

The Myth of Cross-Cultural Competence

by Ruth G. Dean

Abstract

Cross-cultural competence has become a byword in social work. In a postmodern world in which culture is seen as individually and socially constructed, evolving, emergent, and occurring in language (Laird, 1998), becoming “culturally competent” is a challenging prospect. How do we become competent at something that is continually changing and how do we develop a focus that includes ourselves as having differences, beliefs, and biases that are inevitably active. After considering this and several other contemporary perspectives on cultural competence, the author questions the notion that one can become competent at the culture of another. The author proposes instead a model based on acceptance of one’s lack of competence in cross-cultural matters.

A Clinical Vignette

TWO CHILDREN IN AN AFRICAN AMERICAN family, Kareem (age 13) and Malik (age 10), were brought to the child unit of a community mental health clinic by their 62-year-old, great aunt and legal guardian, Mrs. W. She was seeking help because the children were “acting up” at school and in church, and she had been advised to get psychological testing for the oldest boy. Mrs. W took custody of these boys, their older sister, Jade (14), and younger brother, Ken (7), and brought them to live with her 4 years ago when the Department of Social Services (DSS) removed them from their grandmother’s home where they had been severely neglected. According to Mrs. W, the children were “wild” when they first came to live with her and she spoke with pleasure of the ways she had introduced them to disciplined living and to religion through her church, where they were now enthusiastic members of the band. Although she made it clear that raising four young children was not what she wanted to be doing at age 62, having raised her own children to be responsible adults, Mrs. W was clearly proud of what she had been able to accomplish. The children’s mother, her sister’s daughter, a woman who chronically suffered from substance abuse, had given up each child at birth and never saw them again. Kareem was born with an addiction to cocaine.

At the intake meeting Mrs. W focused on Kareem who, she explained, was lying and stealing. He had recently

solicited money from one of her friends at church and then lied about it; he also stole money from her and denied it when confronted. Touched by Mrs. W’s efforts to raise this second family, I volunteered to be the member of our intake team who would work with them. At the time, I was on sabbatical from my job as a professor of clinical social work and I was volunteering at the clinic to learn more about practice in the inner city. I am a White, Jewish woman, the same age as Mrs. W, and have over 35 years of experience in direct practice including some work with families living in economically disadvantaged communities.

Within a few weeks of beginning my work with Kareem, and after he charged some pornographic videos to her account, Mrs. W decided to ask DSS to arrange a voluntary foster home placement for him. I was concerned about the disruption this would create in Kareem’s life and wanted more time to work with the family but she was determined to proceed. We agreed on the need for the family to maintain close contact with Kareem after his placement and for my work with him to continue, but this was not possible. The DSS worker could not provide Mrs. W or myself with a phone number for Kareem due to a requirement that protected the foster mother’s privacy. Initially, no other plan for maintaining contact was provided and the DSS worker and her supervisor perceived as rude my insistent efforts to reinstate communication for this family and to resume my work with Kareem. When the DSS worker told this to Mrs. W, she

disagreed and protested that I was helping the family. After 6 weeks, Kareem began regular weekend visits to his aunt's home.

Following his brother's placement, Malik's disruptive behavior in school increased. I began to see him and Mrs. W on a weekly basis—both separately and together. Malik told me that he was sad at night when he looked across the room and saw his brother's empty bed. Malik's teacher was sending home frequent notes indicating that he was leaving his seat, disrupting the class, and had become a serious behavior problem in the classroom. Mrs. W became more and more concerned over his behavior and indicated that she was now thinking of placing him in a "disciplinary" setting where he would learn to behave. Malik looked very upset each time she spoke of this, and again I tried to persuade her to give us time to work together. With Mrs. W's permission, I arranged for a psychiatric consultation to see if medication might help Malik stay more focused in school. When the psychiatrist recommended a trial of medication based on a tentative diagnosis of attention deficit disorder, Mrs. W rejected this idea. She was concerned that Malik would have the same problem when he stopped using the medication and worried about the family history of addiction. She said she would try to monitor his school behavior more closely and I agreed to help with this.

