BEYOND ONE-COURSE COMPETENCY FOR ADDRESSING THE CHALLENGES OF MULTICULTURAL EDUCATION AND ADVOCACY IN CSU'S

By

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Abstract

Current counseling standards adopted by the Board of Behavioral Sciences require therapists to familiarize themselves with multicultural issues. There has been little research about the scope of their implementation in the educational curriculum. My research aims to analyze California State University (CSU) counseling Master's programs by examining the breadth of their multicultural education through analysis of their syllabi. By utilizing a keyword search derived from the definition outlined by the American Counseling Association (ACA), I identify key topics in the curriculum, infer an educational model being employed to disseminate the knowledge and analyze whether CSU course descriptions encompass the topics and issues the ACA has highlighted. Findings indicate that most CSU schools utilize a single course model; however, due to the lack of standardization in the curriculum, some graduate programs lacked inclusion of some subjects that the ACA emphasized as topics requiring consideration. By noting the relationship between the educational system and modes of further education, like continuing education credits, I endeavor to highlight methods to expand the curriculum further. This included incorporating topics seldom taught, such as spirituality and religion.

Literature Review

The West has systematically mischaracterized spiritualities' influence on mental illness. Psychologists have minimized the topic, claiming that the secularization of their field makes their own treatments more acceptable and generalizable. However, this lack of integration of the topic is quite ethnocentric and fails to account for the fact that 84% of individuals worldwide claim religious affiliation ("Global Religious Landscape"). This oversight on the topic is especially seen in research, as there is little analysis of the effects of spirituality in diagnosis and treatment. Research conducted in the West is used to diagnose, treat and understand the world population. This lack of attention to religion is especially problematic when studying psychology, as religion often informs philosophical and moral beliefs. As a result, through understanding religion, therapists can hope to address the subject in a sensitive manner. This lack of appraisal on this subject becomes apparent when discussing the research process. Most research is conducted using the WEIRD population (White, Educated, Industrialized, Rich, and Democratic) as subjects for example, despite the fact that they only make up a minority of the world population. What's more, the WEIRD populace is the least likely to be religious, with only 30% of them stating that religion is important in their lives (Cox et al., 7). Scientists themselves are statistically less likely to be religious than the general population, moreover, with this population almost half as likely to believe in God or a higher power (Wormald). A comparative lack of spirituality among subjects of these studies as well as among researchers themselves may point to the disinterest in pursuing or addressing these topics in research. By understanding this discrepancy, I argue, therapists and researchers can address the omission of spiritual and religious competency in counselors' training and thus consider how to better appraise the concerns of the client population. I believe this can be achieved through multicultural

competencies relating to religion and spirituality and addressing spiritual concerns when integrating therapies that have religious roots, like mindfulness. The language and culture surrounding diagnosis are at the core of the issue. I argue, in fact, that cultural imperialism has fed a eurocentric understanding of mental illness that has globalized mental disorder knowledge, enabling insensitive treatment that neglects local and client input.

The pathologization of spirituality was a common discussion amongst many pioneers of psychology, including Sigmund Freud and Jean Charcot. Along with other psychologists, they viewed religion as irrational, with the language surrounding the topic bearing a tendency toward reductionism. Freud writes in his book *Civilization and its Discontents*: “The whole thing [religion] is so patently infantile, so foreign to reality, that to anyone with a friendly attitude to humanity it is painful to think that the great majority of mortals will never be able to rise above this view of life” (74). Religious devaluation in psychological treatment carried over for decades, with this trend most famously seen in the third edition of the Diagnostic and Statistics Manual (DSM), which considered religious experiences as symptoms of psychological illness (Verghese). Appendix C of DSM 3 included 45 case examples; however, 22% of the illustrations reference religion and spirituality, implying that religious phenomena suggest mental illness. The accumulation of religious examples pathologizes faith, especially as the illustrations are meant to guide therapists' understanding of psychological descriptions and definitions (Post 82). Although recent editions of the DSM have remedied this language, they have yet to address the long-standing association of religious experiences equating to pathology. The negative bias surrounding religion has contributed to unfair stereotypes of religious persons. It has made therapy goers reluctant to express their religiosity in the therapy session, although they may feel it pertinent in discussions. This prevalent research orientation has characterized the way

psychologists and psychiatrists have addressed spirituality, with studies often designed to examine religion as a variable of disease outcome.

