Chapter X: Cultural Competence in Mental Health Practice

4 CE Hours

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Learning objectives

- Explain three strategies to strengthen communication in a multicultural setting.
- Describe three methods to avoid becoming “affectively charged” and build cultural competence.
- List strategies to create cultural awareness and competence in therapeutic intervention.
- Discuss four common cultural missteps and three strategies for remediation.
- Identify two forms of cultural competence self-assessment.
- Explain the continuum of cultural competence and progress toward proficiency.
- Discuss the impact of multicultural competence on the supervisory relationship.

Introduction

Demonstrating cultural competence is an integral part of mental health service delivery. On the national level this issue has received greater support as the United States government recognizes the influence and impact of converging nationalities and cultures. Because divisions of race, ethnicity and culture exist in the United States, there is an increasing awareness of cultural competence and how it can eliminate disparities in care for people of diverse racial, ethnic and cultural backgrounds.

While the population in the United States continues to diversify, the U.S. Department of Health and Human Services (DHHS, 2001) has continued to report disparities in mental health services for ethnic minorities. Ethnic minorities are less likely to have access to and receive mental health services, often receive a poorer quality of services, and are under-represented in mental health research (DHHS, 2001).

In addition, ethnic minorities experience higher disability rates compared to European Americans (Smart and Smart, 1997). Disability and chronic illness often co-exist with mental disorders, such as depression and anxiety (Bairey-Mertz et al., 2002; Falvo, 2005). This points to the need for clinicians’ competency in addressing mental health concerns of minority clients with disabilities. However, many clinicians are inadequately prepared to serve ethnically diverse populations (DHHS, 2001) or to address disability issues in counseling (Sue and Sue, 2003).

Given the consistent mental health service disparities, a lack of clinical cultural competencies poses a significant problem that needs to be addressed in the counseling field. Because of the significant role that training programs can play in enhancing the cultural competency of clinicians, DHHS recommends clinicians complete training programs that address the impact of culture on mental health and mental health services so they can provide culturally responsive services for minority clients.

The American Counseling Association in its 2005 Code of Ethics defines culture as membership in a socially constructed way of living that incorporates collective values, norms, boundaries and lifestyles. These elements are created with others who share similar worldviews including biological, psychosocial, historical, psychological and other factors (ACA, 2005).

The ACA states that multicultural/diversity competence comes when counselors possess cultural diversity awareness, knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and their client groups. This type of counseling recognizes diversity and embraces approaches that support the worth, dignity, potential and uniqueness of individuals and their historical, culture, economic, political and psychosocial context (ACA, 2005).

The National Association of Social Workers (NASW) notes in its revised Code of Ethics (2008) that social workers should understand culture and its function in human behavior in society, which requires recognizing the strengths that exist in all cultures. The counselor should have a knowledge base of the client’s culture or be able to demonstrate competence in the provision of services that are sensitive to the client’s culture and to differences among people and cultural groups (NASW, 2008).

There is no specific form of counseling that is multicultural because “we are all multicultural individuals, and everyone lives in a multicultural society” Arredondo et al., 1996). All counseling is multicultural. This does not mean that mental health professionals need different counseling theories and practices for all the possible groups in the society. No mental health counselor can be prepared to counsel every possible client specific to his or her ethnic group. Mental health counselors will need special preparation to work with clients from a particular group. It is here that knowledge of the backgrounds of particular clients is necessary. Such knowledge provides a basis for understanding clients, colloquially, knowing “where the client is coming from.” (Patterson, 2004). Multicultural competencies simply provide a compendium of the elements of this knowledge. The knowledge is acquired not from specific academic courses but instead by living in the community with the kind of clients mental health counselors serve in their practice.

The assumption that simply having knowledge of the culture of the client will lead to more appropriate and effective therapy has not been established. Sue and Zane (1987) stated that “recommendations that admonished therapists to be culturally sensitive and to know the culture of the client have not been very helpful.” They continue:

The major problem with approaches emphasizing either cultural knowledge or cultural-specific techniques is that neither is linked to particular processes that result in effective psychotherapy. Recommendations for knowledge of culture are necessary but not sufficient for effective treatment. The knowledge must be transformed into concrete operations and strategies.

Several researchers on multicultural counseling have gone beyond counseling as a matter of knowledge and skills and have listed a
number of practitioner characteristics or attitudes necessary for effective practice. Wohl (1976) noted that the healing function includes a caring and concern on the part of the healer, and that therapy promotes a special, close relationship.

Pederson (1976) identified the “expectations of troubled contrasting culture clients and the personal qualities of a counselor as being closely related to healthy change, accurate empathy, and non-possessive warmth and genuineness that are essential to effective mental health care.”

Vontress (1976) emphasize the importance of rapport as “the emotional bridge between the counselor and the counselee. Simply defined, rapport constitutes a comfortable and unconstrained mutual trust and confidence between two persons.”

Over time, it was recognized that professional confidence is inherent in the personal qualities of the mental health practitioner. The competent mental health counselor is one who provides an effective therapeutic relationship. The nature of this relationship has long been known and is the same regardless of the group to which the client belongs.

In the list of multicultural competencies developed by Arrendondo in 1996, there is not a specific list of groups or specific treatments or techniques appropriate for each. Those therapeutic decisions are left to the mental health practitioner. Pederson (1976) wrote that “each cultural group requires a different set of skills, unique areas of emphasis, and specific insights for effective counseling to occur.” In one early review, Peterson reported that:

Native American Indian culture presents unique requirements for an effective counseling. When counseling Native American Indian youth, the counselor is likely to be confronted by passively nonverbal clients who listen and absorb knowledge selectively. A counselor who expects clients to verbalize their feelings is not likely to have much to do with Native American Indian clients.

Several researchers have proposed that clients from ethnic minority groups desire a structured relationship in which the mental health practitioner gives advice and solutions to problems (Sue and Sue, 1990; Sue and Morishima 1982; Vontress, 1981). However, cultural groups are not pure and discrete, but overlapping. The process of globalization is blurring the differences. The only workable product of a multicultural society is a society of individuals who must ultimately absorb different cultures into themselves. In the current global society, few discrete classifications are possible.

If classifications were possible, because every client belongs to a number of combinations and permutations of these groups, the number would be staggering. Attempting to develop different theories, methods and techniques for each of these groups would be an insurmountable task. This approach is not only impossible, but also irrelevant and harmful when counseling individual clients (Patterson, 2004).

Differences among clients fall into two kinds, accidental and essential. Cultural, ethnic and racial differences are accidental. The accident is the place of birth. But all clients are alike in one basic, essential way in that they are all human beings (Patterson, 2004).

Pinker (1997) notes that “surveys of the ethnographic literature show that peoples of the world share an astonishingly detailed universal psychology.” The nature of all human beings provides the basis for a solution to the problem of multicultural counseling. What is needed is a system of counseling or psychotherapy therapy based upon these common characteristics.

### A universal system of counseling or psychotherapy

The essence of a universal system of mental health counseling (Patterson, 1995) has long been known. It is what is known as client-centered therapy. There are five basic counselor qualities in this system (Rogers, 1957):

1. **Respect for the client** – This includes having trust in the client and assumes that the client is capable of taking responsibility for himself or herself, and capable of making choices and decisions to resolve problems. Moreover, he or she should be given the right to do so.

2. **Genuineness** – Counseling is a real relationship. The counselor does not assume a role as an all-knowing expert, is not impersonal and cold, but a real person.

3. **Empathic understanding** – Empathic understanding is more than knowledge based on the group to which a person belongs. It requires that the mental health counselor be able to use this knowledge as it applies to the unique client, which involves entering the client’s world and seeing it as he or she does.

4. **Communication of empathy, respect and genuineness to the client** – This must be perceived, recognized and felt by the client if the counselor is to be effective. This perception becomes difficult with clients who differ from the therapist in culture, race, socioeconomic class, age and gender. Understanding of cultural differences in verbal and nonverbal behaviors can be very helpful. Sue and Sue (1990) explain:

   “Qualities such as respect and acceptance of the individual, unconditional positive regard, understanding the problem from the individual’s perspective, allowing the client to explore their own values, and arriving at an individual solution are core qualities that transcend culture.”

5. **Structuring** – There is another element in all counseling that is of particular importance in intercultural counseling. Vontress (1976) says:

   “On the whole, disadvantaged minority group members have had limited experiences with counselors and related therapeutic professionals. Their contacts have been mainly with people who tell them what they must and should do. Relationships with professionals who placed major responsibility upon the individual for solving his own problems are few. Therefore, the counselor working within such a context should structure and define his role to client. Counselors should indicate what, how, and why they choose to proceed in a certain way. Failure to structure early and adequately in counseling can result in unfortunate misunderstanding.” (Sue and Zane, 1987)

Failure to structure may also result in failure of the client to continue counseling. Structuring is necessary whenever the client does not know what is involved in the therapeutic relationship, how that mental health counselor will function, what is expected of the client, or if the client holds misconceptions about the process (Patterson, 2004).