I visited Malik's school and talked with his very experienced and strict, African American teacher. I arranged for the social worker regularly assigned to Malik's school, who was a member of our intake team, to consult to the teacher regarding Malik's behavior to see if he could help mediate this situation. Mrs. W pursued the idea of placement for Malik, but also made arrangements for Kareem to return to her home because she was troubled by his reports of discriminatory treatment in the foster home.

I approached this case with the idea that maintaining continuity of care for these boys whose lives had already been disrupted was paramount. When I tried to discuss this with Mrs. W, she told me that Malik was "conning" me. She assumed that he could control himself when he wanted to. She asked why it was that he could sit still for 5 hours in church every Sunday but not sit still in school. We seemed to be at an impasse with her believing that the only way to cure Malik of his bad behavior was to scare him by placing him out of the home. I thought this would be very hard on Malik. Mrs. W could now point to a "reformed," well-behaved Kareem, who had just returned to her home, as evidence that her method worked. I wondered if our positions represented cultural differences.

"Competence" and Cross-Cultural Work

The purpose of this article is to show that the concept of multicultural competence is flawed. I believe it to be a myth that is typically American and located in the metaphor of American "know-how." It is consistent with the belief that knowledge brings control and effectiveness, and that this is an ideal to be achieved above all else. I question the notion that one could become "competent" at the culture of another (Goldberg, 2000). I would instead propose a model in which maintaining an awareness of one's lack of competence is the goal rather than the establishment of competence. With "lack of competence" as the focus, a different view of practicing across cultures emerges. The client is the "expert" and the clinician is in a position of seeking knowledge and trying to understand what life is like for the client. There is no thought of competence—instead one thinks of gaining understanding (always partial) of a phenomenon that is evolving and changing.

... the concept of multicultural competence
is flawed. I believe it to be a myth that is
typically American and located in the
metaphor of American "know-how."

Much has been written about multicultural practice in social work and the need for competence in working with people from whom one is different. This seems to be an important goal. We live in a multiethnic, multiracial, multiclass society. We work with people who represent every subgroup or identity imaginable. In our schools of social work, we attempt to prepare students for practice in a culturally diverse world. We want them to be competent to practice with members of many groups (Goldberg, 2000). This is currently referred to as being "culturally competent" or "multiculturally competent."

In order to discuss the concept of "cultural competence," it is necessary to first define "culture." In *Webster's New World Dictionary*, culture refers to "ideas, customs, skills, arts, etc of a people or group, that are transferred, communicated, or passed along ... to succeeding generations" (1988, p. 337). In a slightly different approach, Becker states that culture is "concerted activity" based on shared ideas and understanding (1986, p. 12). Membership

in cultural categories can be assigned according to particular aspects of identity such as race, ethnicity, class, age, gender, sexual orientation or able-bodiedness.

In these early definitions, cultural categories or groups are treated as if they are static and monolithic with defining characteristics that endure over time and in different contexts. Within this definition of culture, “cultural competence” involves learning about the history and shared characteristics of different groups and using this knowledge to create bridges and increase understanding with individual clients and families.

In more contemporary views, culture is believed to be individually and socially constructed. “It is always contextual, emergent, improvisational, transformational, and political; above all, it is a matter of linguistics or of language, of discourse (Laird, 1998, p. 28–29). If we start with this view of culture, then the prospect of becoming “culturally competent” takes on a different meaning. How do we become competent at something that we see as continually changing? How do we move beyond “the limited number of ways” our culture provides for portraying subgroups (Harris, 1998) and the tendency to think in terms of common and fixed characteristics? How do we shift the center in our discussions of culture to keep the focus on ourselves as having the difference that must be encountered in some way (Laird, 1998)?

These different ways of defining “culture” represent two perspectives that are prominent in the current discourse on cross-cultural practice—modernist and postmodern. In the material that follows, each will be discussed briefly along with two other important viewpoints: psychoanalytic intersubjectivist and sociopolitical. I will consider my work with Mrs. W and the boys in light of each of these perspectives and then discuss what I believe to be the important elements in cross-cultural work.