Over the course of a couple decades, there has been a rise in recognition of spirituality as a distinct construct compared to religion. However, the language and usage surrounding both terms may have contributed to the unfavorable view of religion. There is a tension present between the connotations of religiosity and spirituality that often pit the two terms against one another. Dr. Kenneth Pargament, a professor of psychology and theology, elaborates on this tendency when he describes the rigid dualistic framework in both terms' usage. Religiosity, according to Pargament, is often equated with rigidity, institutions, and objectivity, while spirituality is held to be dynamic, subjective, and functional. There is a dichotomy between the "bad" religion, which is described in relatively static terms, and spirituality which is dynamic and "good" (Pargament et al.). The two terms are made to compete, although they are within the same semantic field. This usage is seen within the field of psychology as well. Psychological research has striven in recent years to include social, historical, and political considerations instead of focusing solely on the individual. This research has not broadened its traditional perspectives on the study of religion; however, religion is mainly studied within the confines of social, not individual, contexts. Spirituality, on the other hand, is discussed almost exclusively as an individual matter. To some extent, this understanding of these terms and their usage in the vernacular can be better comprehended within the context of Western culture. Generally, in Western society, individualism is valued, so it is no coincidence that spirituality has grown in popularity. Collective religious belief, on the other hand, often shades into 'group think' and can be viewed less favorably. For many, including religious practitioners themselves, traditional authority has become valued less, and religion's conventional connotations of rigidity are seen as

impediments to ‘true belief.’ This connotative understanding has pervaded the study of religion within psychology and limited researchers' scope of analysis.

Cultural Relativities Translation to Treatment

As seen previously, language, an essential aspect of culture, significantly influences how individuals and societies view certain constructs. It could be argued that language is perhaps the most important tool in psychology as it is the key to treatment. Thus, how the scientific community and psychologists talk about religion and spirituality can impact the way clients view and approach the subject in treatment. Culture is intrinsically linked to this appraisal process, and faith is an important aspect of culture. Religion has seen the historical fluctuation of its usage in different fields, including psychology and medicine, depending on the contexts of society.

A study of history suggests that the progression of diagnosis and the labeling of symptoms are better understood as curvilinear rather than linear. This is because communities have oscillated between including and excluding religion from people’s understanding of illness. Loschen elaborates, stating: “As medical science advanced . . . physical illnesses as religious phenomena were slowly removed from religious doctrine. Behavior, including mental illness, has not undergone such a clear change” (140). Religion has, for most of history, been the ultimate source of power, and thus, the community derived meaning through it for all aspects of life. However, medicine and science have, in recent centuries, taken over and ultimately dictate what society views as deviant. This shift has proved beneficial, especially for those individuals who, a century ago, would have been denied rights and privileges because they were not understood. However, this change in thinking also comes with its own challenges, especially for studying psychology and its application. Current scientific knowledge is defined and explained based on

limited samples that are primarily situated in the West and interpreted using a eurocentric viewpoint. In recent years, this has also meant that it is secular. The eurocentric framework will inevitably imply that illness metaphors describe illness and make social judgments based on the community in which they are used.

Cultural relativity has thus shaped what people consider normal or maladaptive deviant behavior. This has inevitably influenced our characterization of mental illnesses as it changes based on time and culture. Bartholomew and O'Dea explained the ramifications of this framework, stating that: "Illich (1976) used the terms 'medical colonization' and 'diagnostic imperialism' to characterize medical practitioners due to their tendency to use the neutral guise of science to insidiously impose eurocentric bourgeois norms and values transculturally and transhistorical, onto various behaviors that do not conform to . . . what constitute appropriate or acceptable actions" (2). Western ideals and values thus confined many scientists as most came from similar backgrounds and noted signs and symptoms within their own homogenous community. It can be reasonably claimed, then, that the early compilers and consolidators of psychological diseases operating in 1945 were significantly shaped by culture.

As culture is intrinsically linked to religion, one can see its effect on shaping what society views as normal and deviant psychological behavior. This dependency highlights why religion has played an active role in treatment for much of history. One of the earliest and best-documented examples of the eurocentric mindset affecting our current understanding and treatment of disorders was highlighted by Captain James Cook, a British Royal Navy officer. Cook was one of the first to explore the Pacific Archipelago and Australia. His extensive journals dating from 1769 give insight into what the Diagnostic and Statistical Manual (DSM) now calls culturally bound syndromes (Haque 687). These syndromes are broad categories of

behaviors that are believed to exist in certain non-Western cultural populations. An example Captain Cook writes about is Amok, a condition he witnessed in Malaysia wherein primarily males with no prior history of aggressive behavior go through a period of social withdrawal that culminates in a violent unprovoked outburst that the assailant usually does not remember. Martin explains Captain Cook's observations stating, “He described the affected individuals as behaving violently without apparent cause and indiscriminately killing or maiming villagers and animals in a frenzied attack” (Saint Martin). Although religion may seem unrelated, at first glance, it heavily influences the decisions of many of the individuals diagnosed or who are said to have gone through this experience. For many, culturally bound diseases can be explained through religious connotations such as having a crisis of faith. Those removed from the social, cultural, and religious community may pathologize their actions when they may be part of a claimed religious expression. Its treatment, thus, may need religious as well as psychological intervention in order to address all problem areas effectively.

