The Invisible Veil: Changing Paradigms in the Art Therapy Profession

Savneet Talwar, Washington, DC, **Jayashree Iyer,** Seattle, WA, and **Cheryl Doby-Copeland,** Washington, DC

According to Sue and Sue (1999), the invisible veil is a worldview which affects all individuals as products of cultural conditioning and which operates outside the level of conscious awareness. Further, they state that the "values, assumptions, beliefs, and practices of our society are structured in a manner as to serve only one narrow segment of the population" (p. 31). Given this sense of haze or dysconsciousness (Ponterotto, Casas, Suzuki, & Alexander, 2001) and ethnocentrism, it becomes imperative for art therapy to revisit its cultural and social identities to become more inclusive. The incidents of racist attacks on individuals of visible racial ethnic groups and the changing demographics of the United States are forcing art therapy to address issues of diversity. These include culture, race or ethnicity, gender, religion, historical experiences within the dominant culture, sexual orientation, disability, socioeconomic status, education, political views, lifestyle, and geographic regions within the profession. Furthermore, while the fields of social work and counseling have greatly improved their recruitment of minority students and staff, minority numbers have not changed in art therapy (Boston, Doby-Copeland, & Short, 2001). Our goal in this article is to examine how our collective biases, beliefs, and values have been masked and how they continue to impact our educational programs.

A Need for a Multicultural Focus: Issues in Art Therapy

Talwar (2002a) surveyed art therapy programs approved by the American Art Therapy Association (AATA) to assess whether they offered a multicultural class. Only 70% of training programs offered such a class, meaning that almost a third of the programs were apparently not in compliance with AATA standards. Closer examination of the data revealed that the multicultural class might not be offered every year, it might be offered for variable credit, and it might not be a requirement for graduation. This cannot be overlooked given that AATA has changed its

ethical guidelines to include multicultural standards (American Art Therapy Association, 2001). On the other hand, in Doby-Copeland's experience as an educator of multicultural issues in art therapy, students have indicated that a course focusing on strategies to develop cultural competence has favorably influenced their selection of a graduate program.

We, as educators, ask two essential questions:

(1) If the field is to impose a standard of cultural proficiency (the highest level of cultural competence) for its practitioners, are the faculty training the practitioners culturally proficient?

(2) Does the curriculum for multicultural training reflect the same measure of proficiency?

Ethnocentric Monoculturalism in Art Therapy

Sue and Sue (1999), who coined the term "ethnocentric monoculturalism," stated that many mental health professionals believe that counseling and psychotherapy can be "hand maidens of the status quo," "instruments of oppression," and "transmitters of society's values" (p. 32). Therefore, an ethnocentric monocultural approach is a tool for oppression in a pluralistic society like the United States.

The authors of this article have observed a compelling pattern of ethnocentrism in the art therapy profession in that (a) the cultural identity of art therapy lies in its Euro-American roots; (b) there is a serious lack of publications discussing the need to include issues of culture, race or ethnicity, gender, religion, historical experiences within the dominant culture, sexual orientation, disability, socioeconomic status, education, political views, lifestyle, and geographic regions in art therapy discourse (Burt, 1997; Cattaneo, 1994; Hiscox & Calish, 1998; Hogan, 1997; Lofgren, 1981; Spaniol & Cattaneo, 1994; Talwar 2002b; Wadeson, 1989; Westrich, 1994); and (c) the most recent AATA membership survey indicates 90% of its membership is Caucasian American and 91% is female (Elkins, Stovall, & Malchiodi, 2003), suggesting the prevalence of an ethnocentric monocultural perspective.