These professional qualities are not only essential for effective counseling, they are also the elements of all facilitated interpersonal relations. They are neither time-bound nor culture-bound.

Reviews of recommendations and suggestions for specific methods and techniques for counseling multicultural clients indicate there is no evidence for the appropriateness or effectiveness of such methods. Other methods suggested for counseling clients from other cultures are generally recognized, inextricable methods for which there is evidence. It follows that we do not need specific competencies for
multicultural clients, but we need methods and approaches that are effective with all kinds of clients. These methods constitute a universal system of counseling (Patterson, 2004).

The universal nature of counseling is reflected in the code of ethics for all mental health organizations. The National Association of Social Workers’ primary mission is to enhance well-being and help meet the basic needs of all people, with particular attention to the needs of those who are vulnerable, oppressed and living in poverty. The historic and defining feature of social work is the profession’s focus on the individual’s well being in a social context and the well-being of society (NASW, 2008).

NASW states that the social work profession is rooted in a set of core values. These core values, embraced throughout the profession’s history, are the foundation of social work’s unique purpose and perspective:

- Service.
- Social justice.
- Dignity and worth of all people.
- Importance of human relationships.
- Integrity.
- Competence.

These core values must be balanced within the context and complexity of the human experience. The ACA Code of Ethics Preamble states that the American Counseling Association serves educational, scientific and professional organizations whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the lifespan. Association members recognize diversity and embrace a cross-cultural approach in support of worth, dignity, potential and uniqueness of people within their social and cultural context (ACA, 2005).

In the 21st century, cultural competence includes recognizing historical and social prejudices in assessment, misdiagnosis and inference of pathology; minimizing bias; respecting diversity; support network involvement; communication; privacy; sexual orientation; environmental adaptation; social advocacy; and ethics competence.

The continued growth in the number of individuals and families from diverse backgrounds challenges counselors’ ability to meet the needs of a growing and diverse society. In 1994, Sue, Arredondo and McDavis published what became known as the multicultural counseling competency framework. These competencies provide a foundation for all counselors to focus on the cultural makeup of the counselor and client as well as how culture affects daily living in a diverse society.

Cannon (2008) reported that the changing demographics of the United States population demand that counselor education programs provide training experiences that facilitate the development of multicultural competent counselors. The growing population of diverse individuals in the United States will put more pressure on counselors to be culturally competent in their service delivery.

During the American Counseling Association (ACA) 2010 conference, the Multicultural Social Justice Leadership Development Academy (MSJLDA) was held to open a dialogue about the many issues in multicultural competence and social justice advocacy. The academy presented information about the development of multicultural competence and offered suggestions to help participants improve their applications of multicultural competence.

### What is multicultural competence?

The definition of multicultural competence means in part to approach the counseling process from the context of the personal culture of the client (Sue, Arrendondo and McDavis, 1994; Sue and Sue, 2007). Professional ethics compel counselors to ensure that their cultural values and biases do not override those of the client (ACA, 2005).

Presenters at the MSJLDA conference shared personal examples of their individual cultures and how these impacted their personal and professional lives, including professional self-awareness, knowledge and skills.

They also shared experiences that included several variables of discrimination. For example, one of the presenters, an immigrant from India, also shared personal experiences of sexism as a woman. Another presenter, an African-American male raised in the United States, represented racism and how it continues to affect how societies view people of color (Lodge, 2010).

### Barriers and challenges

The need for cultural competence became more evident during the 20th century when the American population tripled. This rapid growth was due to an increase in immigration (Urban and Orbe, 2010) and the birthrates of racial/ethnic groups currently present in U.S. communities.

During this time it was noted that there were barriers and challenges faced by counselors who belong to a minority community. Some counselors described a feeling of culture shock and inadequacy. The challenges and struggles indicated that they were not adequately prepared to assimilate into the white culture.

Counselors often sought to consult colleagues, books and research literature. Many counselors found that while there was a strong focus on the challenges faced by counselors with clients from ethnic backgrounds different from theirs, there was less focus on the challenges that a minority counselor faces in meeting the needs of clients who are culturally different (Consoli, Kim, and Meyer, 2008).

According to Pederson (1997), the main features of cultural competence are counselor self-awareness, knowledge about culture, and skills. This belief is consistent with the multicultural counseling competencies developed by Sue, Arrendondo, and McDavis (1994).

These studies noted that to become culturally competent, it is imperative to have cultural knowledge that is perceived as a coalition of theoretical concepts and life experiences (Kisielica and Maben, 1999). Therefore, counselors from another culture must make genuine efforts to integrate their knowledge of culture and life experiences from their country and the United States. Knowledge about two cultures and the experiences from living in both cultures provided scope for reflection and promoted counselor self-awareness (Zalaquett, 2011).
The next important ingredient for multicultural competence, according to the research, was cultural skills. A skilled counselor uses interventions that are client-based and serve client needs (Chung and Bemak, 2002). This study discussed the significance of updating knowledge about various counseling techniques, becoming more knowledgeable about the indications and contraindications of the techniques, and emphasized the significance of establishing collaborative relationships between the counselor and the client.

In multicultural counseling, the counselor and the client need to discuss which techniques will be beneficial to the client. While adhering to the normal counseling and ethical practices in multicultural counseling, counselors need to be more aware of the limitations in their counseling skills in the multicultural context. It is vital to have cultural skills in order to serve multicultural populations in the most productive way to facilitate rapport.

Being culturally aware and recognizing how culture will affect the counseling process helps counselors develop empathetic understanding toward clients (Pederson, 1991). Ridley (2002) stresses the importance of empathic understanding in multicultural counseling based on self-experiences, self-awareness and knowledge of culture. Cross-cultural awareness facilitates the counselor’s knowledge, understanding and respect for culturally diverse clientele (Fukuyama and Niemeyer, 1985).

While being cognizant of one’s own culture, beliefs and values, it is crucial that counselors do not become culturally encapsulated. Cultural encapsulation puts counselors at risk of using stereotypes, becoming judgmental, and imposing their values on their client.

Counselors are encouraged to respect and accept their clients and their lifestyles, receiving them as who they are, non-judgmentally. However, immigrant counselors are faced with many challenges. They must first educate themselves about the new culture and learn more about the beliefs and values of the people around them. Counselors might need to ask clients to better educate them about their cultures. It is especially important for counselors to establish trust with clients and to demonstrate unconditional positive regard (Zalaquett, 2011).

### Stereotypes and perception of other groups

Stereotypes, perceptions and beliefs that counselors hold about groups that are culturally different could hinder their ability to form helpful and effective relationships. Collaborative relationships might be difficult to form in the presence of such hindrances. Counselor educators must prepare counselors to become culturally competent through:

- Revamping training programs.
- Developing multicultural competencies as core standards for the profession.
- Providing continuing education for current service providers.

Culturally competent counselors do not see their group’s cultural heritage, history, values, language, tradition or parts as superior to that of others. Culturally competent counselors are open to the values, norms and cultural heritage of clients, and do not impose their values or beliefs on clients (Sue and Sue, 2007).

### Qualities of a multicultural counselor

There are several common qualities seen in multicultural competent counselors, not unlike those listed in the section above on the universally shared view of counselor competence. The qualities below have a particular focus on recognition of aspects of multiculturalism (Zalaquett, 2011; Ahmed (2011):

- **Credibility**, which may be defined as the constellation of characteristics that makes one appear worthy of belief, capable, entitled to confidence, reliable and trustworthy.
- **Competence**, which includes credentials and qualifications and on how well informed, capable or intelligent others perceive the person to be. Mental health professionals practice within their areas of competence and develop and enhance their professional expertise. They continually strive to increase their professional knowledge and skills and apply them in practice. In addition, they should aspire to contribute to the knowledge base of their profession.
- **Trustworthiness/integrity**, which is confidence clients hold in a counselor’s ability to make valid assertions. All mental health practitioners must act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.
- **Awareness and sensitivity**, which includes cultural meanings of confidentiality and privacy. Counselors must respect differing views toward disclosure of information and have ongoing discussions with clients on how, when and with whom information is to be shared. Sensitivity also includes recognition that culture affects the manner in which clients’ problems are defined. Clients’ socioeconomic cultural experiences should be considered when diagnosing mental disorders. Counselors should recognize that historical and social prejudices can lead to the misdiagnosis of certain individuals and groups, and that mental health professionals may play a role in perpetuating these prejudices through diagnosis and treatment. Counselors may refrain from making and reporting a diagnosis that they believe would cause harm to the client or others.
- **Proper assessment**. Counselors must be cautious when selecting assessment instruments for culturally diverse populations so they avoid the use of instruments that lack appropriate psychometric properties for the client population. Counselors should seek techniques that represent the norms of the population similar to those of a client. They must recognize a client’s culture during test administration and interpretation, and place test results in proper perspective with other relevant factors (ACA, 2005).
- **Nondiscrimination** (see next page).
- **Commitment to clients**. All mental health practitioners’ primary responsibility is to promote the well-being of clients, which includes respecting cultural diversity.
- **Self-determination**. Mental health practitioners must respect and promote the right of clients to self-determination and help them identify and clarify goals and cultural perspectives that may impact their goals.
- **Privacy, confidentiality and informed consent**. Mental health practitioners should use clear and understandable language to inform clients of the purpose of their service, risks related to service, limits to service, costs, the client’s right to refuse or withdraw consent, and the HIPAA Privacy Rules that govern sharing of information. Mental health practitioners must respect
the client’s right to privacy. Once private information is shared, standards of confidentiality apply; therapists may disclose confidential information when appropriate, with valid consent from the client or a person legally authorized to consent on behalf of the client. When providing counseling services to families, couples or groups, they should seek agreement among the parties involved on each individual’s right to confidentiality. The culture and language of the client may dictate how counselors convey these aspects of multicultural competence.