The interconnectedness of religion and mental illness can be seen through Dhat syndrome. The condition is characterized by anxiety surrounding losing semen, as individuals, especially from the Indian subcontinent, perceive semen as an integral component of Dhat, or the bodily substance associated with vitality. Nocturnal emission or ejaculation thus creates anxiety that manifests into Dhat syndrome. The Ayurveda, a medieval system of medicine, describes semen as derived from flesh and blood that undergoes a lengthy process of purification, with forty cycles producing one drop of semen (Bhugra). Ancient Vedic religious text, like the Vedas and Puranas, also clarifies semen’s importance as Brahmacharya, which describes the adoption of the path to reach Brahma, is linked to conserving semen as it is believed to provide strength (Prakash). Thus, semen is considered an integral part of an individual's vitality, and its loss is

viewed as a harbinger of diseases or death. Therefore, it can be interpreted that the cultural and religious ideology of the Indian subcontinent influenced the development of Dhat syndrome. Although treatment and management of the syndrome begin with educating the patient on sex, challenging a patient's belief without considering the religious and cultural context in which they were formed will lessen the efficacy of treatment.

Examples such as these show how spiritual reductionism has led to the misattribution and disconcerting understanding of pathology. The Western lens that has been applied to medicine and psychology has secularized a field that has, for much of history, relied on religion for understanding. Although science has claimed secular views, people have not, with the majority of individuals today still claiming religion or spirituality is important in their lives. Neglecting this aspect of a person's identity when trying to treat a psychological issue may affect an individual's values and perspective and create dissonance in treatment.

Western Perspective on Culturally Bound Diseases

The category of culturally bound syndromes was created as diseases, such as Amok, were often seen as deviant from a 'standard' diagnosis as they are rarely found in Western cultures and patients. However, this categorization method can be biased as this framework subsumes all diseases in varying degrees in all cultures, as a diagnosis will depend on the patient's background and where they get treated. Reflection from the West's perspective may lead us to understand that culture-bound syndromes can be applied to us in the West as well, as illnesses have a social history rooted in the culture the patient is a member of. This explains why mental illnesses do not occur universally, which consequently brought about the classification of culturally bound syndromes. However, some cultural and social systems have caused some diseases rarely found outside the West to become part of the lexicon of diagnosis that is always discussed, although the

condition is a Western construct. An example is Anorexia Nervosa which can be classified as the most Western culturally bound syndrome. Cultural values are clearly implicated in the disease progression, and as a result, some researchers have highlighted religion's role in assisting society's construction of the syndrome. Researchers like J. Griffin and E.M Berry have highlighted the link between religious language and culturally bound syndromes like Anorexia.

Culture, and by extension, religion, is intrinsically linked to society's perception of what constitutes normal and deviant psychological behavior. Moralistic conduct is often governed by faith, and Berry explains that this relationship is important to understand what he calls holy anorexia. For much of recent history, Christianity has been imbued in all aspects of Western life as it was the religion of most people. Its ideals have thus penetrated our collective perception of what constitutes good moral attitudes (Stammers). The Christian faith believes in dualism as a way to control behavior, and many early leaders used this concept to establish the tradition of becoming closer to God by renouncing the body. As a result, self-reunification in the form of ascetic practices like fasting grew into prominence and was especially taken up by women in the twelfth to the seventeenth century. Self-imposed discipline was often regarded as a way to achieve spiritual perfection and gain autonomy in a patriarchal society (Griffin and Berry). Female saints like Catherine of Sienna were known to partake in such rituals and were living symbols of the suffering of Christ. This monastic practice, however, soon began to decline as the church began to view it as undermining its authority. However, the convention was never lost but was rather redefined in the modern era due to the changing cultural context. As a result, religious fundamentalism and consumerism replaced monastic asceticism.

Fundamentalism has become a prominent cultural presence and extended to all aspects of life, including food. This form of modern asceticism which can be described as moral

masochism, denounces pleasure to achieve self-discipline. Prevalent throughout the conversation is the mention of avoiding temptation and controlling one's body. This has translated into a particular consumer ethos that has permeated the religious market. Christian broadcasting and publications highlight weight loss and diet culture by advertising it as a spiritual sin stemming from yielding to temptation. Christain programs like 'The Weight Down Diet' are rooted in this ethos. The refusal of food and the renunciation of the body is a common theme that reverberates in modern and historical examples of anorexia nervosa. As a result, moralistic language stemming from religious doctrine is used to shape socio-cultural norms that further reinforce disciplinary forces in people's lives.

As a result, culturally bound syndromes can be understood from the West's perspective as long as one acknowledges that they are a relative term used to describe symptoms and behaviors that may only be culturally relevant to the dominant group making the framework. Thus, cultural standards have routinely been evolving to fit religious language to describe behavior better.