Some Current Perspectives

A modernist view. In the 70s and early 80s, a small number of studies of African American families and other ethnic and racial groups began to emerge and become integrated with clinical literature (Atkinson, Morten, & Sue, 1979; Staples, 1971; Sue, 1981). McGoldrick, Giordano and Pearce’s *Ethnicity and Family Therapy*, first published in 1982, is one example of early clinical writing on culture and ethnicity. These books tended to contain chapters about the particular beliefs, practices, and characteristics of different ethnic groups.

These initial writings, rooted in ethnological and anthropological studies, are based on more static or mod-

ernist views of ethnicity and culture. Members of a group are seen as sharing some essential characteristics that define them. If a group can be seen as a stable entity that can be characterized in certain ways, then it is possible for clinicians to develop schema that allow them to interact “more competently” with members of the group. There continues to be support in the clinical community for this position.

A postmodern view of cross-cultural practice. By highlighting the continually changing and evolving nature of cultural identities, Laird (1998, p. 23) and others who write from this perspective, encourage us to engage in an ongoing process of learning about others and to operate, as much as possible from a “not-knowing” position (Anderson & Goolishian, 1992). But with some deliberate contradiction, Laird states that we must be “informed not-knowers” (1999, p. 30). She asks us to become aware of our own cultural baggage and separate ourselves from it in so far as is possible so that it will not interfere with our efforts to get to know another. I would agree but emphasize that it is very difficult to separate ourselves from our own “cultural baggage.” Becoming aware of it and keeping this awareness in the forefront of consciousness, makes it more likely that we will limit its impact on our work. Our task as clinicians is to sift through and sort out different impressions, layers of meaning and awareness as we concurrently learn about others and ourselves. Laird’s important contribution here is to emphasize what we do not know. What if we shift the focus so that we are as concerned with increasing self-knowledge as with increased understanding of the other?

A psychoanalytic intersubjectivist position. Foster (1999), a self-defined psychoanalytic intersubjectivist, takes a psychological perspective on cross-cultural clinical work that focuses attention on the clinician’s self-knowledge. In the intersubjective view, therapists are seen as bringing a mixture of knowledge and feelings to work with clients at conscious and unconscious levels and this participation forms an “ineradicable” part of the therapeutic exchange (Gerhardt, Sweetnam, and Borton, 2000, p. 8). This, together with clients’ thoughts and feelings becomes a field of interaction operating on multiple levels, within which client and clinician work to construct meaning together.

Foster’s contribution to the intersubjective paradigm has been to focus on those aspects of the interactional field that operate in cross-cultural clinical situations. She speaks of “the clinician’s cultural countertransference”—defined as cognitive and affect-laden experiences and beliefs that exist at different levels of the therapist’s con-

sciousness. They include the therapist's values, academic theories, practice orientations, personally driven idealizations and prejudices toward ethnic groups, and personally driven biases about one's ethnicity (1999, p. 276). In a similar approach, Comas-Diaz and Jacobsen state that ethnicity, culture, and race activate deep unconscious feelings and "become matters for projection by both patient and therapist, usually in the form of transference and countertransference" (1991, p. 401).

... it is very difficult to separate ourselves
from our own "cultural baggage."
Becoming aware of it
and keeping this awareness in
the forefront of consciousness,
makes it more likely that we will
limit its impact on our work.

It is important that clinicians explore the beliefs and affects that inform their views of themselves and their clients as cultural entities. The way these phenomenon operate in the treatment can be investigated introspectively, and then discussed with clients so as to avoid their enactment in ways that distort, limit, or prematurely end the clinical work. But the timing of these discussions is critical. They need to unfold within the natural flow of the clinical work. While they help us build relationships with clients, they require exquisite sensitivity and are easier to conduct in the context of already strong and trusting relationships. While recommending an introspective process, these writers do not indicate how we get beyond rationalization to a kind of reflection that opens new possibilities.

Thus far, we have considered three views that inform cross-cultural work: an anthropological approach to culture, a postmodern view of cultural identity and a psychoanalytic intersubjectivist perspective. Each directs the clinician's attention to the micro level, the client-worker dyad, albeit in different ways. We have shifted from an emphasis on "competence" to an emphasis on lack of cultural competence and the need for therapists to learn about their own biases and values. But in order to see values clearly, it is necessary to see them in relation to the

larger system in which they are embedded. The fourth perspective to be considered shifts the conversation about culture to a macro, sociopolitical level of analysis that challenges some of the basic assumptions of the society.