How can counselors provide validation for others and for themselves?

In the context of multicultural counseling, validation can mean confirming what another person says. It can also mean having respect for other another person’s communication by acknowledging the experiences, opinions and thoughts of that person as legitimate. These definitions describe validation as the confirming and affirming action, but convey nothing about being right or wrong. There are many ways to use validation with clients to let them know their counselor respects what they are saying.

Validation is vital to gaining respect and increasing the therapeutic alliance between mental health service professionals and their clients. When clients affirm that the validation process is working, counselors also feel validated for their efforts to positively connect with the client’s lives, feelings, struggles and thoughts.

The validation process is viewed as a way of allowing clients to help their counselors gain confidence and growth through the clients’ verbal or nonverbal communication of “a job well-done” (Wilson, 2006). It may be less complicated to validate situations with people who have cultural backgrounds similar to our own (Gamez, 2009). Validation has nothing to do with agreeing with others, just letting others know that what they have conveyed has meaning.

In reviewing many studies of ethnic and racial minorities in counseling services, it becomes clear that there are many other reasons why disparities exist. One reason is that some racial and ethnic minorities spend less time in psychotherapy, for example, in the case of European American human service workers who perceive a lack of validation. Perhaps outcomes would improve if human service workers learned how to employ the awareness, knowledge and skills of multicultural competence (Zalaquett, 2011).

It is also important to apply the multicultural competences when social issues arise. In fact, many people do not react to situations that are damaging to clients and peers alike because of:
- Fear of isolation.
- Not knowing what to do to advocate.
- Fear of lost wages, a job, or both.

Evaluating and expanding multicultural competences

Validating justice when speaking out against injustice is about affirming and confirming action, not about being right or wrong.

When people do not feel validated in their workplaces, they struggle with low levels of self-confidence. This low self-confidence negatively impacts the counseling process as well as their personal lives. Learning to become more culturally competent is an active process; it requires less lecture and more active involvement in the learning process. It requires collaboration and teamwork. A counselor’s validation of clients’ feelings and perceptions will benefit the clients’ self-efficacy and self-confidence (Cormier, Nurius, and Osburn, 2009).

Studies of multicultural competency are often grouped into several identified themes. These themes are discrimination, validation, multicultural competence, and the sharing of knowledge. Each of these themes is discussed below:

Discrimination

Counselors must not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status, partnership, language preference, socio-economic status or any other basis prescribed by law (ACA, 2005).

Counselors must not discriminate against clients, students, employees, supervisees or research participants (ACA, 2005).

The Ethical Standards for School Counselors states that counselors must respect students’ values, beliefs and cultural background and not impose their personal values on students or their families (2010).

In addition, it notes that school counselors must develop competencies and understand how prejudice, power and various forms of oppression – disability, age, class, familiarity, gender, gender identity, immigration status, language, racism and religion – affect them, students and all stakeholders.

The National Association of Social Workers (2008) states that social workers should not practice, condone, facilitate or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political beliefs, religion, immigration status, or mental or physical disability.

In addition, social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference and the expansion of cultural knowledge and resources. They should be advocates for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people. The organization concludes that social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group or class on the basis of race, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political beliefs, religion, immigration status, or mental or physical disability (NASW, 2008).

Although overt discrimination has diminished, it has been replaced by a more subtle discrimination called micro-aggression that is often hard to identify and address. Micro-aggressions are insults to people who are not in the “dominant” group (Constantine, 2007) and are many times unconscious. It is vital that counselors work as a profession to spearhead community change designed to eliminate this in society.

Mental health professionals often have to address micro-aggression in advocacy work in the community. Helping non-diverse communities become more open and embracing of difference and supportive of change can be challenging, but is essential. Reducing micro-aggression is a collective responsibility of counseling professionals. Counseling professionals might better address social environmental issues, such as sexism and racism, that bring many counselors to counseling, by increasing public awareness and by changing work cultures to be more inclusive (Zalaquett, 2011).
Multicultural competent counselors are culturally self-aware, aware of clients’ culture, and willing to bring culture into the discussion during interaction with clients (Sue, Arrendondo, and McDavis, 1994). They are open to listening to and helping clients with goals and objectives without imposing their own cultural values on clients. They are respectful of the counselor-client relationship and of the client’s uniqueness, and meet clients where they are, go on the journey with them, and provide them with the assistance they seek.

Multicultural competent counselors do not judge clients by their own values and their own core cultural beliefs, and do not engage in negative stereotyping.

Being culturally competent is an ongoing process. It is having the awareness that none of us ever knows everything there is to know, and so are always engaged in becoming more competent. It is indeed about being a true advocate for the client.

**Sharing knowledge**

Multi-culturally competent counselors must be prepared to teach their peers and students about the importance of multicultural competence and willing to stand up to their colleagues and speak out against micro-aggression. They must ask important questions about why some people hesitate to take a stand, allowing subtle aggressions to continue.

Much work is needed to encourage more therapists and counselors to become more open-minded in their professional and personal lives. To become a truly multicultural competent counselor means a person must want to help all mankind. To do so, counselors must challenge the “I” centeredness of their society and the assumptions or myths that breed fear and a sense of self-preservation over others, and assert regard and respect for all mankind (Ahmed, 2011).

Technology offers counselors new and exciting ways to challenge their centeredness. To succeed, they must increase communication and decrease isolation. They must learn about one another and adopt a more global focus.

Counselors must seek to become sensitive to and help clients become aware of family, work and community differences, and factor those in their decision-making. Counselors must develop the ability to hear and understand the basis for client goals and their values and concerns, and offer alternatives in ways that support and respect clients’ cultural values.

Counselors must learn to speak in the language of their listeners. They must help clients engage their significant others, family, friends and colleagues in more constructive conversations. Counselors must be as concerned with the wellness of the environment as they are about their own well-being. They must ask open-ended questions upfront, reflective questions about tradition, spiritual centering and other aspects of their own as well as the client’s personal cultures to help clients focus on issues and solutions in relationship to their culture (Arrendondo, et al., 1996).

**PROMOTING THE BALANCE OF POWER AND MUTUAL RESPECT**

**Boundaries in a dual relationship**

A boundary can be visualized as a frame or membrane surrounding the therapeutic process that identifies a set of roles for those involved in the therapy. (Smith and Fitzpatrick, 1995; Kathryn (1991) defined boundaries as “limits that promote integrity.” Boundaries protect the well-being of clients when the mental health practitioner assumes two or more roles, either concurrently or sequentially, with the help-seeker (Herlihy and Corey, 1997).

The second role commonly is social, financial, as friend or teacher. Role-blurring ethics charges constitute the majority of ethics complaint and licensing board action (Bader, 1994; Nuekrug, Milliken and Walden 2001; Sonne, 1994).

**Bartering**

In the past several decades, licensing boards that protect consumers from therapists’ harm and abuse have more vigorously pursued issues such as bartering of professional services. California licensing boards, for example, sent a pamphlet to all therapists in the state noting that “hiring a client to do work for the therapist or bartering goods or services to pay for therapy” represented “inappropriate behavior and misuse of power” (California Department of Consumer Affairs, 1990).

A larger power and prestige difference between therapist and client exist in dual relationships, and a greater potential for client exploitation; power is generally assigned to healers in most societies (Smith and Fitzpatrick, 1995).

Some inherent concerns with multiple-role relationships include:

- Your relationship can deteriorate the professional nature of the therapeutic bond, which is based on predictable boundaries.
- The essential professional nature of the therapeutic relationship is altered and compromised when the therapist is also the client’s employer, friend or teacher.
- Dual relationships may establish conflicts of interest, jeopardizing the objectivity and neutrality required for professional judgment.
- Clients do not have equal power in a business or secondary association because of the nature of the therapist-client relationship.

A client who feels mistreated in a financial or social change with the therapist faces barriers in legal redress because therapists can use client-shared secrets to create a defense. Further, therapists can use diagnostic labels to discredit clients (Pope, 1998).

The ACA (2005) Code of Ethics contains a section on bartering that is considered a dual financial relationship. Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requested it, and if such arrangements are an accepted practice among professionals in that community or culture.