Case Study of Religion and Spirituality in Treatment: Mindfulness

Psychotherapy, like much of science, has, in recent years, been regarded as a secular field. Although in practice, many of the implemented therapies and treatments have roots in religion and spirituality. One such approach that has garnered much attention and research has been mindfulness. In recent years, mindfulness-based interventions have been proven effective in treating various psychological problems like anxiety, depression, and eating disorders. Various interventions have emerged that have incorporated the principles of mindfulness into treatment, with one popular mode being mindfulness-based cognitive behavioral therapy. The implementation of mindfulness practices in psychological treatment and healthcare is typically characterized by increasing a patient's awareness of thought patterns through inward-focused

activities like meditation, breathing exercises, body scanning, and yoga (Sipe). Through activities such as these, therapists help clients identify and perhaps unlearn dysfunctional thoughts. Thus, mindfulness is a clinical tool that offers a structure wherein clients can facilitate treatment.

Although mindfulness as a practice is seldom denounced for its therapeutic objectives and method, in recent years, it has been criticized for its dissociation from the religious framework from which it originated. Carolyn Chen, in her book *Work, Pray, Code* highlights this tension when she writes: "they have turned Asian spiritual practices into tools to optimize work performance, and Buddhist values into [a] 'skill set'" (152). The rhetoric surrounding religion has made it challenging to acknowledge mindfulness therapy's background without the scientific community distancing themselves from the conversation and claiming the religion's irrelevancy. Mindfulness was never meant to be a commodity that is bought and sold to help individuals relieve stress or perform better in school or work. For example, the Stress Reduction and Relaxation Program helmed by Dr. Kabaz-Zinn and Dialectical Behavior Therapy is acknowledged as a translation of Eastern, specifically Zen practices; however, the influence of Buddhism is seldom discussed (Niazi and Shaharyar).

Some claim that globalization has inevitably fed this exchange of practices and that attributing techniques to one group is unnecessary as the benefit is shared with all. Globalization has inevitably affected the translation of practices into psychotherapy. The universalization of mindfulness was dependent on its decontextualization, and thus the modern construct of mindfulness has been crafted by the East and West in order to respond to the needs of a new audience. Some claim that globalization has made ownership of religious and cultural practices challenging to claim as there is no longer an authentic origin (Ruan). However, this viewpoint

fails to account for the religious influence altogether. One can acknowledge the roots while also benefiting from the teachings, as the two do not need to be mutually exclusive. Mindfulness, as we know it, is mostly attributed to Buddhist teachings, but mindfulness as a concept is found in other religions as well, such as Islam, through the process of *ta'amul*. Mindfulness is used in therapy within a structure of scientific research wherein mindfulness methods are utilized within the configuration of already established cognitive behavioral therapy. However, for many, mindfulness can be a spiritual activity as it is deeply personal. For those who view it as such, it can be beneficial to discuss this connection through the context of incorporating mindfulness in spiritual or religious cognitive behavioral therapy. Redirecting these feelings into a proven therapy method can validate the client's feelings and enable them to explore their spirituality within the framework of psychotherapy.

Mindfulness and spiritual/religious cognitive behavioral therapy (RCBT) share many similarities that can be addressed with clients if they indicate that spirituality could be an important topic to discuss within the therapy framework. For instance, both therapies stress challenging thoughts either through spiritual or mindful practices that teach clients how to stop downward spirals, instruct in ways to renew the mind, and encourage involvement in a community (Pearce et al.). Introducing these methods to individuals who outwardly voice their spiritual tendencies has been shown to improve therapy outcomes. Working with patients' theological constructs on topics often discussed in therapy, like guilt and forgiveness, can help promote recovery, especially for depressed patients (Dein).

Soliciting spiritual histories along with routine orientation questions during the intake interview can help therapists familiarize themselves with the client's religious and philosophical orientation. Spirituality can be an important social and psychological factor that must be

addressed in order to fully understand and address the issues within a client's life. As a result, therapists can feed this desire by allowing people to engage in spirituality if they choose. Providing multicultural competencies to therapists that include understanding how to approach spirituality can enable this positive inclusion (Vieten). Spirituality and religiosity have already seeped into therapies through models like mindfulness-based cognitive behavioral therapy. Consequently, it is only natural for therapists to address this inclusion in ways that do not diminish spirituality's importance but affirm it if the client so chooses. Instead of dissociating spirituality from therapy, this new model can show how better to integrate a diverse range of practices from religions and cultures while recognizing the spiritual roots and not disparaging those who find value in them.

