ARTICLE

CULTURAL COMPETENCY: FROM PHILOSOPHY TO RESEARCH AND PRACTICE

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Cultural competency in the delivery of mental health services has gained considerable momentum. This momentum has been accompanied by questions about the meaning, usefulness, and precision of cultural competency. The author argues that cultural competency is composed of general processes (scientific mindedness, dynamic sizing, and culture-specific skills), as well as a series of concrete and trainable strategies. The incorporation of these processes and strategies into treatment can improve treatment outcomes with clients from diverse cultural backgrounds. © 2006 Wiley Periodicals, Inc.

Because of past inadequacies in mental health care and in mental health research with culturally diverse populations, the philosophy and practice of cultural competency have emerged. Cultural competency is one of the most exciting and challenging movements in the mental health field. It has been identified as being critical in promoting effective mental health care to all populations (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2001), and guidelines for cultural competency have been established by not only local governments and states but also national organizations (American Psychological Association [APA], 2002) and federal agencies (Center for Mental Health Services, 2000). Despite its importance, there are a number of unresolved issues and dilemmas that need to be addressed. It is argued that cultural competency should be examined as a process and as specific content.

WHAT IS CULTURAL COMPETENCE?

In general, guidelines for cultural competency have been based on the assumption that therapists and mental health providers should possess cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture. In terms of the specific knowledge and skills required, D. W. Sue, Ivey, and Pedersen (1996) devel-

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oped the most widely recognized conceptual framework. Their conceptual scheme included three general areas:

- Cultural awareness and beliefs: Provider's sensitivity to her or his personal values and biases and how these may influence perceptions of the client, client's problem, and the counseling relationship.
- Cultural knowledge: Counselor's knowledge of the client's culture, worldview, and expectations for the counseling relationship.
- Cultural skills: Counselor's ability to intervene in a manner that is culturally sensitive and relevant.

This framework has been adopted by the American Psychological Association's *Multicultural Guidelines* (2003). However, the guidelines have been largely aspirational or hortatory in effect (e.g., emphasizing that therapists should consider the cultural background of clients), with less attention given to how cultural competence can be measured, conceptualized in terms of skills, implemented in practice, and trained in others. The most critical problem facing the cultural competency movement is to progress from a *philosophical* definition to a *practice-* or *research-oriented* one. A philosophical definition that lacks operational specificity has led to several questions:

1. What characteristics constitute cultural competency? If cultural knowledge is important, is it possible to "know" all cultures? How much knowledge is necessary and what are the contents of this knowledge? Is cultural competency a skill that can be manualized and scripted?
2. Do different competencies exist for different groups or does cultural competency reside in individuals (e.g., clinicians) independent of groups? For example, if one is culturally competent, is he or she competent with all culturally diverse groups or are the skills specific to a particular ethnic group?
3. Are different cultural competencies required at different times in the treatment process? In other words, can cultural competency be measured at one time and assumed to be in effect for all times?
4. Is cultural competency a unidimensional versus multidimensional phenomenon; if it is multidimensional, are certain dimensions more important than others?

Furthermore, in discussing cultural competence, it is important to distinguish between levels of analysis. The first level, and the one that has received most attention, is the provider level. The provider works one-on-one with clients usually in a treatment or case management role. Interpersonal sensitivity, rapport-building, therapeutic alliance, and credibility are examined for cultural appropriateness and effectiveness. The second level occurs within an agency. Is the mental health program or service culturally competent? Issues concerning organizational structure, hiring, establishment of programs, evaluation, outreach, access and availability of service, utilization, costs and benefits, and quality of care are examined for their effectiveness for members of different cultural groups. Finally, the third level is molar and deals with systems of care within a community. The organization and structure of mental health services for different ethnic populations (e.g., health maintenance organizations, geographic areas served, and collaboration with community agencies, churches, schools, and law enforcement agencies) are of interest.

To address the complexities and ambiguities in the concept, it is important to view cultural competency as both a process and a substantive content area, especially in dealing with providers.

Process

S. Sue (1998) views cultural competence as a multidimensional phenomenon. In his view, there appears to be three important characteristics that underlie cultural competency among providers: scientific mindedness, dynamic sizing, and culture-specific skills. One important characteristic of a good therapist appears to be scientific mindedness. Scientific mindedness in the context of treatment refers to therapists who form hypotheses rather than make premature conclusions about the status of culturally different clients; who develop creative ways to test hypotheses; and who act based on acquired data. For many years, cross-cultural investigators have admonished therapists to be flexible and sensitive in working with ethnic minority clients. There is the concern that people frequently make assumptions or apply concepts and theories that are developed in their own culture to clients from different cultures.