Bartering with the client for good or services is not ethically prohibited but it is not recommended as the customary practice. Therapists generally enter bartering arrangements with good intentions. They may barter to offer services to those with limited finances; however, the potential for problems often exists. Often, client services do not equal the monetary value, on an hourly basis, to that of therapy (Kitchener and Harding, 1990).

It should be noted that most professional liability insurance policies exclude financial and other business relationships with clients. Counselors must consider the cultural implications of bartering,
discuss relevant concerns with clients and document such agreements in a clear written contract.

In addition, ACA Code of Ethics contains a section on receiving gifts. “Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and show gratitude. When determining whether to accept a gift from a client, counselors must take into account the therapeutic relationship, the monetary value of the gift, the client’s motivation for giving the gift, and the counselor’s motivation for wanting or declining the gift” (ACA, 2005).

The American Psychological Association’s (APA) Ethical Principals of Psychologists and Code of Ethics 2010 amendments addressed bartering as well.

“Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologist may barter only if it is not clinically contraindicated, and the resulting arrangement is not exploitive.” The APA also classifies bartering as a multiple relationship that the psychologist should refrain from entering if the relationship could reasonably be expected to impair the psychologist’s objectivity, competence, effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists (APA, 2010).

### Case study: Bartering

A counselor presented an unemployed farm worker the option of doing yard work in exchange for psychotherapy. Bartering was an accepted practice in the client’s home country. The counselor charged $100 per hour and credited the client with $15 an hour, thus the client had to work more than six hours for each therapy session. The client protested to the therapist that the time required for the yard work prevented him from finding full-time employment. The therapist countered that the client could choose to terminate therapy and resume when he could pay the full fee. The therapist calculated a below-fair-market value for the client’s labor. The bartering contract contributed to the client’s dissatisfaction as did his difficulty with the English language and understanding monetary value. The therapist interrupted the agreement and abandoned the client upon hearing the client’s complaint. The client sued the therapist for considerable damages (Koocher and Keith-Spiegel, 2008).

### Attitudes and beliefs

Counselors must be open to having leaders in their organizations who represent diverse political viewpoints and in the definition of social action. No one viewpoint can serve as the dominant viewpoint because counselors potentially serve all members of society and must be viewed as open to viewpoints held by others.

### Knowledge

Counselors must gain knowledge about many different political perspectives so they can open a dialogue of mutual respect that leads to openness and respect of differences. Many counselors hold viewpoints that are not necessarily representative of the public at large. Is very difficult to serve others and open up leadership positions if one is not aware of others’ views and how they come to hold them. Knowledge about the worldviews of others is at the core of the development of multicultural competent counselors and will form the basis for opening up professional organizations to leaders from a wide variety of backgrounds (Zalaquett, 2011).

### Skills

Counselors must seek ways to help that do not place values held by the counselor onto clients, so the clients can find their own way of growth and development. Counselors must seek out opportunities to gain insight into their own views and motivations as well as the views and motivations of those they serve. Counselors must develop new ways to engage in discussions of the many multicultural and social justice issues that mental health professionals and society face. To this end, counselors must familiarize themselves with the research on social justice and multicultural issues that address the wide spectrum of viewpoints that exist.

Counselors must stop trying to force one particular viewpoint onto others, and when others reject that viewpoint, must not label them as not supporting multicultural and social justice issues. Difference is what leads to compromise, and it is the skill of compromise that will lead to the balance of power and mutual respect. Reflecting on personal growth, one author pointed out that his grandmother once said, “All who care about the welfare of others must first care about themselves. We cannot help others if we are blind to our own views and the effect they have on others” (Hazier and Wilson, 2010).

### Group-specific and multicultural approaches

Over the past two decades, the counseling profession has underscored the importance of multicultural counseling training, which has become an integral part of counselor education (Ridley, Mendoza, and Kanitz, 1994). Sue and his associates (Sue, Arrendondo, and MacDavis, 1992) proposed a tripartite conceptualization of multicultural counseling competencies, which became a major force when multicultural counseling gained significant attention in the field.

The tripartite model has three components, awareness, knowledge and skills:

1. **Awareness** refers to the counselor’s awareness of his or her own worldview and cultural biases.
2. **Multicultural knowledge** requires counselors to be knowledgeable about various cultural factors that might influence the counseling process.
3. **Skills** include a counselor’s ability to form rapport with culturally diverse clients and to implement culturally responsive interventions.
The tripartite model has stimulated research along with the development of instruments that purport to measure the multicultural counseling competencies (Worthington et al., 2007). While the tripartite model made much contribution to the field, it also received criticism.

One criticism noted by some researchers was the lack of empirical support for the model and almost exclusive focus on for racial and ethnic groups in the U.S.; African-Americans, Asian Americans, Latino Americans, and native Americans. Constantine, Gloria and Ladany (2002) evaluated the factor structure of multicultural counseling competency measures and did not find support for the theoretically proposed three-factor structure. With the exception of the Cross-Cultural Counseling Inventory, Revised (CCCI-I-R), other competency measures use self-report (CCCI-I-R; LaFramboise et al., 1991).

Content analysis of multicultural counseling competency research noted a theory-research gap in the multicultural counseling literature, which led to debate on what cultural aspects should be included in divining multicultural counseling competencies (Worthington et al., 2007).

The original multicultural competency model focused exclusively on racial and ethnic issues (Sue et al., 1982), although the second paper in 1992 attempted to define the multicultural counseling competencies more inclusively by considering other diversity factors, including sexual orientation, disability, gender, religion and socioeconomic status, but with the major emphasis still on race and ethnicity. In addition, while the inclusive approach avoids becoming exclusive, there has been the argument that such an all-inclusive approach obscures the understanding of each factor as a powerful dimension of human experience (Sue and Sue, 2003).

Helms and Cook (1999) argued that such all-inclusive definitions lack precise conceptualization to understand the role of race in the counseling process and its sociopolitical implications on clients’ mental health. With the emphasis on specificity, Helms and Richardson (1997) suggested that researchers and professionals address the question of which competencies work best for what aspects of diversity.

To emphasize the significance of race, Helms and her associate developed racial identity development models for European Americans and African Americans as well as instruments to measure the racial identity statuses. Those racial identity development models generally assume that individuals begin developing with a racially unaware state, then going through racial awakening and psychological dissonance to move toward a fuller acceptance and awareness of racial issues. The models lead to a body of research that related racial identity with various psychological constructs, including defense mechanisms (Utsy and Garnet, 2002), racism (Pope-Davis and Ottavi, 1994), and self-reported multicultural counseling competencies for counselors (Constantine, 2002).

There are other group-specific models of focus on the identity and development of specific socio-cultural groups, such as gays and lesbians (Cass, 1979) and feminists (McNamara and Rickard, 1989). Group-specific models often provide rich information specific to the group and a more explicit operational definition of the construct.

Group-specific models render themselves suitable for yielding instruments and large-scale quantitative research. Because of the specificity, the group-specific approach produces more research and a better understanding of the impact of each socio-cultural factor on people. However, this specificity approach does not consider salience of group membership for individuals and the interaction effects of multiple socio-cultural factors.

Pederson (1991) emphasized individuals’ multiple identities, such as a person who is a Latino gay man with a disability, and argued that all counseling relationships are essentially cross- or multiple-cultural. In highlighting the complexity of multicultural counseling, he asserted that because such multiple identities within a client are affected by contextual factors, it is important for counselors to assess which identity is more salient for the client in a given context.

From a social constructionist perspective, Collins (2000) described the concept of intersectionality that suggests complex and dynamic interactions between social oppression and individuals’ identity and everyday experience. According to conceptualization, different social categories, race, social class, gender, sexuality and so forth create different oppression systems that interact and intersect each other and influence individuals’ social positioning in a given context. It is much like a matrix; for instance, although women’s social proximity may be close to the context of experiencing sexism, it becomes distant in the context of dealing with mobility issues if such a woman has a spinal cord injury. In contrast to the single-dimensional approach to multiculturalism, those views attempt to theorize the impact of multiple socio-cultural factors on individuals and the interactions among different socio-cultural factors (Collins, 2002).

Clinical values of the multidimensional approach to can be supported by the data that show a high concentration of risk factors among certain socio-cultural groups as well as high co-morbidity rates in clinical populations. For example, because ethnic minorities are less likely to receive effective treatment, they bear higher rates of disability burden than European Americans (DHHS, 2001). Demographic variables, such as having a disability, being a woman, African-American, Latino American, or having less education, have been associated with an increased likelihood of living in poverty (Kruse, 1998).

Focusing on wide-ranging impacts of poverty, Evans (2004) suggested that poverty does not occur in isolation and that it is the accumulation of multiple social and environmental risk factors that make chronic poverty more detrimental to the individual’s physical and psychological well-being. The data point to the need for counselors to consider interrelations among physical, psychological and social factors that may affect clients presenting issues.

The multidimensional approach can provide more realistic conceptualization in practice because it addresses the intersectionality among different socio-cultural factors and the complexity inherent in multicultural counseling. On the other hand, because of the complexity, the multi-dimensional approach is less likely to be research-friendly to quickly generate empirical data (Ishii, 2012).