The lack of multicultural competence points to insufficient training, an issue the community must confront to provide better care for clients. Religious practices (or lack thereof) affect multiple facets of life, and thus, a therapist can only claim to be culturally competent if they are aware of how to address an individual's religious orientation. Religion impacts variables often assessed and referenced during sessions, such as behavior, social support networks, and identity. This lack of training is especially problematic as it affects minority communities the most as they are the principal bearers of religiosity. As a result, their worldview may be neglected if this facet of their identity is not addressed or even acknowledged, further isolating them from psychological services. Cultural humility is needed to provide a safe environment for discussing identities and cultural issues that affect the individual and, consequently, treatment outcomes. At the heart of a psychologist's values should be openness and non-judgment, which directly feeds into the strength of the therapeutic alliance. In order to achieve patient-centered care, efforts to improve cultural and religious competence are needed at both the interpersonal

and organizational levels. Only through harnessing a client's complete social ecology can therapists hope to facilitate progress and, hopefully, recovery.

The Study

This study aims to outline California-based schools, specifically California State University (CSU) counseling programs, and their approach to teaching aspiring counselors multicultural competence. I chose to highlight the CSU system as it is one of the most accessible ways to attain a Master's degree in counseling in California. All the CSU programs I examined were also accredited by the Board of Behavioral Sciences, the governing body in California responsible for issuing licensure for counselors. Students who complete these master's programs are eligible to become Licensed Professional Clinical Counselors or Marriage and Family Therapists if they pass the California Law and Ethics Exam and Clinical Exam. I plan to outline the deficiency in training for multicultural competence in counseling programs and how it may be remedied to serve our community better.

Multicultural perspectives have become increasingly regarded as an essential feature of any mental health higher education curriculum as it is viewed as a strategy to decrease cultural disparities. Multicultural counseling has consequently become a required course in many state counselor graduate programs, including California. State education departments, licensing boards, and professional organizations have all taken steps to incorporate multicultural competencies into their accreditation process. This increased need for proficiency is corroborated by a recent Delphi poll conducted by expert psychology panelists who predicted psychotherapy's future. The experts indicated that multicultural therapy is most likely to become an increased form of intervention in the forthcoming decade (Norcross et al.).

The American Counseling Association (ACA) recognizes the importance of multicultural treatment and has issued Multicultural and Social Justice Competencies to help therapists consider diversity within professional counseling. The guidelines provided a framework wherein

therapists can recognize the evolving nature of providing multicultural services (Ratts et al.). However, although the guidelines are presented as a means to consider cultural competence as a lifelong goal, they are merely conceptual frameworks. They are aspirational competencies, with the association hoping that knowledge and actions necessary to dispense competent counseling will be gained through the educational system and practicum. However, at the moment, the educational system and the practicum are ill-equipped to provide this training.

Multicultural advocates have been trying to address these challenges, particularly in places like America, where it is becoming increasingly clear that the population is becoming more culturally and ethnically diverse. Counselors must be competent in addressing this diverse population to work effectively and ethically. In order for therapy to remain a viable and relevant option for individuals from non-European and non-White backgrounds, several obstacles impeding multicultural competence need to be addressed. Some of these hindrances include a sense of apathy toward the cultural-racial transformation. This passivity has resulted in some forms of resistance in the mental health field. It can be exhibited through counselors' reluctance to direct effort into familiarizing themselves with resources necessary to foster competence. There also seems to be deference in the subject's importance, with counselors pointing to the apparent lack of operationalization of the term multicultural competence, or periodical criticism is directed toward the absence of valid and reliable testing for counselors to measure their multicultural competence (Pope-Davis et al. 156). These obstacles have been addressed in recent years as advocates have fought to provide more proficient services within the mental health field.

Educational Structure's Lack of Consensus on Multicultural Training

Despite the understanding of the importance of implementing a multiculturally sensitive curriculum, there is little consensus on how it should be accomplished. There is variability in the

procedures and methods counseling programs utilize in their teaching philosophy and, consequently, a difference in how well they prepare their students for incorporating the knowledge into practice. There are predominately two ways counselors can acquire the experience, skills, and knowledge necessary to dispense multiculturally competent therapy: through the educational system and the continuing education units counselors must engage in for re-licensure. I aim to highlight how both methods provide little incentive to gain multicultural competence.

Michael D'Andrea and Judy Daniels (1991) described the teaching strategies of multiculturalism in counseling psychology curricula as lying within four stages. The most basic form of competence is described as Cultural Encapsulation, where training programs provide a minimal exploration of issues relating to the needs of minority populations. An awareness emerges about multicultural issues, and students are encouraged to attend workshops. The counseling communities have largely graduated from this stage as the community has acknowledged the importance of introducing some form of multicultural education in their curriculum. In the second stage, which researchers coined 'Cross-Cultural Awakening', there is little incorporation of multiculturalism in training, although a broader cultural awareness emerges. The third stage, called 'Culturally Conscientious,' is where the administration acknowledges factors such as race, ethnicity, and class that play a role in the development and implementation of institutional changes. Multicultural topics are taught in a class or multiple classes specializing in this subject. The final stage is Cultural Infusion, where multicultural issues are incorporated into the entire curriculum. The administration is committed to including culturally diverse education opportunities in classes, research, supervision, and through the faculty.