Another valuable characteristic (dynamic sizing) are skills in knowing when to generalize and be inclusive and when to individualize and be exclusive in working with clients. That is, the therapist can flexibly generalize in a valid manner. The skills are quite important because one of the major dilemmas facing individuals is how to appreciate culture without stereotyping. Often, when the cultural values or characteristics of various groups are discussed, there is a stereotypic quality to the discussion. Statements such as, “Asians are collective rather than individualistic in orientation,” “Native Americans appreciate nature in contrast to Americans who try to master nature,” and “For African Americans, the Church and spirituality are important,” can be viewed as accurate cultural portrayals or overgeneralizations and stereotypes. On the one hand, the statements may reveal important cultural characteristics of groups. Those who are skilled in dynamic sizing are able to avoid stereotypes of members of a group while still appreciating the importance of culture.

Finally, culture-specific expertise is also important. While general skills and dynamic sizing are important general assets, conducting effective psychotherapy with culturally diverse clients also requires knowledge and skills specific to the culture of the client. For example, knowing the history of an African American male client who has experienced prejudice and discrimination may help a therapist to evaluate whether mistrust of the therapist is attributable to “healthy paranoia” or “functional paranoia” (Ridley, 1995).

Scientific mindedness, dynamic sizing, and culture specific expertise are processes that are orthogonal in that it is possible to be proficient in none, one, two, or all three. Thus, cultural competency is difficult to measure and conceptualize.

Content

In addition to process characteristics, cultural competency also includes some concrete steps that can be taken to improve the effectiveness of a provider’s work with an ethnic minority client. In other words, there are strategies or tools that one can use in becoming more culturally competent. While there are no quick and easy ways exist to become culturally competent, certain “orientation” strategies can concretely help therapists to address cultural issues, as shown in Table 1.

Table 1. Concrete Steps to Take in Improving Cultural Competency in Treatment

Self-awareness and stimulus value
Assessment of client
Pretherapy intervention
Hypothesizing and testing hypotheses
Attending to credibility and giving
Understanding the nature of discomfort and resistance
Understanding clients' perspective
Strategy or plan for intervention
Assessment of session
Willingness to consult

Self-awareness and stimulus value. In developing a multicultural theory of counseling, Sue et al. (1996) have proposed that: (a) therapists bring to the therapy session their own cultural backgrounds and world views, (b) clients may have very different backgrounds and worldviews, and (c) such differences are often barriers to effective therapy. They believe that therapists must become aware of their own values, biases, and stereotypes. By understanding themselves, therapists can increase their levels of comfort with clients who differ in values. Sodowsky, Kuo-Jackson, and Loya (1997) believe that adherence to the axiom, "Counselor, know thy cultural-self," facilitates a multicultural therapy relationship because therapists and counselors can consciously deal with their own defenses, projections, and any internalized racist reactions. Self-awareness also allows therapists to understand the relativity of many cultural beliefs, values, and practices so that they are less likely to misinterpret their own cultural values as ethic or universal values. Therapists should assess their own awareness of their cultural selves and strive to understand their own values, beliefs, and behaviors as a reflection of their culture. Furthermore, clients may react to, or perceive, therapists in ways that reflect the clients' culture. For example, in some cultures, men may find it difficult to confide in women or older clients may believe that younger therapists cannot have the wisdom to help. Therapists should be aware of how clients may react to their own personal characteristics (i.e., gender, age, ethnicity, etc.).

Assessment of client. To work with clients, therapists must perform evaluations to understand clients better. In the case of ethnic clients, therapists need to understand clients' background and characteristics, such as country of origin, family structure, immigration history (if clients are immigrants), birth order, sex roles, social class, and culture. Assessment and evaluation are particularly important in two domains. The first is concerned with culture and acculturation. Ethnic minority group or culturally diverse clients exhibit great heterogeneity. Some may be immigrants who come from very different social, cultural, and political systems. Their values and experiences may be at considerable variance with those of mainstream Americans. By contrast, other members of the same ethnic minority group may be quite acculturated and "Americanized." They are more likely to understand Western psychotherapy. Therefore, it is critical for the therapist to determine the level of acculturation and cultural background of clients. Therapists can, therefore, make some educated guess as to whether the clients will find psychotherapy strange or unfamiliar. In addition, the cultural values and behaviors of clients may conflict with those in American society and cause considerable stress (Marin & Gamba, 2003). This further underscores the importance of evaluating the acculturation level of clients. Clients who are not well

acculturated may prefer or work better with an ethnically and culturally similar therapist (Sue, 1998). The second important area of assessment is the degree to which the client has had minority group experiences. Ethnic minority individuals have encountered to varying degrees racism, prejudice, and discrimination in society. Such experiences may have an important effect on the clients' personal problems and on their interactions with therapists. For example, an African American client who has had very negative racial interactions with White Americans may find it difficult to work with a White therapist. Therapists, then, can be perceived very differently, depending on clients' experience as a member of a minority group.

