 2001) and for linking theory with practice (Cangelosi & Whitt, 2006), both of which are key strategies for learning and applying MCCs.

We begin with participant stories, the focus of which is typically dependent on the composition of the group. To determine the focus for this activity when planning the workshop with administrative staff, we ask whether any consumer providers who are participating in the workshop would be willing to share their recovery stories and their experience of homelessness. If so, we ask these participants to share their stories with the group, including ways that cultural issues were, or were not, addressed in their treatment and recovery process. We then hold a large-group discussion in which participants ask questions or discuss any other thoughts or ideas that came up for them in hearing the consumer participants' stories of recovery. If consumer providers are not enrolled in the workshop, we ask participants to work in groups and share stories from their work in which they used, or wish they had used, some combination of cultural competence and outreach principles. We then have these small groups share their stories in the larger group. Following this, we have a full-group discussion of thoughts or ideas "sparked" by the stories related to any of the material discussed during the day.

We find this exercise to be a valuable part of the workshop in that it allows participants to hear and learn from each other about

strategies that have worked, or failed to work, in their efforts to address cultural issues in their encounters with clients. Although storytelling occurs throughout the workshop, at this point, participants have learned a number of new concepts and principles related to the MCCs. Thus, much of the sharing of stories in this activity involves an integration of the various competencies. In addition, in discussing their successes and challenges, participants often share information about relevant resources, including community agencies that have bilingual and bicultural staff, assessment measures that address key dimensions of culture, books they have read that helped them in working with diverse clients, movies that address key cultural issues, or Web resources. A key resource we frequently discuss with participants is the Outline for Cultural Formulation and the Glossary of Culture-Bound Syndromes in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; American Psychiatric Association, 2000).

A final exercise involves posing to the group two alternative and "equally justifiable" approaches to working with a person with mental illness—one that focuses on the uniqueness of the person and the assumption that from the start we know nothing about him or her, and the other that focuses on human qualities common to all people. We ask participants to imagine that the length of the room represents this continuum, and note that there are many other approaches along this continuum between these two poles. We then ask participants to take a place along the continuum that represents their approach to understanding their clients. Following this, we ask participants to imagine that they are a client and instruct them to take a place along the continuum that represents the approach they would like a clinician to take with them.

During discussions of this activity, participants frequently note a difference in where they stood on the first question versus the second question, with many stating that, in working with clients, they tend to assume that they knew some general things about the individual from the start and build the relationship from there. In responding to the second question, however, participants frequently state that, in imagining themselves as clients, they would prefer that a clinician not assume anything about them, wishing instead that they would ask them about their unique individual characteristics to reduce the possibility of being stereotyped. Others note that for them it is difficult to pinpoint their approach to working with clients because it varies on the basis of the client's individual characteristics. Finally, some participants note that in working with clients whom they perceive to be similar to them (in ethnicity, for example), they use what they know about their own membership in that ethnic group as a point of departure for asking about whether group-specific issues apply to the individual client.

Closing and Evaluation

We facilitate a brief closing activity in which participants have the opportunity to discuss one thing that they will take away from the workshop and how they think it will affect their work. Participants then complete a brief evaluation form, including items such as what they liked best, improvements they would suggest, and whether they would recommend the workshop to others. We are currently in the process of collecting long-term outcome data regarding program efficacy, and preliminary satisfaction ratings have been quite positive. For example, in a recent workshop, 24 of 25 participants (96%) indicated that they would recommend the training to others. In our experience, a rating above 95% is fairly typical, with the remaining 5% of respondents having left the training early and not completing an evaluation. In addition, in a recent training evaluated by the host agency, 96% of participants ($n = 22$) indicated that the scope and depth of the material were appropriate and at the right level for them. Dimensions of the workshop that participants reported liking most have included the interactive nature of the training, *The Lunch Date* film, the Walk Through Privilege exercise, the opportunity to learn more about the cultural background of their colleagues, and being able to hear different culturally relevant stories from other participants' work. Areas for improvement have included a longer training period, longer breaks, and more time for personal reflection. Perhaps the strongest endorsement for the workshop's value is that it is not advertised, and the majority of requests for the workshop come from people who have heard about it from previous participants.