A review of single and multidimensional approaches to multiculturalism can be compared with landmark research on the multicultural counseling competency model (Sue et al., 1992). The single-dimension approach advanced research and understanding of the impact of specific socio-cultural factors on clients. The multidimensional approach provides clinically useful concepts that help better understand the salience and intersectionality of different socio-cultural factors for a given client.

Given the emphasis on a universal or holistic approach in counseling, researchers suggest that multicultural counseling research and practices use knowledge gained from the group-specific approach and move toward a multidimensional approach in addressing multicultural issues in counseling (Ishii, 2012). To foster empirical endeavors, researchers are encouraged to incorporate a multidimensional nature of social-cultural identity and the interactional effect of different socio-cultural factors in their research. In particular, the development of instruments or assessment strategies to measure the multidimensional, socio-cultural factors will facilitate much needed research.

Similarly, counselors are encouraged to become confident in addressing various socio-cultural issues in counseling, including ethnicity, race, gender, disability, sexual orientation, age, socioeconomic status and religion. In addition, counselors must understand the concept of saliency and intersectionality to conceptualize socio-culturally diverse clients.
Eliminating long-standing disparities in the mental health status of people of diverse racial, ethnic and cultural backgrounds. There are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, native Americans, Asian Americans, Alaskan natives and Pacific Islanders as compared with the U.S. population as a whole (U.S. Department of Health, 1998).

Improving the quality of services and health outcomes. Fundamental differences among people arise from nationality, ethnicity and culture in addition to family background and individual experience. These differences affect the health, beliefs and behaviors of both clients and mental health practitioners and their interaction.

Understanding critical factors in the provision of culturally competent mental health services. These include:

- Knowledge of beliefs, values, traditions and practices of a culture.
- Culturally defined health-related needs of individuals, families and communities.
- Culturally based belief systems of the etiology of illness and disease and those related to health and healing.
- Attitudes toward seeking help from health care providers.

Meeting legislative, regulatory and accreditation mandates. The federal government has a pivotal role in ensuring culturally competent mental health care services. State and federal agencies increasingly rely on private accreditation entities to set standards and monitor compliance with these standards. Both the Joint Commission on the Accreditation of Healthcare Organizations, which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance, which accredits managed care organizations and the behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care.

Gaining a competitive edge in the market place. The provision of publicly financed health care services is rapidly delegated to the private sector. The potential for improved services lies in state managed-care contracts that can increase retention and access to care, expand recruitment and increase the satisfaction of individuals seeking health care services. To reach these outcomes, managed care plans must incorporate culturally competent policies, structures and practices to provide services for people from diverse ethnic, racial, cultural and linguistic backgrounds.

Decreasing the likelihood of liability/malpractice claims. Insensitivity and ignorance about cultural competence could create liability under tort principles in several ways. For example, providers may discover they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand health beliefs, practices and behavior on the part of providers or patients breaches professional standards of care. In some states, failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.
In addition, the ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. A 1994 study appearing in the Journal of the American Medical Association indicates that the patients of physicians who are frequently sued had the most complaints about communications. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate.

Defining culture, competence and diversity

Cultural and linguistic competences are at the base of cultural competence. They are defined here.

**Culture** – An integrated pattern of human behavior, which includes:

- Thought.
- Communication.
- Languages.
- Beliefs.
- Values.
- Practices.
- Customs.
- Courtesies.
- Rituals.
- Patterns of interaction.
- Roles.
- Relationships.
- Expected behaviors of a racial, ethnic, religious, social, or political group, and the ability to transmit the above to succeeding generations.

Culture is dynamic in nature. It defines us as individuals and makes us who we are. Everyone has culture that influences how each of us sees others. And organizations or systems have distinct cultures that are developed by their mission and goals. Communities have different cultures influenced by their members, the environment and socioeconomic conditions. Culture is a framework for making human connections, as we see things from our own perspective.

Intervening factors that influence culture include:

- Level of education.
- Level of income.
- Geographic residence.
- Place of birth.
- Age.
- Gender.
- Identification with community groups.
- Length of U.S. residency.
- Personal experiences.

**Competence** – The ability to incorporate values, knowledge, attributes and skill sets in order to work effectively cross-culturally.

**Diversity** – A range of human perspectives, backgrounds and experiences reflected in characteristics such as age, class, ethnic origin, gender, nationality, physical and learning ability, race, religion, sexual orientation and veteran’s status. Other diversity variables include but are not limited to:

- Education.
- Marital status.
- Employment.
- Geographic background.
- Cultural values, beliefs and practices.

Five essential cultural competence elements

Five major elements comprise cultural competence. They include valuing diversity, conducting cultural self-assessment, managing the dynamics of difference, acquiring and integrating cultural knowledge and adapting to diversity and cultural contexts:

1. Valuing diversity embraces behaviors, practices, policies and attitudes as well as larger systems and structure.
2. Conducting cultural self-assessments challenges mental health professionals to assess for personal as well as professional proficiency in cultural competence.
3. Managing the dynamics of diversity occurs within natural, formal or informal support, and facilitates networking within clinical and neighborhood settings, ethnic-social-religious organizations and spiritual communities.

4. Acquiring and integrating cultural knowledge prompts mental health practitioners to seek out consultation, coaching and mentoring and from a variety of sources. For example, in some cultures it would be appropriate to request an interview with the religious leader before working with the community as a whole.

5. Adapting to diversity and cultural contexts challenges mental health practitioners to formulate and practice new behaviors and beliefs that might include:
   - Revisiting policies and procedures that are no longer relevant and, in fact, could be counterintuitive to providing culturally competent mental health services.
   - Restructuring systems and methodologies to more appropriately meet the needs of the people served.
   - Enhancing and adopting different values with the commitment to provide culturally competent, evidence-based practice.
   - Revising service practice to incorporate culturally sensitive mental health protocols. Applying cultural competence to mental health practice.

The majority of mental health practitioners are culturally sensitive. When mistakes occur, it is usually because there is lack of cultural awareness, communication, perception or other disconnects between a mental health provider and client, especially when a provider becomes “affectively charged.” For example:

Janet, a licensed clinical social worker, has been seeing 6-year-old Annette for several weeks. Annette was traumatized when she witnessed her parents’ fighting, which eventually sent her mother, Tilda, to the hospital with a concussion and broken arm. Annette’s grandmother looked after Annette while her daughter was recuperating, and when Tilda was released from the hospital, she moved into her mother’s home with Annette. Annette had already been seeing Janet and was soon joined by her mother, engaging in dyadic therapy.

In subsequent weeks, Annette appeared to be more anxious and often argued and fought with her teachers and other students. In counseling sessions, Janet struggled to communicate to Annette’s mother that Annette was reenacting her traumatic experience with her teachers and classmates. Tilda, on the other hand, felt that Annette was being blatantly disobedient. During one session, Janet became “affectively charged” by Tilda’s comments that Annette could overcome her behavior through punishment and reprimands. Being “affectively charged” causes therapists to stick to a message that, at the moment, cannot be heard. The message is usually more solution focused rather than strength-based focused.

Because Janet felt passionately about trauma and how it affects children, she forgot to “check-in” with Tilda and ask about Tilda’s mother’s perception that children could be curbed through corporal punishment as well. Janet was unaware that Tilda’s mom had a powerful influence on her daughter and vicariously used her to express her own feelings, even though she wasn’t in the session room with her daughter or granddaughter.

Janet was also unaware that even if Tilda felt differently, her upbringing taught her not to question her own mother’s authority. In addition, her guilt about leaving her marriage was overwhelming due to her cultural orientation toward marriage. Had Janet asked Tilda about Tilda’s culture and also examined her own professional agenda, Janet would have been equipped to communicate her message more effectively to her client.

Janet’s orientation toward her role as a child advocate is not unusual. Circumstances such as hers often initiate professional discussion of what is best for children and how to handle seemingly resistant parents when they are at odds with the therapist about a child’s health and well-being.

**In their own words**

A lot has been written about cross–cultural environments from the viewpoint of Americans. However, how often have natural-born Americans stepped back to appreciate the challenges, frustrations, emotions and sometimes amusing experiences that immigrants have faced as they tried to assimilate. The following stories are unique experiences of people who came to work and live in the United States. These stories are in their own words, with few grammatical changes (Lindsell-Roberts, 2011):

**Jürgen from Germany**

In the workplace we do not use the word “problem.” There is just a challenge. The word problem seems to be restricted to life-threatening conditions only.

It was difficult to adjust to working in a cubicle with no natural light. In Germany, it was a law that every permanent office workplace has daylight access.

I had to adjust to women’s liberation. At one time I opened the door and a woman was walking behind me, so I held the door open for her. She rudely yelled at me, “I can open the door myself.” So I just did what I felt like: slamming the door in her face.