It is projected that ethnic minorities—including African American, American Indian and Alaskan Natives, Asian and Pacific Islanders, and persons of Hispanic origin—will make up 47% of the population in the United States by year 2050 (Banks, 2003). Such demographic changes are

Editor's note: Savneet Talwar, MA, ATR-BC, is Assistant Director/Assistant Professor and Cheryl Doby-Copeland, MPS, ATR-BC, is Adjunct Professor for the Art Therapy Program, The George Washington University, Washington, DC. Jayashree Iyer, DA, ATR-BC, is a member of the core faculty for Programs in Psychology, Antioch University, Seattle, WA. Correspondence concerning this article maybe addressed to stalwar@gwu.edu, jayarohini@yahoo.com, or cheryl.copeland@dc.gov.

believed not to be a problem as long as the psychological constructs of all individuals adhere to the "notion of unyielding universal psychology that is applicable across all populations" (Sue & Sue, 1999, p. 32) and to the belief in a meritocracy (Neville, Worthington, & Spanierman, 2001). While very few art therapists will admit to using a universal psychology, the lack of discourse on the subject suggests an ethnocentric, male, Anglo-Saxon perspective in the conception of human relationships that dominates art therapy discourse, theories of psychological development, and psychopathology (Fabre-Lewin, 1997; Talwar, 2002b). Thus the therapeutic practices in art therapy continue to be culture-bound, reflecting a monocultural perspective that is antagonistic and inappropriate to the values and lifestyle of minority populations.

In 1998, the Division of Counseling Psychology and Society for Psychological Study of Ethnic Minority Issues identified five components of ethnocentric monoculturalism (Sue & Sue, 1999). The authors have reflected on each point in the context of art therapy.

The belief in superiority (Sue & Sue, 1999) considers that Euro-American cultures are seen as most desirable and normative. These include physical characteristics such as fair skin, blond hair, and blue eyes; a Christian culture that has a monotheistic view of God; and emphasis on individualism, Protestant work ethic, and capitalism (Katz, 1985). People possessing these traits are considered and treated more favorably with greater access to the larger society. This is referred to as "White privilege" (McIntosh, 1989; Sidun & Ducheny, 1998; Sue & Sue, 1999) whereby individuals who fit a certain mold can cash in each day on advantages not given to those who are culturally and ethnically different. Addressing the ethnocentrism prevalent in our profession is both an organizational and pedagogical responsibility to help the members build an awareness of their own and others' cultural values.

The second belief is in "the inferiority of all other groups' cultural heritage that extends to its customs, values, traditions, and language" (Sue & Sue, 1999, p. 33). Culturally different groups have been seen as less qualified, unpopular, primitive, less developed, uncivilized, and pathological, because they do not meet the dominant cultural norms. Lofgren (1981) was one of the first art therapists to voice the cultural biases inherent in our psychiatric settings and art therapy practices when she worked with a Native American client with schizophrenia. Chebaro (1998) wrote about her distress, voicing the lack of cultural sensitivity in her university art therapy practicum setting when she raised issues of culture and race. She cautioned art therapists about the risks of misdiagnosis and overgeneralization of the symbolic meaning of art.

Third, the power to enforce standards implies that a dominant group is one that imposes its standards and beliefs upon the less powerful groups (Helms & Cook, 1999; Sue & Sue, 1999). To a certain extent, all groups are ethnocentric, but unequal status among the groups defines ethnocentric monoculturalism. A large monocultural group that represents an ethnocentric perspective has overshadowed art therapy discourse on multicultural issues. This elit-

ist stance has impaired recruitment of students from nondominant groups, as they don't receive much in the way of mentorship or information with which they can identify. Additionally, although several art therapists of color have made significant contributions to the field of art therapy—such as Sarah McGee, Cliff Joseph, Georgette Powell, and Lucille Venture—their efforts have not received much recognition. The first minority ad hoc committee was formed in 1978 to "investigate encouraging minority groups to enter and study in the field of art therapy" (Boston, Doby-Copeland, & Short, 2001). During the 10th Annual AATA Conference in 1979, a special committee on recruitment of minorities was formed, and 24 years later minority membership has not increased (Boston et al.).

Fourth, ethnocentric values and beliefs are manifested in institutions in whatever vision, plans, policies, and standards the institution implements (Sue & Sue, 1999). For example, AATA did not recommend a class in multiculturalism until 1994, and this recommendation did not require that an art therapist teach the class. This inclusion recognized the importance of addressing multicultural issues but marginalized the importance by excluding this course from the core of the educational program curriculum. Not until July 2002 did AATA require that an art therapist teach this course. The educational requirements set forth by AATA (American Art Therapy Association, 1994, 2002) represent its ethnocentric membership and vision.