Summary and Recommendations

Cultural competence continuing education and training are frequently cited as one strategy for enhancing provider skills in working with diverse individuals. We have presented a cultural competence workshop model that teaches participants about specific MCCs in relation to community mental health outreach work. With adaptations, we have presented this introductory workshop to a broad array of health care providers and residence hall counselors. On the basis of the lessons learned, we offer the following recommendations for behavioral health service providers, administrative staff, and consultants interested in cultural competence continuing education:

1. Demystify cultural competence. The term *cultural competence* can elicit defensiveness or feelings of incompetence. Cultural competence continuing education and training can be "demystified" through discussion of its key premises at the outset of a workshop. Discussion of the principle that "cultural competence is a process not an endpoint" helps to dispel the notion of "getting it" or "not getting it," and highlights the dynamic nature of enhancing one's cultural knowledge, skills, and awareness. In addition, facilitator discussion of stereotyping as a natural part of the human perception process, but one that can be harmful to others, shifts the focus away from whether or not the trainee has "the right stuff" to be culturally competent and toward the need to challenge cultural stereotypes by gathering information about clients related to their full cultural identity spectrum, including their race and ethnicity, religious or spiritual orientation, economic status, and other domains.

2. Balance ethnically specific and diversity-related material. Cultural competence attends both to racial and ethnic group patterns and to the unique characteristics of individuals based on the full cultural identity spectrum—gender, religious or spiritual orientation, and socioeconomic status, etc. Facilitators should address these aspects of cultural competence at the beginning of a workshop to create a shared understanding of the focus of the workshop and to communicate the importance of an integrated approach to teaching and practice. They may accomplish this through the discussion of the principle that "to do" and "how to" or "cookbook" workshops can promote stereotyping. As part of this discussion, facilitators should also note that race- and ethnic-specific information may be used as a point of departure for exploring

whether the information applies to a given individual (Andres-Hyman, Ortiz, Anez, Paris, & Davidson, 2006). Similarly, identity dimensions such as gender, religious or spiritual affiliation, or sexual orientation can be used to develop a more extensive picture of a person's life space and worldview, which in turn can serve to minimize bias and stereotyping.

3. Provide workshop participants with clear informed consent. Interactive cultural competency workshops designed to promote self-exploration and group discussion of such areas as cultural identity, stereotyping, privilege, and racism can elicit a range of emotions, including anger, guilt, or sadness. In keeping with the APA Ethical Guidelines, workshop facilitators should provide participants with informed consent by discussing these possible responses at the beginning of the workshop and offering support mechanisms for responding to any adverse outcomes stemming from the workshop (APA, 2002). Examples of follow-up support include scheduling debriefing sessions with participants, scheduling phone contacts with agency administrative staff, and providing participants with bibliographic and resource information for further reading.

4. Develop and continually refine workshop facilitation skills. The provision of cultural competence education and training requires unique skills to promote cultural learning while, at the same time, creating a safe environment for cultural dialogue among participants. We recommend that prospective trainers have some measure of expertise both in the literature on cultural competence and mental health outreach, as well as direct involvement in the use of these principles through previous involvement in service delivery, program design or implementation, consultation, or training on these topics.

5. Plan for ongoing education and training. Cultural competence continuing education is frequently approached from a "one-shot deal" perspective based on the belief that once one has attended one training session the work of becoming culturally competent is complete. We recommend that providers, supervisors, administrators, and support staff seek out and take part in ongoing education and training as a means of continuing the process of multicultural learning and skills building and as a means of fostering a cultural climate in their agency that is responsive to the needs of diverse clients. Finally, we encourage agencies to engage in "in-house" informal continuing education activities such as viewing and discussing films rich in cultural information or celebrating cultural holidays with presentations from relevant community members.