**Robin from Germany**

I found it difficult when I came to America to have a conversation without having to speak of Nazis. My first challenge was and still is to meet as many Americans as possible to talk about my country and let them know that Germans are human beings like everybody else, and in each country there are good and bad people. I met a lot of Jewish people who did not like me at the beginning and became good friends of mine after long talks and disagreements. I have a few memories of Jewish families I became friendly with through strange circumstances, and they learned to have a better understanding of Germans.

My second challenge was this: Most Americans have always been aware of Germans being good mechanics, keeping good records, and making sure everything is accurate. When I came to this country, I was shocked when I read letters and other documents written by Americans and saw numerous mistakes in their writings. In Germany we were taught grammar until it came out of our ears. We disliked our English teachers because they were very strict, but after coming to the states, I thanked him 1000 times for making sure we would always speak, talk, and write correctly.

My third challenge, if you want to call it that, was to learn how to smoke and chew gum at the same time. There was a lady in my department who was always chewing gum and smoking at the same time. I thought it was absolutely fascinating the way she made noise and blew bubbles at the same time with a cigarette in her mouth. I succeeded after a while, and it drove my family crazy but I was proud of myself. This was my way of becoming “more of an American.”

**Ari from Israel**

I grew up in Israel in an Orthodox Jewish family. I went to an all-boys school and after my Bar Mitzvah I wasn’t allowed to have any physical contact with females, except my mother, sisters, grandmother, then later my wife and daughters. That meant no hugging, kissing, or even shaking hands. When I moved to the United States, I started my own consulting company. I dressed in regular street clothes but I still wore my yarmulke, I found it uncomfortable to shake the hands of women because of my religious upbringing. I do shake women’s hands to be polite but it is very uncomfortable for me.
Suzie from Taiwan
I would like to share my challenges with you when I came to America. I’m from Taiwan. The challenges I have faced are as follows:

- **English** – I learned English from my Taiwanese English teacher, so the pronunciation was way off from standard. I spent so much time to correct it and I’m still trying.
- **Religion** – Here the churches are all about Jesus. Mine are Confucian and Taoist temples.
- **Background** – I was taught the more humble you are the better you are. Here you have to express yourself, speak out, otherwise people won’t understand you or respect you.
- **Culture** – I’ve learned to accept gay marriage, living together, and having children without marriage.
- **Dress** – Showing your body here is very wild. I’ve been taught the more you cover up the safer you will be.

April from China
My Chinese name is Chunlin but I adopted the American name April. Chunlin means “forest in the spring,” and my parents wanted me to be lively, just like the trees that bloom in the spring time. When I lived in China I got my degree in English language and culture and I taught English there. So I was very well prepared to live in the U.S. I did find some cultural differences and was prepared for most of them.

People here talk very fast and it took me a while to get used to that too.

In China it is commonplace to ask people personal questions about their families, their children, and their income. It shows that you care about them. In the U.S., information like that is very private.

People here are much more direct. In China we would not disagree with you to your face because we wouldn’t want to make you feel bad. We try to show disagreement through body language and in other discrete ways.

Jianyao from China
There are some things you may call cultural differences. For instance, Americans usually offer compliments on what you have done well. The Chinese don’t, because there is always room for improvement. We do not jump up and down when the boss tells you “You did a good job” because he may just mean it is not too bad. In contrast, if someone in Chinese said that you could do a much better job you would not be upset.

Another difference is how people address others. Here in the states, everyone uses first name even if you are the president of the company, a respected professor, or a grandfather. You don’t do this in China unless you are talking to a sibling or friend of the same or younger generation. Otherwise people will think you are rude and disrespectful. To the older generation or to people in higher positions, you better say their title first, then their last name, for example, Uncle Chen, or Manager Chou.

Aman from India
Having grown up in India I came to the U.S. with a very strong English accent and lingo. I tried very hard to lose the accent and the lingo because I wanted to blend in. But I realized I wouldn’t blend in, because I look different. I wear a turban. People at work were very welcoming, but I noticed that people in my neighborhood didn’t talk to me, maybe because I was different.

My life in the U.S. was good until 9/11 when I became a victim of a hate crime. The perpetrators saw my turban and mistook me for a Moslem. As they victimized me, they shouted, “Go back to Osama bin Laden.” As a result, I am now part of an organization based out of New York called Sikh Coalition. It is a nonprofit organization born in the aftermath of the bigotry, violence, and discrimination against New York Sikh population following the terrorist attacks of 9/11.

We go to schools to help children understand Sikh traditions such as why we never cut our hair and why we wear turbans. The goal of the organization is to teach understanding and tolerance.

Simon from England
Going out for a “pie and a pint” at lunchtime is somewhat of a tradition during the workday in England. Across the nation many white- and blue-collar workers find themselves in a local pub at lunchtime downing a pint of their favorite beer. I’m sure there are some who follow one pint with the second or even third, no doubt to help them slide through the afternoon with ease, though hopefully not literally! When I joined the ranks of corporate America in San Francisco I started to navigate my way around the different work culture to the one I was familiar with in London, England.

On my first day at work in the U.S., after my boss took me out for my “welcome lunch,” along with my New York colleagues, I was promptly called in to her office for a “chat.” She told me, in no uncertain terms that drinking alcohol during the workday would not be tolerated, and that the beer I had ordered at lunch not be acceptable under normal circumstances! Oh boy, that put away those work afternoon sliding by with ease, and I wondered what other little cultural gems I was to discover.

As it turns out, I have never been pulled up on such a cultural nuance again, but working in corporate America has shown some other more painful differences to those I was used to in dear old England.

The most challenging one, that I still struggle with on occasion, is that of the “work-life balance.” The thought of having two weeks of vacation a year to reinvigorate and rejuvenate oneself after the stresses and strains of 50 weeks of work seems like a tall order. In my native England, and even across the rest of the European continent, where six weeks of vacation is typical, this thought would make people break out in a sweat. It would likely incite some to civil unrest.

Big issue gets compounded if those 40 hours of work a week, for which one is contracted and paid, routinely ends up being closer to 60 hours or more, spilling into evenings and weekends. I have often been asked to work late or finish some work up over the weekend to meet a timeline, with no consideration given to other plans I may have. After numerous times missing a theater performance, being late for a friend’s birthday dinner, or disappointing myself or someone else, as I allowed work time to dictate my personal time, I realized that I had to set my own boundaries. This has not always been easy, as one can often be perceived as not being a “team player,” and with the knowledge that it’s far easier to be fired in the U.S. than the UK, I have seen the softening of my own boundaries.

This is the reason why the U.S. is one of the wealthiest countries in the world! Americans spend much of their time at work being productive. And when they are not talking about it, even when they are not there, they are often thinking about it.

In England I am not always asked, within a minute or two of meeting someone new, what I do for a living. This extends to social settings also, and trying to use British humor to make light of this invariably falls flat. Americans often misunderstand satire. Warning: do not use satire in the workplace!

Fortunately I enjoy my work so I don’t mind answering those questions sometimes. I do wonder how easy it ends up being for those of us working in the U.S. to genuinely turn off from our heavily defined work roles, and turn our attention to the many other rich facets of American life. Now I know it’s possible with that wonderful American “can-do” attitude that puts many other countries’ work culture to shame.

Mohammed from Iran
I came to the U.S. from Iran to attend the University. After I got my PhD I got a job at a biotech company and got along well with my colleagues. Then 9/11 hit. A few people started making comments in front of me about those “blank, blank Moslems,” and they made other comments that made me feel uncomfortable. Things quieted down after a few months, but every time there’s an international terrorist
Nalini from India
My biggest challenges were the American accent and colloquialisms. Although I knew English, I was unfamiliar with most phrases commonly used in a work setting including something as simple as “wrapping up a meeting.” Even if I knew the phrases, they meant different things to me.

I also noticed that people would ask questions that did not sound like questions to me. I often did not realize I was expected to respond until people looked at me. I frequently ask people to repeat things they said just to understand the accent but I did not have the nerve to ask people to explain colloquialisms. After hearing them a few times, I interpreted what they meant by the context.

I also thought people spoke a lot, not always related to the topic of discussion. I sometimes struggle with trying to figure out if the speaker was saying something important.

My communication issues made me feel intimidated, and I didn’t socialize or talk to anyone much, other than on work issues. I think people thought I was unfriendly, but I’m not.

Also, time was the problem at first. In India, maybe because the roads are so crowded, getting places on time isn’t easy and it isn’t important. Instead of saying when we’ll arrive, we say when we’ll leave. I had to train myself to be places on time because that’s important here.

Keiko from Japan
I came to the U.S. to work for a pharmaceutical company that my Japanese company purchased. Everyone was very nice to me. A lot of the U.S. managers made many trips to Japan and they counted on me to help them understand Japanese customs and traditions, which I’m always glad to do.

Marita from Sweden
I was in for a few shocks when I came from Sweden to work in the U.S. as a graphic designer. My first job was at a small advertising firm that had a small in-house staff and a lot of “on-the-road” salespeople. The owners were very unprofessional, immature, and downright mean to people. It was a very stressful place to work. The two owners would brag about how they had reduced someone to tears or how they had turned down job applications because they weren’t Caucasian or weren’t good looking enough. I found that if you looked good and didn’t oppose anything, then you are less likely to be harassed or fired. Good work ethics were not valued at all, this was something I had a very hard time understanding. I still don’t understand it and I didn’t stay there very long.