The Cultural Infusion model is the gold standard in regard to its effectiveness; however, it is a less popular strategy as it demands an inordinate amount of resources and coordination to be effective. The Infusion model presents students with various opportunities to develop cross-cultural competencies, including training, mentorship, competency evaluation, and supervision (D'andrea et al., 1991). The multicultural perspective is more fully integrated into the curriculum, so many classes can offer training in the subject, each from a different viewpoint. However, this level of integration requires the allocation of resources and commitment that is seldom extended. Introducing multicultural theories and topics alone does not supplement and empower counselors, as Heppner and O'Brien (1994) found that assigned reading was the least effective mode of multicultural dissemination. Instead, the most important components in the learning process were experiential opportunities that the Infusion model would be equipped to provide.

Operationalization of Multicultural Competence

In order to claim an individual is multiculturally competent, one must define the terms so the construct can be understood and applied by all parties in the field. The counseling community has taken steps to operationalize the term, with the Association for Multicultural Counseling and Development (AMCD), a division within the American Counseling Association, provisioning such a framework to go by. The AMCD developed a set of thirty-one multicultural competencies that outlined the minimum requirements counselors should meet to work effectively with patients of diverse backgrounds. A spectrum of domains is utilized in the definition in order to assert the term's evolving nature, as the competencies mentioned are part of a multilevel framework. The framework, first introduced by Derald Sue et al. (1992), was developed to generate competencies in broad counseling areas. They highlighted client worldview, counselor self-awareness,

counseling relationship, and advocacy intervention as developmental domains that must be addressed to accrue competence. Within these frameworks lie a counselor and client's attitudes, beliefs, knowledge, actions, and skills that come together to shape an individual's understanding of the world.

Counselor awareness starts with assessing one's attitudes and beliefs, as culturally skilled counselors are sensitive to how their cultural background and experience can influence psychological processes. Most importantly, counselors must be aware of their shortcomings, come to terms with their limited expertise, recognize their topics of discomfort, and analyze them. Knowledgeable counselors are aware of their own cultural heritage and realize how that affects their bias of normality. One's capacity for social impact is addressed, and one acknowledges how a counselor's personal style may impact the counselor-client relationship regarding communication skills or how institutions impact both individuals. Finally, skills refer to how culturally competent counselors seek training and educational experiences that effectively address their shortcomings by pursuing more trained individuals, familiarizing themselves with relevant research, or seeking a non-racist identity (Arredondo 1996).

The characteristics offered by Sue and associates are quite comprehensive; however, every counseling program utilizes its own interpretation when defining the term' cultural education in their coursework. As a result, although operationalization of the term has been sought within the counseling community, it has not been definitively outlined. In keeping with this trajectory, the definition I will utilize in my study has been adapted from the American Counseling Association and the Substance Abuse and Mental Health Services Administration.

Based on these sources, the definition of cultural education I employ for my study is as follows: culturally competent counselors are aware of their values and biases and are sensitive to

the limits of their expertise. Culturally skilled counselors know how their attitudes, values, and biases affect their personal and client psychological processes. They also have knowledge of how discrimination, oppression, racism, and stereotyping effects their work and how they may have indirectly or directly benefited from institutional racism. Culturally skilled counselors seek knowledge through education and training opportunities and improve their effectiveness in working with different populations. They also seek out consultations with more knowledgeable and skilled individuals when they recognize the limits of their competencies. Congruent behaviors, attitudes, and policies among professionals enable effective work within cross-cultural situations. Knowledge of integrated patterns of language, customs, behavior, values, and the capacity to function effectively within these contexts as presented by clients and employed by counselors to better serve them (Substance Abuse; Association for Multicultural).

Case Study CSU

In order to become an accredited counseling degree program in California, graduate schools must abide by the guidelines established by the Board of Behavioral Science. One such guideline stipulates that counselors must seek "an understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery" (Board of Behavioral Science 26). The California State University (CSU) system, which I will specifically highlight, has abided by the guidelines and has elected to meet the requirement by utilizing a one-course model when dispensing multicultural training in their masters for counseling.

Of the twenty-three CSU schools, fifteen have accredited Master's programs for either Licensed Professional Clinical Counselor (LPCC) or Marriage and Family Therapy. The schools are California State University Fresno, Fullerton, Bakersfield, Dominguez Hills, East Bay, Long Beach, Los Angeles, Northridge, Sacramento, San Bernadino, Stanislaus, San Diego State, San Francisco State, San Jose State, and Sonoma State University.