6. Adopt a systemic approach to enhancing cultural competence. Ongoing education and training can improve service delivery for diverse racial and ethnic groups. As a means of creating an overall organizational climate committed to enhancing cultural competence and eliminating behavioral health disparities, we encourage agency staff to engage in formal cultural competence strategic planning. Interventions such as forming creative collaborations and partnerships with community agencies, monitoring client performance and outcome data based on race and ethnicity, and conducting regular organizational cultural audits can contribute to improved service delivery and the elimination of behavioral health disparities for diverse groups (Evans, Delphin, Simmons, Omar, & Tebes, 2005).

7. Remember—one size does not fit all. In an effort to develop agency-tailored workshops, facilitators should gather information from front-line and administrative staff regarding past experiences with cultural competency training, including what staff have found helpful or unhelpful and key areas they would like to see covered in their workshop. In addition, it is critical to inquire about "pressing" cultural issues in the agency to determine whether conflict management and resolution are advisable prior to having staff participate in a cultural competence workshop. Eliciting such information is also helpful in tailoring the workshop to specific interest areas, and it can inform the development of case vignettes and other specific workshop activities. Such groundwork can help foster a participatory partnership with trainees, which may increase staff "buy in" regarding the workshop itself and contribute to an agency's assuming ownership of the cultural change process within their organization.

Conclusion

Cultural competence continuing education has special relevance in the field of community mental health. Mental illness itself is a stigmatizing experience in our culture, and membership in a historically oppressed, stigmatized, or underserved group can enhance a sense of marginalization for diverse populations. Design and delivery of interactive workshops that integrate key principles of cultural competence with relevant aspects of community mental health work may increase the accessibility of the construct and, in turn, enhance the cultural competence of direct care staff and the public mental health system as a whole.

References

Allport, G. (1954). *The nature of prejudice.* Cambridge, MA: Addison-Wesley.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct.* Retrieved October 1, 2006, from http://www.apa.org/ethics/code2002.html#principles

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

Andres-Hyman, R., Ortiz, J., Anez, L., Paris, M., & Davidson, L. (2006). Culture and clinical practice: Recommendations for working with Puerto Rican and other Latinas(os) in the United States. *Professional Psychology: Research and Practice, 37,* 694–701.

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development, 77,* 102–108.

Arredondo, P., & Perez, P. (2006). Historical perspectives on the multicultural guidelines and contemporary applications. *Professional Psychology: Research and Practice, 37,* 1–5.

Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42–78.

Arthur, N., & Achenbach, K. (2002). Developing multicultural counseling competencies through experiential learning. *Counselor Education and Supervision, 42,* 2–14.

Ashby, J. S., & Cheatham, H. E. (1996). Multicultural counseling and supervision. In J. L. DeLucia-Waack (Ed.), *Multicultural counseling competencies: Implications for training and practice* (pp. 47–59). Alexandria, VA: Association for Counselor Education and Supervision.

Beach, M. C., Price, E. G., Gary, T., Robinson, K. A., Gozu, A., Palacio,

A., et al. (2005). Cultural competence: A systematic review of healthcare provider educational interventions. *Medical Care, 43,* 356–373.

Berardi-Coletta, B., Buyer, L., Dominowski, R., & Rellinger, E. (1995). Metacognition and problem solving: A process-oriented approach. *Journal of Experimental Psychology, 21,* 205–223.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57,* 181–217.

Brickner, P. W. (1992). Medical concerns of homeless persons. In R. H. Lamb, L. L. Bachrach, & F. I. Kass (Eds.), *Treating the homeless mentally ill: A report of the Task Force on the Homeless Mentally Ill* (pp. 249–261). Washington, DC: American Psychiatric Association.

Calman, K. (2001). A study of storytelling, humor and learning in medicine. *Clinical Medicine, 1,* 227–229.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13,* 181–184.