I interviewed at a publishing company and I was told that I could “work with other women and it would be less technical.” That didn’t sit well with me. I did take the job though, because it came the closest to my job in Sweden, but even there I felt that it was a little sexist, starting with my job interview.

The overall biggest difference I noticed in the U.S. would be the sense of teamwork, or rather, lack of teamwork. It doesn’t seem like employees work together as a team, instead of what can we do together as a team to make our products and services better. I definitely feel less valued as an individual at any of these jobs than I ever felt at any of my jobs in Sweden.

Akram from Pakistan
When I arrived here I had a very hard time finding a job. I had a bachelor’s degree in chemistry from Pakistan, and every company I contacted would not accept my degree. I went to college for four years in the U.S. and got a degree in chemical engineering. After that I got a job quickly. I got an entry-level job with low pay, but over the years I worked my way up to a nice job.

John from Darfur
I’m one of the “lost boys of the Sudan.” I saw my mothers and sisters raped and killed and my brothers and father killed. I was wounded and still walk with the bad limp. They thought I was dead or they would have killed me too. I lived in a camp in Darfur for several years and I changed my name to John. A charity brought me to America and found me a place to live with three other boys from my country. After all the horrors we went through the black community shunned us. We didn’t fit in because we were too black.

The people from the charity were very nice. Help me get into community college, and I worked in a grocery store stocking shelves to help pay for my food and clothes. The people are treating me well. Many white people have invited me to their homes for Thanksgiving and Christmas, and I like that. When I finish my education, I want to move back to Darfur to help the people were still there. Maybe I’ll even find some living relatives.

Tony from Johannesburg
I came to the U.S. from South Africa when I was in my 20s and made an easy transition. This happened because English was my first language and students are educated to know that because of ongoing political strife in South Africa they’ll be leaving the country when they graduate. I came to the U.S., had a family, and became an American citizen.

It wasn’t until my children were in their teens that I learned I wasn’t “an American.” My son came home from school one day and announced, “Dad, I’m going to teach you how to be an American. First, you can’t leave your cars in the garage. The garage has to be full of junk. Second, you can’t be so in the serious about. We smoke and drink, so don’t think we are innocent. American fathers already know that about their kids.” Then when my son went off to college and my wife and I visited him, he said, “American fathers always empty their pockets before they leave.” So this is what it takes to be an American, I wondered?

Claudio from Brazil
I trying hard to learn better English and take classes after work. The people I work with know I’m taking English classes, and one person always correct my English. I get embarrassed, but I guess she’s just trying to be helpful.

In my country we would stand close together when we speak. In the U.S. I found that people like what I learned is called “more personal space.” That worked for me because I work with someone who smells of garlic. Now I have a good reason to stand far away from her. Maybe I give her too much personal space, but that’s okay.

Anonymous from the United States
I guess because I’m an African-American, a minority, and I’m used to my race being highly visible to myself and others, it just never occurred to me that white Americans wouldn’t be equally aware of their race or hardly think of it at all. Many white Americans seem to be frustrated and angry that black Americans attribute racial causes as the root of a lot of social problems for the African-American population. Many black Americans don’t necessarily feel it’s normal to be black, because throughout the history of the U.S. they have been made to feel anything but normal.

An example of how an initial impression can be a barrier to seeing the real person happened during my diversity class. Our instructor said that her first impression of me was an intimidating one. Initially she said it was because of my height and size but, when we got right down to it, her feeling was because of the darkness of my skin. She found something about dark brown skin anxiety inducing. Conversely, the instructor didn’t feel intimidated by a fellow African American male student who had lighter skin that I did.

As a counseling student, I think “good counseling” takes into consideration the contents of the client’s ethnic background and keeps them in full view at all times. I think this would be valuable for anyone to do in his or her daily lives.
Lessons learned

Cheryl Lindsell-Robert notes that the United States has always drawn its strength and greatness from diversity, and a lot can be learned from the challenges and experiences of others. Although the stories told above are a sampling of people Roberts interviewed, they contain many lessons we can learn as we strive to understand others. Some of those lessons follow:

- **Check stereotypes at the door.** Many stereotypes have been passed on by families and sometimes by the individual themselves. Stereotypes may seek to create order or systems from observations, but they are destructive because they lead to invalid conclusions and rob people of their individuality. The counselor must always remember they are communicating with a person, not a stereotype.

- **Never correct people in English unless they ask you to.** People whose English is a second language are trying to speak correctly, and they are made to feel uncomfortable by correcting them. If they say something offensive because of a problem with translation, mention it privately. Even people whose primary language is English make mistakes.

- **Allow for cultural differences.** People from different cultures often have challenges in terms of language, etiquette, work practices, and behavior. These differences must be respected, and the counselor has an obligation to manage communication so that the individuals can work together productively and cohesively.

- **Learn about gestures and other body language** and all you can about others’ personal space, cultural norms, eye contact and facial expressions.

- **Don’t judge a book by its cover.** People may act certain ways because of cultural differences and experiences. For example, although some people may naturally be shy and reserved, others may just feel out of place or intimidated. Some may feel that being reserved and quiet is a sign of respect. Counselors must work to seek them out to and get to know them.

- **Avoid humor and jokes.** Some people in Western cultures try to build rapport through humor, but this is not universally appropriate. Many cultures don’t appreciate humor and jokes and may see laughter as a sign of disrespect.

- **Sequence your message strategically.** People from different cultures encode and decode messages differently. This increases the chances of being misunderstood. Recognizing this, think of a logical order in which to present information.

- **Be attuned to timing.** People in the U.S. are concerned with schedules and the consequences of arriving late and missing appointments. People from other cultures may not see or understand the significance of time.

Cultural influence on practice

Culture is considered to be “the configuration of learned behavior and results of behavior whose components and elements are shared and transmitted by the members of a particular society” (Linton, 1945). Culture exerts its influence in every part of one’s life. Therefore, it is not a surprise that it affects one’s health and health-seeking behaviors.

Influence of the client’s culture

As counselors incorporate a greater awareness of their client’s culture, they must realize that historically, cultural differences have been viewed as deficits (Romero, 1985). Adherence to white cultural values has brought about a naïve imposition of narrowly defined criteria for normality on culturally diverse people (Peterson, 1986). Multicultural counseling, however seeks to rectify this imbalance. Although the variety of cultures is vast, the following examples indicate the types of cultural issues and their effects on the counseling situation.

In the cultural value system of Chinese Americans, passivity rather than assertiveness is revered, quiescence rather than verbal articulation is a sign of wisdom, and self-effacement rather than confrontation is a model of refinement (Ching and Prosen, 1980). Because humility and modesty are so valued, it is difficult for counselors to draw out a response from a Chinese-American in a group setting.

The reticence, which reinforces silence and withdrawal as appropriate ways of dealing with conflict, may be interpreted as resistance by an uneducated counselor. Democratic counselors may also be uneasy with the role of the “all-knowing father” that the Chinese respect for authority bestows on them (Ching and Prosen, 1980).

Africans place great value on social relationships, with a great emphasis on the community and their place in it. In this context, social conflict resolution becomes important so that peace and equilibrium may be restored to the community, while personal conduct becomes secondary (McFadden and Gbekobov, 1984).

In a discussion of counseling the northern natives of Canada, counseling is seen as cultural racism when it does not fit native values. These values are cooperation, concreteness, lack of interference, respect for elders, the tendency to organize by space rather than time, and dealing with the land as animate, not inanimate, objects (Darou, 1987).

Bernal and Flores-Ortiz (1982) point out that Latin cultures view the family as the primary source of support for its members. Any suggestion that the family is not fulfilling this obligation can bring shame, stress, and increase reluctance to seek professional services. Involving the family in treatment will most likely ensure successful counseling outcomes with Latinos.

Mental disorders such as schizophrenia, depression and bipolar disorders are seen in people from all across the world. However, the manifestation varies greatly according to age, gender, culture, race and ethnicity. It has been found that clients from different cultures tend to be selective in expressing their symptoms in a more culturally accepted way. The clinician needs to have multicultural competence to be able to overcome this challenge.

Research has shown that culture influences the treatment-seeking behavior of clients. It has been noted that members of certain minority groups tend not to seek the help of mental health specialists; they prefer informal sources of care like the clergy, traditional healers, family and friends.

Findings also show that members of some minority groups have a feeling of mistrust that can have cultural and racial roots. The method of communication also varies widely from culture to culture and must be taken into account.

Influence of the health professional’s culture

A major assumption for culturally effective counseling and psychotherapy is that counselors must acknowledge their own basic tendencies, the ways they comprehend other cultures, and the limits culture places on comprehension. It is essential to understand our own cultural heritage and worldview before we set about understanding and assisting other people (Ibrahim, 1985; Lauver, 1986).
understanding includes an awareness of one’s own philosophies of life and capabilities, a recognition of different structures of reasoning, and an understanding of their effects on communication and counseling style. Lack of such understanding may hinder effective intervention.