A *sociopolitical perspective on oppression and social justice*. Green asserts that issues of "minority group oppression" are at times confused with "minority group differentness" (1998, p. 99). He states that it is not just the traditions, norms, and patterns of behavior that influence the functioning of a member of a cultural group but also the way that group is treated within the larger culture. This treatment is based on various racial ideologies operating in the larger society that attribute particular cultural traits to certain groups (Wilson, 1987). "Cultural, racial, and sexual orientation differences are *not* problems in and of themselves. Prejudice, discrimination, and other forms of aggressive intercultural conflict based on these differences *are* problems" (Green, p. 100). Furthermore, the "dynamic interplay" between the lack of economic opportunities and characteristics that are observed in individuals and families who are systematically oppressed is often overlooked as these characteristics become defined as cultural differences.

If we start with this sociopolitical analysis, we are likely to inquire as to the ways that various forms of oppression have resulted in racial and economic stratification and limited opportunities for our clients and ourselves. This perspective brings in issues of power and the ways that some cultural groups are positioned to control other groups in society. Limiting our focus to studying the beliefs, customs, and historical traditions of individual groups can obscure the oppressive relations between groups.

Discussion

Using the four perspectives briefly outlined above—what I have called modernist, postmodern, intersubjective, and sociopolitical—let us now return to the case introduced at the beginning. How would each of these approaches have affected work with this family?

The modernist perspective instructs me to read about African American families and become better informed about their cultural traditions and customs. I would need to find out more about Mrs. W's history such as when and how her family came to this country, whether or not they lived in the South and their possible experience of slavery to fully appreciate the aspects of African American culture that pertained.

In doing so, I might come to understand the importance of kinship bonds and role flexibility in African

American families and this would help me understand Ms. W's commitment to her cousins (Boyd-Franklin, 1989). I would also see Mrs. W's concern with school performance as part of a "strong achievement orientation" that is common in African American families (Boyd-Franklin, p. 17). Her strict discipline and use of a temporary placement as a way of demonstrating her seriousness could be understood as an effort to protect these children from the potentially serious consequences of acting out behavior in a community where violent responses from police or peers are common. Studying about African American families would also allow me to appreciate the centrality of a spiritual orientation and of the church in the Black community. All of this information would serve as an important backdrop to understanding Mrs. W's life and belief system.

"Knowing" about these issues might have prepared me for Mrs. W's emphasis on discipline and her efforts to achieve it through expelling Kareem and Malik for brief periods when they misbehaved. Perhaps this knowledge would have enabled me to understand and integrate her emphasis on discipline with my emphasis on continuity of care. But I'm not sure that this understanding would have resolved our strongly felt differences. And if having this limited information had caused me to *act* as if I *knew* what Mrs. W was going through, it might also have alienated her from me. Without further exploration of her ideas and beliefs, I could not have understood her struggles.

My ideas, based on what I had read would only lead to tentative hypotheses until I had inquired about and understood Mrs. W's specific concerns. But this knowledge might have guided my efforts at understanding in certain directions—for example toward asking about the need for discipline and ways Mrs. W had achieved this with her own children or asking about her church and the support it provided. My reading would have led me to ask more focused and informed questions. As it happened, at the time of Kareem's placement, my efforts at understanding Mrs. W's decision, were limited by the force of my own, very different ideas. It was a challenge to contain my own belief in stability for the children and continuity of care while trying to understand her beliefs and how they came to be and still maintain a new and fragile relationship.

The postmodern perspective offered by Laird encourages me to consider the "cultural baggage" I brought to this family situation. This included a theoretical orientation toward a gradual unfolding of the separation/individuation process that avoided premature separation and loss. While I could understand Mrs. W's emphasis on teaching values and discipline to Kareem and his brother

Malik, I was put off by what I experienced as an unnecessarily harsh approach. The rapidity with which the placement of Kareem occurred left little time for me to examine the differences in our perspectives and I was not particularly in touch with my own biases.