Cangelosi, P., & Whitt, K. (2006). Teaching through storytelling: An exemplar. *International Journal of Nursing Education Scholarship, 3,* 1–7.

Chafetz, L. (1992). Why clinicians distance themselves from the homeless mentally ill. In R. H. Lamb, L. L. Bachrach, & F. I. Kass (Eds.), *Treating the homeless mentally ill: A report of the Task Force on the Homeless Mentally Ill* (pp. 95–107). Washington, DC: American Psychiatric Association.

Cheung, F. K., & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26,* 277–291.

Cohen, N. L., & Marcus, L. R. (1992). Outreach intervention models for the homeless mentally ill. In R. H. Lamb, L. L. Bachrach, & F. I. Kass (Eds.), *Treating the homeless mentally ill: A report of the Task Force on the Homeless Mentally Ill* (pp. 141–157). Washington, DC: American Psychiatric Association.

Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47,* 155–164.

D'Andrea, M., & Daniels, J. (1997). Multicultural counseling supervision: Central issues, theoretical considerations, and practical strategies. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 290–309). Thousand Oaks, CA: Sage.

Davidson, A. (Writer/Director). (1990). *The lunch date* [Motion picture]. New York: DuArt Film and Video.

Davis, K. (1998). Race, health status, and managed health care. In F. L. Brisbane (Ed.), *Cultural competence for health care professionals working with African American communities: Theory and practice* (pp. 145–163). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Dennis, D. L., Buckner, J. C., Lipton, F. R., & Levine, I. S. (1991). A decade of research and services for homeless mentally ill persons: Where do we stand? *American Psychologist, 46,* 1129–1138.

Evans, A. C., Delphin, M. E., Simmons, R., Omar, G., & Tebes, J. (2005). Developing a framework for culturally competent systems of care. In R. T. Carter (Ed.), *Handbook of racial–cultural psychology and counseling, training and practice* (Vol. 2, pp. 492–513). New York: Wiley.

Fiske, S. T., & Neuberg, S. L. (1990). A continuum of impression formation, from category-based to individuating processes: Influences of information and motivation on attention andinterpretation. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 23, pp. 1–74). New York: Academic Press.

Fouad, N. (2006). Multicultural guidelines: Implementation in an urban counseling psychology program. *Professional Psychology: Research and Practice, 37,* 6–13.

Gregg, J., & Saha, S. (2006). Losing culture on the way to competence: The use and misuse of culture in medical education. *Academic Medicine, 81,* 542–547.

Hamilton, D. L. (1979). A cognitive–attributional analysis of stereotyping. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 12, pp. 53–84). New York: Academic Press.

Hamilton, D. L., Stroessner, S. J., & Driscoll, D. M. (1994). Social cognition and the study of stereotypes. In P. G. Devine, D. L. Hamilton, & T. M. Ostrom (Eds.), *Social cognition: Contributions to classic issues in social psychology.* New York: Springer-Verlag.

Hansen, N. D., Randazzo, K., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., et al. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37,* 66–74.

Holcomb-McCoy, C. C. (2000). Multicultural counseling competencies: An exploratory factor analysis. *Journal of Multicultural Counseling and Development, 28,* 83–97.

Ibrahim, F. A. (1991). Contribution of cultural worldview to generic counseling and development. *Journal of Counseling & Development, 70,* 13–19.

Johnston, L. C., & Macrae, C. N. (1994). Changing social stereotypes: The case of the information seeker. *European Journal of Social Psychology, 24,* 581–592.

Kim, B. S. K., & Lyons, H. Z. (2003). Experiential activities and multicultural counseling competence training. *Journal of Counseling & Development, 81,* 400–408.

Lamb, R. H., Bachrach, L. L., Goldfinger, S. M., & Kass, F. I. (1992). Summary and recommendations. In R. H. Lamb, L. L. Bachrach, & F. I. Kass (Eds.), *Treating the homeless mentally ill: A report of the Task Force on the Homeless Mentally Ill* (pp. 1–10). Washington, DC: American Psychiatric Association.