The assessment task is to determine the cultural background and degree of acculturation among clients and the extent of exposure to minority group status. What is the cultural background of the client? In what ways is the client acculturated or traditionally ethnic? Has the client experienced prejudice or discrimination? Answering these questions can help to place clients' situations into proper perspective and can help to explain their behaviors in therapy. It can also serve to alert therapists to their own strengths and deficiencies in understanding clients. The valid assessment of clients is dependent on not only the information gained about the clients but also the dynamic sizing skills of the therapist. The ability to determine the relevance of clients' cultural background in the manifestation of symptoms is extremely important, as mentioned previously.

Pretherapy intervention. Because many ethnic minority clients are likely to be unfamiliar with Western psychotherapy, one helpful treatment process appears to be pretherapy intervention. Ethnic minority clients may not know what psychotherapy is, how psychotherapy can help, what to do, or what to expect. Client-orientation programs aimed at familiarizing clients to psychotherapy have been found to be quite beneficial, depending on client's previous knowledge about psychotherapy (Acosta, Yamamoto, & Evans, 1982). They involve explaining the process of psychotherapy—what psychotherapy is, how psychotherapy can help, what the typical roles of therapists and clients are, how confidential matters are, what to expect in treatment, and what confidentiality is. Therapists or mental health providers can use slides, audiotapes, or videotapes, pretherapy interviews to explain matters to clients and show clients the process of seeing a therapist, means by which to express problems and self-disclose, and methods to communicate needs. Acosta, Yamamoto, Evans, and Skilbeck (1983) found that exposure to orientation program can increase knowledge and favorable attitudes toward psychotherapy among African American clients. Interestingly, therapist-orientation programs have also been devised to familiarize therapists with the backgrounds of ethnic minority clients. Client and therapist preparation programs have been favorable (see Jones & Matsumoto, 1982).

Hypothesizing and testing hypotheses. Consistent with the view that scientific mindedness is a particularly important characteristic among therapists, therapists should systematically form hypotheses about clients. These hypotheses are most valuable when therapists are unsure if the behaviors, attitudes, or circumstances of clients are influenced by culture or by the general internal dynamics of clients. In an attempt to resolve the dilemma, therapists need to form testable hypotheses and confirm or disconfirm the hypotheses. Ideally, therapists should use multimethod procedures. Multimethod procedures involve the use of different strategies to test hypotheses. For instance, if therapists suspect that their clients are not functioning well despite the clients' assertions to the contrary, they can use a variety of methods to test how their clients are doing. This can involve the use

of informants (asking friends or relatives how well the clients are functioning) and job-performance measures (productivity on the job and number of absences). Do these assessments reveal that the clients are functioning well? If the different assessment provides inconsistent results, therapists should use additional measures or should explain the inconsistency.

Attending to credibility and giving. Clients vary in the extent to which they find Western forms of psychotherapy credible as a method of alleviating distress. For ethnic minority clients, many of whom who have a non-Western background, psychotherapy and counseling may not have much credibility. In an analysis of credibility, Sue and Zane (1987) proposed two factors in credibility—ascribed status and achieved status. Ascribed status is one's position or role that is assigned by others or by cultural norms. Clients may ascribe high or low credibility to therapists and psychotherapy, depending on cultural values. In some cultures, the young are subordinate to elders, women defer to men, and those who are naïve listen to those who are educated. Thus, an elderly Chinese man may not consider a young therapist as being very effective or credible. Credibility can also be achieved. Achieved credibility is attained when, through the skills and actions of therapists, clients perceive therapists as being competent or helpful. Ascribed and achieved credibility have distinct effects. The lack of ascribed credibility helps to explain why clients avoid services (they see little value in them) while the lack of achieved credibility may better explain why clients prematurely terminate treatment and do not form a therapeutic alliance in treatment. By understanding the culture of clients, therapists can understand their levels of credibility and the need to develop those skills that will enhance achieved credibility.

One means of increasing achieved credibility is to give clients a direct benefit from treatment. This benefit or gift can help to overcome clients' skepticism over the effectiveness of Western psychotherapy. For example, clients who are depressed or anxious will have increased confidence in psychotherapy if there is an alleviation or reduction of these negative emotional states during the treatment session. For clients in a state of crisis and confusion, therapists can increase their credibility if they help clients to develop cognitive clarity or a means of understanding the chaotic experiences. Such techniques are often used in crisis intervention. Gift giving is intended to provide some type of meaningful gain early in therapy and to increase the rapport or therapeutic alliance between therapists and clients. Although therapists try to establish achieved credibility and to provide gifts to all clients, these practices are especially important to clients who may not understand psychotherapy and who may doubt the effectiveness of treatment or provider. In treatment, therapists need to focus on gift giving and attempt to offer benefits from treatment, even in the first session. In trying to give gifts, it is important to know the clients' cultural backgrounds because what is defined as a gift, how gifts are best delivered, etc., depend on the clients, their situation, and cultural experiences.