Foster recommends that clinicians work actively with such feelings that she labels the "cultural countertransference." She would encourage me to dig deeper into the forms that my so-called "American values" take and to consider any particular idealizations, biases, and prejudices that might be operating in regard to African American families, fundamentalist religions, and ideas about disciplining children. Finally, she would have me consider the ways that my own identity as a White, Jewish, middle-class woman might be entering the intersubjective matrix. If I was not consciously aware of the impact of my identity and beliefs she would look for signs of unconscious ideas that were being enacted and possibly distancing Mrs. W.

This analysis causes me to reconsider my response to learning of the misbehavior of first Kareem and then, Malik. While their aunt was alarmed, I saw their behavior as problematic but still within the normal range. While I agreed that it was clearly wrong of Kareem to order and charge pornographic films to his aunt's account, I, with a more liberal orientation, saw his interest in the pornography as part of normal adolescent development. It came on the heels of a letter he had written to a girl in church that had been intercepted by Mrs. W that contained some sexually explicit invitations. While Mrs. W was horrified by the letter and the pornography, I was more amused and sanguine. I tried to encourage Mrs. W to get a male leader at the after-school program to talk to Kareem about his sexual development but she was not interested in encouraging this discussion. She wanted him to stop acting and thinking and feeling this way. I made little effort to bridge the gap between our different approaches—assuming a rightness about my position without exploring her concerns and understanding them in the context of her own history, her belief system, and her current situation with her second family. I wonder if showing an interest in her ideas and how they came to be would have allowed me to understand and accept her more fully. Then, perhaps I might have shared my views with her about Kareem's behavior and we might have had a true exchange of ideas and an awareness of our differences and similarities.

Finally, if I had been operating out of a sociopolitical perspective on oppression and social justice, I might have spent more time asking about and trying to understand

the social context for Mrs. W's fears for her charges. We would have discussed the problems she experienced living in a neighborhood with high levels of poverty, unemployment, violence, drugs, and other forms of crime. Her approach to discipline would have made more sense to me if our discussions had included the context in which it occurred. We could have considered how her need to continue to work at age 62, and place the children in after-school programs affected her ability to raise them in the way she thought was best. Perhaps Mrs. W's sense of frustration and fatigue could have been linked to her concern for the limited opportunities for her family due to racism and oppression. I needed to appreciate her relationship to the staff of the neighborhood schools and other institutions serving her family, including her difficulty in getting attention and services for them. These concerns, if articulated, would have provided a broader context for our discussions and might have led Mrs. W to see that I more fully understood and sympathized with the family's situation.

The paradoxical combination of
these two ideas—being “informed” and
“not knowing” simultaneously—
captures the orientation to one's
“lack of competence” that I am suggesting
is needed in cross-cultural work.

In summary, each of these perspectives directs my attention to an important area for study and questioning. The modernist orientation encourages reading about the culture; the postmodern perspective turns my attention to my own cultural baggage; the intersubjective focus suggests digging deeper into understanding the kinds of countertransference feelings operating at conscious and unconscious levels that are at risk of being enacted. Finally, the sociopolitical analysis directs my attention to intersecting forms of oppression as they impact on the client's life. Together these four perspectives help clinicians to become, in Laird's words, “more informed not-knowers” (1998, p. 30).

The paradoxical combination of these two ideas—being “informed” and “not knowing” simultaneously—

captures the orientation to one's “lack of competence” that I am suggesting is needed in cross-cultural work. I believe that while the information I would have obtained if I had pursued the lines of questioning suggested above would have been helpful, it is not the information per se that would have made a difference with the W. family. It is the act of respectful, nonjudgmental, and deeply interested questioning and the exchange of beliefs that would have strengthened the trust and understanding between Mrs. W and myself. If I see my limitations as the problem, then I see Mrs. W as someone who can, in telling me about her life, provide opportunities for me to do the work involved in better understanding myself and my cultural attitudes. This approach could lead to a truer exchange of ideas between us.