Macintosh, P. (1989). White privilege: Unpacking the invisible knapsack. *Peace and Freedom, 49,* 10–12.

Martin, M. (1990). The homeless mentally ill and community-based care: Changing a mindset. *Community Mental Health Journal, 26,* 435–447.

McRae, M. B., & Johnson, S. D. (1991). Toward training for competence in multicultural counselor education. *Journal of Counseling & Development, 70,* 131–135.

Parham, T., & Whitten, L. (2003). Teaching multicultural counseling competencies in continuing education for psychologists. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. L. Toporek (Eds.), *Handbook of multicultural counseling competencies in counseling and psychology* (pp. 262–574). New York: Sage.

Parker, W. M., Moore, M. A., & Neimeyer, G. J. (1998). Altering White racial identity and interracial comfort through multicultural training. *Journal of Counseling & Development, 76,* 302–310.

Pope-Davis, D., Reynolds, A., Dings, J., & Nielson, D. (1995). Examining multicultural counseling competencies of graduate students in psychology. *Professional Psychology: Research and Practice, 26,* 322–329.

Pope-Davis, D., Reynolds, A., Dings, J., & Ottavi, T. (1994). Multicultural competencies of doctoral interns at university counseling centers: An exploratory investigation. *Professional Psychology: Research and Practice, 25,* 466–470.

Rasmussen, T. (1996). *The ASTD trainer's sourcebook, diversity: Create your own training programs.* New York: McGraw-Hill.

Resnik, J. (2006). Strategies for implementation of the multicultural guidelines in university and college counseling centers. *Professional Psychology: Research and Practice, 37,* 14–20.

Ridley, C. R., Chih, D. W., & Olivera, R. J. (2000). Training in cultural schemas: An antidote to unintentional racism in clinical practice. *American Journal of Orthopsychiatry, 70,* 65–72.

Ridley, C. R., Mendoza, D., & Kanitz, B. (1994). Multicultural training:

Reexamination, operationalization and integration. *The Counseling Psychologist, 22,* 227–289.

Rowe, M. (1999). *Crossing the border: Encounters between homeless people and outreach workers.* Berkeley: University of California Press.

Speight, S. L., Thomas, A., Kennel, R., & Anderson, M. (1995). Operationalizing multicultural training in doctoral programs and internships. *Professional Psychology: Research and Practice, 26,* 401–406.

Steward, R. J., Morales, P. C., Bartell, P. A., Miller, M., & Weeks, D. (1998). The multiculturally responsive versus the multiculturally reactive: A study of perceptions of counselor trainees. *Journal of Multicultural Counseling and Development, 26,* 13–27.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70,* 477–486.

Sue, D. W., Bernier, Y., Durran, A., Feinberg, L., Pederson, P. B., Smith, E. J., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10,* 45–52.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., et al. (1998). *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: Sage.

Susser, E., Goldfinger, S. M., & White, A. (1990). Some clinical approaches to the homeless mentally ill. *Community Mental Health Journal, 25,* 463–480.

Tomlinson-Clarke, S., & Wang, V. O. (1999). A paradigm for racial–cultural training in the development of counselor cultural competencies. In M. S. Kiselica (Ed.), *Confronting prejudice and racism during multicultural training* (pp. 155–167). Alexandria, VA: American Counseling Association.

Turk, D. C., & Salovey, P. (1986). Clinical information processing: Bias inoculation. In R. Ingram (Ed.), *Information processing approaches to clinical psychology* (pp. 305–323). New York: Academic Press.

U.S. Department of Health and Human Services, Center for Mental Health Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author.

Wheaton, J. E., & Granellor, D. H. (1998). The multicultural counseling competencies of state vocational rehabilitation counselors. *Rehabilitation Education, 12,* 51–64.

Received May 8, 2006
Revision received April 6, 2007
Accepted April 9, 2007 ■