Understanding the nature of discomfort and resistance. While therapists are trained to attend the resistances that clients exhibit in treatment, they are frequently unprepared to deal with their own feelings of discomfort and resistances in working with culturally dissimilar clients. These clients may directly or indirectly question the value of psychotherapy, have radically different values system, have superstitious beliefs, fail to comply with treatment regiments or assignments, or communicate in ways that are difficult for therapists to understand. As a result, therapists may begin to feel frustration, uncertainty, anxiety, and

even anger. However, in the same way that therapists can use the phenomenon of countertransference to better understand themselves and their clients, they can also use these feelings of discomfort that arise from working with culturally dissimilar clients to understand cultural dynamics. Therapist frustrations may come from the inability to understand clients' styles of interacting, styles that are common in the clients' culture. When experiencing feelings of discomfort or resistances, therapists should attend to several questions: What feeling am I experiencing? Why am I uncomfortable with this client at this time? Is the client doing something that I don't understand or value? What kinds of cultural differences are being portrayed? How can I use the discomfort to understand myself and the client as well as to more effectively help the client?

Understanding clients' perspectives. As noted earlier, in developing an understanding of clients, therapists must gain knowledge of clients' cultural background, values, and beliefs. Obviously, it is impossible to acquire full knowledge of the cultures of different clients. Therapists must decide what cultural aspects are particularly important to know. Among the many cultural values and beliefs that exist, several are particularly germane to therapists: (a) cultural conceptualizations of mental health problems, (b) cultural means for resolving problems, and (c) goals for treatment (Sue & Zane, 1987). How clients conceive of their problems is important to understand. If clients have very different ways of conceptualizing their problems and symptoms from those of therapists, they may be highly antagonistic to Western psychotherapy. Similarly, if clients and therapists have cultural differences in the means for resolving problems or in goals for treatment, psychotherapy will be difficult. Clients may be very resistant in treatment or simply fail to return for therapy. The important tasks for therapists are to gain an understanding of how clients are conceptualizing the problems, what they prefer in terms of ways of solving problems, and what kind of goals that they would like achieve. Therapists can then judge how discrepant the clients' beliefs are from the assumptions of Western psychotherapy. The greater the discrepancy, the less credibility therapists and psychotherapy will have. Note that therapists should not try to reduce the discrepancy by simply pretending to adopt the perspectives of clients. Rather, therapists should use the cultural differences as a warning that the clients may have very different ideas about treatment and that thoughtful strategies must be devised to work with the client and to gift-give.

Strategy or plan for intervention. In working with clients, particularly those from non-Western cultures, strategies or plans for intervention and treatment should be carefully devised. This forces therapists to think about the client, cultural factors, goals for the session, and means of accomplishing goals. If therapists lack knowledge about the culture of a client, they should attempt to learn about that culture as much as possible before the treatment session. An intervention plan or strategy should be developed. While the plan may be to gather information and to minimize structure in the session, the strategy is, nevertheless, a planned and deliberate one.

Assessment of session. After each treatment session, therapists should ask themselves how the session went. Am I credible with this client? Was I able to provide a gift that was well received by the client? Did the client show improvement or greater rapport with me? Is the client better able to understand psychotherapy? Do I understand the client any better? What should I do in the next session?

Willingness to consult. It is difficult to be fully culturally proficient in working with the clients from many diverse groups. Assistance should be sought in the assessment or treatment of clients whose cultural backgrounds or lifestyles are unfamiliar to the therapist or markedly different from that of the therapist. Cultural experts can help therapists to understand whether the attitudes and behaviors of clients are culturally normative or unusual. They can also provide insight into the effectiveness of various intervention strategies and interpret the reactions of the clients. In some intervention programs, such as those established by Lefley and Bestman (1984), treatment teams include members who have particular expertise on the culture of clients, so that cultural input into treatment strategies is readily available.

Working with clients from various ethnic minority groups is difficult but very challenging. Given our multicultural society and world, one can no longer be a competent or effective therapist unless one is also culturally competent. This competence should be viewed both as treatment processes and as a specific set of behavioral tools on the part of therapists. While they are not unique processes or tools, they are important in dealing with all clients; they are especially germane to working with those from ethnic minority or culturally diverse groups.

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