Working From an Appreciation of One's Lack of Competence

Using the example of my cross-cultural experiences with the W. family, I would propose that it is not so much “knowledge” but rather “understanding” that is basic to successful clinical work across cultural divides. When we work toward understanding we are engaging in building a relationship. These two ongoing processes of understanding and relationship building are mutual and intertwined and at the heart of successful cross-cultural clinical work.

We enter cross-cultural work with limited understanding and many biases. This is inevitable because we are all embedded in cultural discourses that are based on stereotypes. And it is the clinician's cultural surround, including all the prejudices (prejudgments) that it entails, that are the problem—not the client's so-called cultural differences. If we believe that culture is a moveable feast and ever evolving, then understanding and self-understanding are, in Gadamer's terms, “always on the way” (1989, p. 102). In that sense, our knowledge is always partial and we are always operating from a position of incompleteness or lack of competence. Our goal is not so much to achieve competence but to participate in the ongoing processes of seeking understanding and building relationships. This understanding needs to be directed toward ourselves and not just our clients. As we question ourselves we gradually wear away our own resistance and bias. It is not that we need to agree with our clients' practices and beliefs; we need to understand them and understand the contexts and history in which they develop.

In building this process of self- and other-understanding we rely on overarching clinical skills and attitudes that

are fundamental to all good clinical work—introspection, self-awareness, respectful questioning, attentive listening, curiosity, interest, and caring. These are the elements of relationship building that lead to mutual respect and help us find our similarities as well as our differences.

This is not to say that becoming informed about the history and central issues of a particular cultural group at different periods in time is not an important aspect of clinical work. Nor do I intend to denigrate learning about culture from books, newspapers, and other forms of discourse. These sources of information can provide a beginning step in the process I am describing as long as they don't lead to a presumption of knowledge or competence. Once we presume to "know" about another we have appropriated that person's culture and reinforced our own dominant, egocentric position. I am proposing that we distrust the experience of "competence" and replace it with a state of mind in which we are interested, and open but always tentative about what we understand.

We need to keep in mind that the narratives that come to dominate the ways we interpret people and culture in our writings, at any given time, are social constructions. We only become aware of the limitations of past narratives and understandings when new and different ones take their place (Bruner, 1986). Consider, for example, the "melting pot" theory and ideas of assimilation that once dominated our thinking about ethnic differences. As Crawford states in advising "Whitefellas" about work with aboriginal people in Australia,

Be tactful and discreet and quietly compare any book learning against the actual situation. Use book learning as an aid to understanding, NOT as a template into which the actual will be fitted.
(1989, p. 56)

Learning about the "actual situation" requires humility and respect for the time and work required to achieve understanding and develop a common set of goals and purposes. If I had begun my work with the W. family with a greater appreciation of my lack of understanding, I might have been less sure of what was needed for Kareem and Malik and more willing to listen and explore Mrs. W's ideas. I would have recognized that I did not necessarily "know" what was best in this situation. I would have worked toward establishing a common language with Mrs. W that took into account our differences and similarities.

Our differences only have meaning in the context of an appreciation of our sameness and at the same time,

our similarities must not allow us to miss important differences. Clinicians need to contain both experiences of sameness and differences simultaneously and tolerate the tension inherent in doing so. If we are guided by principles of social justice and a belief in a common fate—that there but for the grace of God go I—and if we see our lack of competence as the problem and not the client's culture, then there is more of a chance of coming together from our separate centers. Finally, we need to study our society to reveal the ways that forms of oppression create problems out of difference. This form of questioning would allow us to build better communities with more trustworthy services and institutions, as well as better relationships and understanding with our clients.

Epilogue

My work with Mrs. W and her boys has continued. I have observed Malik's class at school and seen how Malik and his classmates are continually scolded and told to sit still and be quiet by a teacher who is herself overwhelmed by a large class containing many kids with problems. I saw how quickly education becomes a tense, unpleasant experience. I found it hard to sit still in such a setting. I have visited their church and seen how children are treasured and that Mrs. W is a highly esteemed leader in this rich, spiritual community. I now understand why it is that Malik can sit still in church and not in school.