Lastly, an underlying feeling of xenophobia or "fear of the other" seems to strain our ability to acknowledge and confront our own cultural and racial biases (Lippard, 1990). This results in individuals assuming the concept of universality or cultural blindness, which has been one of the premises of psychology for the last 100 years.

The mental health field and society at large have produced many metaphors to conceptualize American diversity. In the 1960s and 1970s, the "melting pot" (Helms & Cook, 1999) minimized recognition of differences in race, culture, and ethnicity. Concepts like assimilation and acculturation were highly valued because similarity was cherished more than difference. The melting pot became a guiding metaphor for the homogenizing of America and for responding to an increasingly diverse nation with new immigrants from many parts of the world. In the past 20 years, the modernistic melting-pot metaphor has been largely discarded and replaced by new, postmodern metaphors such as "salad bowl," "mosaic," and "tapestry" (Helms & Cook, 1999; Hiscox & Calisch, 1998; Millet, 2002), which celebrate difference rather than similarity. The latter also emphasize the distinction among, and the uniqueness of, cultural groups that occupy the collective cultural space. Multiculturalism portrays society as a cultural mosaic rather than a melting pot, recognizing all individuals in the context of their culture (Corey, 1995).

For example, "The Special Committee on Recruitment of Third World Groups of (Asian), (Black), (Hispanic), Diaspora and Native Americans to Enter and Study in the Field of Art Therapy" was renamed the "Mosaic Committee" in 1990. This was done to address the serious need to respond to racial, ethnic, and cultural prejudgments of

clients by art therapists working cross-culturally (Doby-Copeland, 1998). The Mosaic Committee was replaced by the Multicultural Committee in 1995.

Despite these paradigmatic shifts within AATA, the "invisible veil" (Sue & Sue, 1999) continues to veil members from each other and even from themselves. This indicates to us that art therapists relegate multicultural inquiry to the few who are "other" within the profession. A general myopia and color blindness among the dominant group impede the development of cultural competence within the organization. Self-recognition and awareness of each art therapist and human being is the key to becoming an effective clinician.

Lifting the Invisible Veil: Strategies for Improving Cultural Competence in Art Therapy

The authors identify two areas in which to develop cultural competence: organizational cultural competence and clinical cultural competence. Organizational cultural competence moves through various stages along the cultural competence continuum. Identifying cultural proficiency in AATA's vision means that our organizational culture, including all of our individual members, is functioning at the highest level of multicultural competence. A culturally proficient AATA would continue to add to the knowledge base of culturally competent therapy approaches through ongoing research, developing innovative treatment approaches, and involvement in efforts that end social discrimination and promote social diversity (Sue & Sue, 2003).

Psychotherapy practices have often failed to meet the needs of individuals who are culturally different. Various cultural barriers such as language, class-bound values, and culture-bound values hinder the formation of a good therapeutic relationship (Corey, 1995; Helms & Cook, 1999; Pedersen, 1994; Sue & Sue, 1999). Applying Wise's (1979) thoughts regarding teaching strategies, clients cannot be seen as a tabula rasa but as "laden with culture." They are encouraged "not simply to 'learn about' their culture, but to envision their own social surroundings as one pattern of alternatives among a wide spectrum of human possibilities" (p. 324). Moving to a more general perspective, one can further persuade individuals "to discover the particular kinds of historical choices that have led Americans to construct their particular social realities in their particular ways. Such a strategy has served to make cultural realities more accessible" (Wise, p. 325).