I aim to analyze the curriculum of the Master's programs listed and describe the educational model they use for dispensing multicultural education and the breadth of knowledge they provide on this topic. My goal is to outline how to better integrate and update the system to reflect the current research on multicultural education and the educational system's limitations when trying to amend this deficiency. As all the Master programs I analyze do not have full syllabi for their classes available, I consider the course descriptions for core classes in each program. I use the definition of multicultural competency outlined above to highlight keywords present when discussing multicultural topics and analyze whether the curriculum utilizes these keywords in its description. Through this methodology, I draw conclusions about whether the

schools use a Cultural Encapsulation, Cross-Cultural Awakening, Culturally Conscientious, or Infusion model.

Based on the definition of multicultural competence I outlined before, I chose the keywords most pertinent to understanding and describing the concept. The words I chose are as follows: multicultural/ culture, diversity, bias, attitudes, values, beliefs, stereotypes, prejudice, racism, customs, oppression, and language. With these keywords as guides, I aim to look at the course description of the core classes in the Master's programs and see if they are included. If these keywords are included in the syllabi of classes other than the multicultural class, then I may be able to ascertain whether the program uses an infusion model or not and tell what level of integration they utilize for multicultural education.

Research Findings

As stipulated by the Board of Behavioral Science, all CSU counseling programs have at least one class specializing in teaching students multicultural and diversity issues. However, through looking at the course descriptors, most programs did not include the keywords in classes other than the multicultural class. Only four of the fifteen schools included the keywords in the descriptions of the required multicultural training classes: Fullerton, Bakersfield, San Bernadino, and San Jose State University. In addition, seven schools utilized the words in less than 20% of their curriculum. Based on D'Andrea and Daniel's (1991) stages, these eleven programs can be classified as Culturally conscientious, as their training incorporates multicultural issues in their curriculum. The administration acknowledges the subject's importance by incorporating a class on multiculturalism and diversity in the curriculum. However, the system has yet to reach the level of Infusion as the majority of the schools only incorporate theoretical curriculum through a single mandatory class and do not offer varied classes or incorporate the framework into multiple classes or experiential options.

Most graduate programs now utilize a single course model, wherein they dedicate one class in their Master's program to teaching this subject. Although it is a step in the right direction, it also presents difficulties insofar as students do not have adequate resources and exposure to integrate the concepts learned into training. This is because a single course marginalizes the content, as students may get the sense that the topic is less germane compared to the core issues always examined in lessons, such as law and ethics. As a result, the lack of exposure to diversity issues does not validate the subject's importance and enables the students to perceive the issues as irrelevant. The integration model also hopes graduate programs utilize supervision to offer students perspective and hands-on experience with diverse clients. However,

although this form of education is encouraged, it can be hard to enforce, especially with a national shortage of psychology supervision internships.

The remaining four programs studied had a higher prevalence of the keywords, with East Bay, Northridge, San Diego, and Sonoma State including the keywords in 63.15%, 66.66%, 41.66%, and 81.25% of the curriculum, respectively (see table 1). The higher integration of the keywords into the course descriptions of East Bay, Northridge, San Diego, and Sonoma State results from the program's explicit emphasis on multicultural education. For instance, CSU East Bay's Marriage and Family Therapy program focuses on multicultural diversity, Northridge emphasizes social justice, San Diego State concentrates on multicultural community counseling, and Sonoma State's program highlights culturally appropriate interventions. These programs have structured their curriculum to train mental health professionals to work in an increasingly multicultural society. These four programs can thus be classified as utilizing the Infusion Model as they have gone beyond incorporating diversity issues into the curriculum. They provide multicultural education through their practicum, as affirmed on their website, underscore their commitment to social justice through their internship placement and their incorporation of culturally appropriate methods of assessment as well as endorsing a diverse student body and faculty.

Table 1

Multicultural themes included in course description of CSU counseling programs

CSU	# of Different classes with keywords	Total required classes	% of classes that have the keywords in description
Dominguez Hills	6	32	18.75%
Bakersfield	0	25	0
San Diego	10	24	41.66%
Long Beach	3	20	15%
San Francisco	4	20	20%
San Jose	0	20	0
East Bay	12	19	63.15%
Los Angeles	1	19	5.25%
Fresno	1	18	5.55%
Stanislaus	3	17	17.64%
Sanoma	13	16	81.25%
Fullerton	0	14	0
Sacramento	1	14	7.14%
Northridge	8	12	66.66%
San Bernardino	0	12	0

Based on this evaluation, we can conclude that few CSU programs incorporate multicultural issues in classes other than the mandatory cross-cultural/diversity class. Cultural perspectives are seldom a core component of education. Students are becoming culturally aware; however, it would be a stretch to assume that the counselors who graduated would be deemed educated enough to provide culturally competent care.