Both boys continue to have intermittent and fairly frequent episodes of misbehavior and Mrs. W, who is concerned about her health, is again speaking of placing them out of her home. I am trying to create as many sources of support for this family as possible, with after-school tutoring, camp and recreation programs, and programs that build esteem in becoming a young African American man. But it takes time to put these programs in place and money that Mrs. W does not have and so it is a slow process. Mrs. W and I go to meetings at the school together and try to obtain testing and services none of which have been forthcoming. Other workers come and go, with recommendations and brief interventions but little time to do the actual day-by-day work with the family and the boys. I am committed to do what I can. I understand Mrs. W much better now and there is a bond between us. She knows that I am there to help but we both know that what I can do is limited and may not be enough.

Most recently Kareem came to my office for a meeting. After telling me how scared he was to cross big streets (he had to walk home alone) and how frightened he was of heights, (as we looked out of my third-floor window)

he told of the many times he was beaten up by kids on the streets when he was living with his grandmother. After hearing and commiserating with him about his fears and frightening experiences, I told him about a program I had discovered where he can learn how to repair a bike and then get to keep it. He and I will visit the program together in 2 weeks. He is excited about it. He knows that he has to keep himself from stealing and lying in the next months or he will be forced to leave Mrs. W's home and we will not be able to work together. He says he can do it. I'm not sure. In the meantime, our work continues.

References

- Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). Newbury Park, CA: Sage.
- Atkinson, D. R., Morten, G., & Sue, D. W. (1989). *Counseling American minorities: A cross cultural perspective* (3rd ed.). Dubuque, IA: Wm. C. Brown Publishers.
- Becker, H. S. (1986). *Doing things together: Selected papers*. Evanston, IL: Northwestern University Press.
- Boyd-Franklin, N. (1989). *Black families in therapy*. New York: The Guilford Press.
- Bruner, E. (1986). Ethnography as narrative. In V. W. Turner & E. M. Bruner (Eds.) *The anthropology of experience* (pp. 139–155). Urbana, IL: *University of Illinois Press.
- Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, 61, 392–402.
- Crawford, F. (1989). *Jalindari ways: Whitefellas working in Aboriginal communities*. Western Australia: Curtin University of Technology.
- Foster, R. (1999). An intersubjective approach to cross-cultural clinical work. *Smith College Studies in Social Work*, 69(2), 269–292.
- Gadamer, H. (1989). *Reason in the age of science*. Cambridge, MA: MIT Press
- Gerhardt, J., Sweetnam, A., & Borton, L. (2000). *Psychoanalytic Dialogues* 10(1), 5–42.
- Goldberg, M. (2000). Conflicting principles in multicultural social work. *Families in Society*, 81, 12–21.
- Green, R. J. (1998). Race and the field of family therapy, In M. McGoldrick, (Ed.), *Re-visioning family therapy*. (pp. 93–110). New York: Guilford Press.
- Harris, S. K. (1998). Introduction to *The minister's wooing*, by H. B. Stowe. New York: Penguin.
- Laird, J. (1998). Theorizing culture: Narrative ideas and practice principles, In M. McGoldrick, (Ed.), *Re-visioning family therapy*. (20–36). New York: Guilford.
- McGoldrick, M., Giordano, J., & Pearce, J. K. (Eds.) (1996). *Ethnicity and family therapy*, (2nd ed.). New York: Guilford.
- Staples, R. (1978). *The Black family: Essays and studies* (2nd ed.). Belmont, CA: Wadsworth.
- Sue, D. W. (1981). *Counseling the culturally different: Theory and practice*. New York: John Wiley & Sons.
- Webster's new world dictionary of American english (3rd college ed.). (1988). V. Neufeldt (Ed.) & D. B. Guralnik (Ed. In Chief Emeritus). New York: Simon & Schuster.
- Wilson, W. J. (1987). *The truly disadvantaged: The inner city, the underclass and public policy*. Chicago: University of Chicago Press.

Ruth G. Dean is professor, Simmons College School of Social Work, 51 Commonwealth Avenue, Boston, MA 02116; e-mail: rdean@simmons.edu.

Manuscript received: August 8, 2000
Accepted: May 30, 2001