Diversity in educational programs means having a sociopolitical cultural framework that considers diversity in values, interactional styles, and cultural expectations. A sociopolitical cultural framework means not only seeing oppression as event specific (for example, trauma), but as a layered event encompassing social, political, and cultural histories in conjunction with psychological and personal stories. Understanding the historical context of oppression and the instances of oppression from a global perspective catalyzes steps to address the use and abuse of power. For example, understanding Black-White relations in America means understanding the history of slavery. Understanding oppression from a global perspective means understanding the role of colonization the world over. These understandings will lead to sharing the same frame of reference or to having empathy for cultural groups other than one's own. Then, in dialoguing with each other within our community, empathy can seal the bond between shattered cultural groups. Art therapists need to commit to developing self-awareness, knowledge, and skills to have a multicultural perspective. Although having an in-depth knowledge of all cultures is not realistic, a comprehensive grasp of the general principles for working successfully amid cultural diversity and recognizing the need constantly to acquire culture-specific knowledge identifies the culturally proficient therapist (Hoshino, 2003). Becoming aware of our assumptions and how they work in facilitating a stance of superiority that leads us to impose our beliefs and values on others is an important factor in the process of cultural awareness or competence.

The art therapy profession has historically been plagued by dichotomies. The art world has struggled with similar issues when viewing art created by culturally different individuals. Lippard (1990) suggests that Westerners tend to polarize their gaze between "what is familiar and what is unfamiliar, on the neutral and exotic, rather than what is liminal and fertile ground where new meaning can germinate" (p. 9). According to Iyer, Talwar, and Doby-Copeland (2003, p. 66), "If we can't understand the workings of oppression, we can't even begin to become culturally competent." Prashad's (2000) view clarifies this point: "US multiculturalism asks that each immigrant group preserve its own heritage (as long as they speak English). The heritage or 'culture' is not treated as a living set of social relations but as a timeless trait" (p. 112). Prashad asks us to see culture not as a "thing" but as a "process" (p. 113).

According to Sidun and Duchney (1998), who have created a model to explore White racial identity, "An individual becomes increasingly aware of the sometimes subtle education White people receive regarding their culture and privilege" (p. 27). Furthermore, their model advocates exploration of White racial identity in community with other White people. They caution that this undertaking can be very intimidating, but it also adds a richness and depth to one's own understanding. Recognizing a certain awareness of other cultures, their boundaries, and context is essential when working with individuals from different cultural and racial backgrounds.

Students often ask, "What do we do now that we recognize there is inequality?" "What do we do to change?" "Do we give concessions to minority groups just because they have been oppressed?" "What if I don't want to be an activist?" Realization about inequality and privilege and color-blind racial attitudes needs to happen on a visceral level. This internal shift itself is a seminal move towards an accurate perception of race relations in America. Social and political action does not have to take place from a pulpit. The arenas are the therapist's self and the clinical situation where diverse combinations of therapist and client en-

counter each other and have an authentic interaction within a matrix of deep awareness. This is sociopolitical action and social justice.

Conclusion

Lippard (1990) states that the process of change is painful and yet exhilarating, but change does not automatically bring happy endings. "You can't understand other cultures until you understand your own" (p. 13). As we look at the years ahead, we must accept the rapid racial diversification of the United States. Racial prejudice and veiled institutionalized oppression continue to exist even today. At the 2003 AATA conference in Chicago, a panel presentation titled "Dialogues on Ethnocentric Monoculturalism in the Art Therapy Profession" (Talwar, Iyer, Doby-Copeland, & Lark, 2003) evoked a strong response from a member of the audience. She said, in effect, "I take issue with the fact that I have to be responsible for slavery that happened so long ago. Do my children and grandchildren have to feel guilty for something in which they did not participate?" Questions such as this tell us that we are still veiled to our historical past and demonstrate a stance of cultural unawareness. There appears to be a conflation between responsibility and blame. In our view, lifting the veil implies that art therapists become change agents for transcending our legacy of ethnocentric monoculturalism. Failing to do so, as Ponterotto and Peterson (1993) conclude, could result in placing counselors and psychologists (and art therapists) at risk of being viewed as irrelevant, unethical, and ineffective by persons from diverse backgrounds and groups. We call for the lifting of the invisible veil, for recognizing and forestalling veiling in our outlook and clinical practice.

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