Some limitations of my search include the fact that I only looked at the core curriculum for the programs, and as a result, elective courses or additional courses needed for specific licensure was not included in my search. However, it must be noted that most CSU master's programs had a fixed class schedule for their students, with all classes being required. As a result, few had elective options, so the number of keywords in each school is unlikely to be higher than indicated. I also only had access to the course description and not the full syllabi, and as a result, the topic and course objectives outlined I had access to were limited. The syllabi may have elaborated on the objectives more, since I did not have access to the material. However, it is difficult to determine whether the additional data from the syllabi would elaborate on how they tackled the inclusion of diversity issues.

Ways to Address Education Limitations

By noting this limitation in the CSU system, it can be inferred that similar counseling programs also face a comparable lack of education on this front. As a result, it is not improbable to claim that counselors have limited practical knowledge of how to address a diverse population. As a result, other means of disseminating this material must be addressed. One such area could be through continuing education (CE) credits, required courses that allow counselors to maintain accreditation. Counselors must complete thirty-six units every two years in California to maintain their license. The board does not approve specific CE courses except for first-time renewals. Even then, the only required courses for an LPCC are on suicide risk, telehealth, HIV/AIDS, and law and ethics. As a result, there are currently no incentives for psychologists and counselors to pursue multicultural competence as part of the continuing education courses. If adequate training is not attained during graduate school, then continuing education should assume a greater level of importance to maintain professional standards of practice.

At present, continuing education is needed more than ever because an estimated 52% of counselors working today are over forty years old (Zauderer 2023). Furthermore, this indicates that the majority of therapists working now were not required to take multicultural education in their graduate programs as the state of California and the Board of Behavioral Science did not make this topic a requirement until 2009 (California). As a result of the lack of specificity in CE credits, it would be unlikely that therapists who graduated before 2009 would have engaged in this training unless they chose to pursue this knowledge, as they were never taught multiculturalism while in school. A continuing education requirement in this topic is thus needed more than ever to enable counselors who graduated before 2009 to at least match the proficiency of newer therapists. Incorporating multicultural topics within the already required continuing

education units may prove a mechanism to recognize the issue's importance and rectify the shortage of class time and supervision afforded to the subject.

Testing Multicultural Competence

Instruments for testing multicultural competence are necessary to quantify advocates' efforts to help counselors increase their knowledge and understanding of their strengths and weaknesses. Testing can be a powerful tool for educators and supervisors to help hone counselors' skills by providing quantifiable feedback. Some of the current disparity in implementing culturally competent care may be the result of therapists' belief that adapting interventions to meet clients' needs, while possibly beneficial, may not fully comprehend the practical justification. Thus, there is little incentive to change treatment practices unless competency testing becomes a standard method of the educational system.

Multiple measures of multicultural competence have been used in recent decades. Some include the Multicultural Counseling Inventory (MCI), Multicultural Counseling Knowledge and Awareness Scale (MCKAS), the Cross-Cultural Counseling Competence Inventory-Revised (CCCI-R) measure, and the Multicultural Awareness Knowledge and Skills Survey (MAKSS). The MAKSS is one of the most widely used as it is easily accessible, only requiring a one-time fee for access, and it has proven reliable for measuring counselor awareness, knowledge, and skills as operationalized by the American Counseling Association (Hulteng). A study by Kim et al. (2003) has confirmed the test's construct validity and internal reliability.

Multicultural measures are applicable for various purposes, and their utility can help graduate programs and practicing counselors understand their biases and direct their areas for improvement. For instance, the MAKSS can be used to assess the school environment's

multiculturalism by making staff and faculty aware of their areas of improvement. This can help engage discussions about the department's salient issues and address how they can improve. This form of evaluation can help the administration assess a program's strengths and weaknesses regarding multicultural training and can provide a means to see the program's growth over the years as the areas of attention are slowly addressed. These tests can also be used as a method to reflect on their progress, especially when diversity training programs have found some success. It can also be employed as a barometer for students entering and leaving a program to understand their perceptions of the environment.

Conclusion

Although counseling standards have been revised to accommodate America's growing diversity, the educational system still has room for improvement in its implementation. No matter how comprehensive the one-course cultural competency class is, it rarely gives students enough time to effectively understand, reflect and implement the information they learn. In a semester-long class, students are likely to focus on one issue per class in order to become acquainted with all the topics needed to discuss. This will inevitably mean some topics are touched on while others are mentioned in passing with little emphasis. The responsibility of the Council for the Accreditation of Counseling and Related Educational Programs (CACRE) is to enforce a more rigorous and comprehensive curriculum. However, counseling programs are currently not incentivized to reconstruct their curriculum or include a more rigorous study of the topic, even though this area of counseling is viewed as an area of interest in psychology. This is why other avenues of further education need to be implemented to supplement general education on the topic.

If I were to expand on this research, some suggestions for further research include utilizing the syllabi in addition to the course description. The syllabi will likely have more thorough information on the curriculum structure and give better insight into the teaching outcomes and the lesson focus. The practicum is also an important focus of counseling education; however, nearly no information on this topic was accessible to me, so it was impossible to understand the placement of the students.

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