Part of this self-awareness is acknowledgement that the counselor culture has at its core a set of white cultural values and norms by which clients are judged (Katz, 1985; Lauver, 1986). Assumptions about a cultural group, personal stereotypes and traditional counseling approaches may all signal acquiescence to white culture. Identification and awareness of the specific influences of white cultural values and bias on counseling will help counter the effects of this framework (Katz, 1985).

“The Invisible Whiteness of Being” (Gibson, 2006), proposes that white Americans do not think about race or have a need to think about it because their race or skin color has never been a problem for them psychologically, and therefore, their skin color is invisible to them. It is something that no one makes them aware of in a negative way. Many unconsciously feel it is normal to be white and have no reason to be aware of it.

The clinician has his or her own culture and worldview and brings this personal culture into the therapeutic setting. The intercultural and worldviews of the clinician and client are different, and they may also have different assumptions of each other’s roles, pathology of the illness and the appropriate treatment options.

Clinicians can also harbor certain stereotyped ideas and bias about the minority community, which can lead to misdiagnosis and poor counseling outcomes. Therefore, it is imperative that clinicians have multicultural competence.

Individual differences

There is always a danger of stereotyping and confusing other influences such as race and socio-economic status with cultural influences. The most obvious danger in counseling is to oversimplify clients’ social systems by emphasizing the most obvious aspects of their backgrounds (Pederson, 1986). While universal categories are necessary to understand human experience, losing sight of specific individual factors would lead to ethical violations (Ibrahim, 1985).

Race, ethnicity, national origin, life stage, educational level, social class and sex roles influence individual clients. Counselors must view the identity and development of culturally diverse clients in terms of multiple, interactive factors instead of a strictly cultural framework (Romero, 1985). A pluralistic counselor considers all facets of clients’ personal history, family history, and social and cultural orientation (Arcinega and Newlou, 1981).

Although it is impossible to change backgrounds, counselors can avoid the problems of stereotyping and false expectations by examining their own values and norms, researching client backgrounds and finding methods to suit clients’ needs.

Clinical sensitivity toward client expectations, attributions, values, roles, beliefs and themes of coping and vulnerability is always necessary for effective outcomes. Three questions that counselors might use in assessing their approach are (Jereb, 1982):

1. Within what framework or context can I understand this client, and what assessment can I use?
2. Within what context do the client and counselor determine what changes in functioning and what goals are desirable?
3. What techniques can be used to affect the desired change, and what interventions would be effective?

Examining the counselor’s assumptions, acceptance of the multiplicity of variables that constitute an individual’s identity, and development of a client-centered, balanced counseling methods will help the multicultural counselor providing effective help.

Defining linguistic competence

The verbal and nonverbal communication of the health professional influences the counseling session and its success. According to Romero (1985), language barriers impede the counseling process when clients cannot express the complexity of their thoughts and feelings or may resist discussing affectively charged issues.

Counselors, too, may become frustrated by their lack of bilingual ability. At worst, language barriers may lead to misdiagnosis and inappropriate treatment (Romero, 1985). Communication in a manner that is sensitive to the client’s culture will be very beneficial.

Linguistic competence is the capacity of a mental health professional to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who are not literate or have low literacy skills, and individuals with disabilities.

In positive communication climates, trust is established and reaffirmed, allowing freedom to explore sensitive issues and express disagreements. (Shirley Pinder Cook)

Positive talk climates are:
- Descriptive rather than evaluative.
- Oriented towards problems rather than control.
- Spontaneous rather than manipulative.
- Empathic rather than neutral.
- Express equality rather than superiority.
- Provisional rather than certain or dogmatic.
Janet, continued …

Janet evaluated Tilda’s comments without delving into them more deeply. Instead, she implied they were not “correct” by her remarks, such as, “Annette is simply acting out her personal traumatic experience. See if you can understand.”

While Janet was probably right about what caused Annette’s fighting, failing to acknowledge the inappropriateness of Annette’s behavior fueled Annette’s mother and grandmother’s contention that spanking was the direction to go.

Janet’s well-intentioned remarks fell on deaf ears. She struggled to control the session and drive home her message while superficially addressing Tilda’s recent past and assuming that Tilda would agree that corporal punishment was wrong. Had she probed more deeply about Tilda’s terrifying abuse and marital separation first, it may have been less challenging to advocate for Annette. And had Janet acknowledged Tilda’s normal grief responses to her own marriage and move, Tilda might have heard Janet’s powerful message that both the mother and her daughter had courageously shared and survived a terrifying experience.

Effective cross-cultural communication includes respect, understanding of the other’s point of view, openness, flexibility, tolerance of ambiguity, curiosity and appropriate humor. Other examples of linguistic competence are demonstrated through:

Different gestures

Very few gestures are universally understood and interpreted. What is acceptable in the U.S. maybe rude, offensive or obscene in other cultures. Here are a few gestures to be aware of:

- **Giving the thumbs-up.** In the U.S. and Europe the thumbs-up means something good. It’s considered rude in many Asian and Islamic countries and a sign of displeasure in Spain.
- **Placing your hand up to indicate “stop.”** In some Asian countries, this means you are requesting permission to speak or go ahead.
- **Placing your hands on your hips.** In the U.S. and Europe, placing a hand on the hip means being open and is a confident gesture. In many Asian countries, it is considered arrogant.
- **Forming a circle with your fingers.** In the U.S., this means okay. In Japan, it means money. In France, it means worthless or zero. In Brazil and Germany, it’s considered obscene.

Respecting personal space

Generally, Germans, Chinese and Japanese appreciate more personal space than Americans, and Americans prefer more personal space than Latin Americans, Italians, French and middle Easterners.

A linguistic competence checklist for organizations

The following checklist was designed by the National Center on Cultural Competence (NCCC) to help primary health organizations develop policies, structures, practices and procedures that support linguistic competence. According to the NCCC, health care organizations have been slow to develop and implement policies and structures to guide the provision of interpretation and translation services, which remain at the practitioner and consumer level. The following checklist can help mental health organizations develop policies, structures, practices and procedures that support linguistic competence.

The organization should have:

- A mission statement that articulates principles, rationale and values for providing linguistically and culturally competent health care services.
- Policies and procedures that support staff recruitment, hiring and retention to achieve the goal of a diverse and linguistically competent staff.
- Position description and personnel performance measures that include skill sets related to linguistic competence.

- Policies and resources to support ongoing professional development and training of linguistic competence.
- Policies, procedures and fiscal planning to ensure translation and interpretation services.
- Policies and procedures on the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of patients.
- Policies and procedures to evaluate the quality and appropriateness of interpretation and translation services.
- Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services provided.
- Policies and resources that support community outreach initiatives to persons with limited English.
- Periodic reviews of the current and emergent policies, procedures and demographic trends for the geographic area served to determine interpretation and translation requirements. (NCCC).
Mental health practitioner responsibility

When mental health professionals successfully incorporate the five culturally competent areas into their work, they can better identify and address client issues and provide best-practice treatment.

Cultural competence requires that they be proficient in:

- Defining a set of values and principles and demonstrate behaviors, attitudes and policies that enable them to work effectively cross-culturally. In other words, when they approach their work with the intention of being culturally sensitive and self-aware, mental health practitioners become better listeners and observers.
- Demonstrating a capacity to value diversity, conduct self-assessments, manage the dynamics of difference, acquire cultural knowledge and adapt diversity to the cultural contexts of clients they serve. Many mental health supervisors drive home the message that actions speak louder than words, but both action and verbal communication are needed to manage the dynamics of difference.
- Designing and implementing services that are tailored or matched to the unique needs of their clients. Providing mental health services tailored to the needs of clients sometimes means that mental health practitioners may have to make a referral to someone else with the capacity to communicate more effectively because they simply speak the client’s language or use sign language. In addition, mental health practitioners must remain mindful of any professional gaps when working with age-specific populations, such as youth or elders.
- Incorporating all of the above in service delivery and seeking out consultation at appropriate times. A variety of networking opportunities provide mental health practitioners with referral sources in addition to ongoing supervision or coaching and mentoring with a person from a different cultural or ethnic background.

Richardson and Molinaro (1996) have suggested that self-awareness is a prerequisite for multicultural competence. Self-awareness often develops from personal and professional socializations to divergent cultural experiences. (Helms & Cook, 1999) When this self-awareness is integrated into clinical roles, mental health professionals are likely to develop complex perspectives on cultural influences in their role. (Inman, 2006)

In addition to self-awareness, mental health professionals also need to recognize unique client variables, such as cultural membership and socialization, that affect client problems. If mental health practitioners do not have self-confidence in their abilities to integrate this information and perform a set of multicultural skills and behaviors, they are likely to experience decreased competence. (Constantine & Ladany, 2001)

Janet, continued …

Janet is an excellent clinical social worker and passionate about domestic violence and traumatic exposure, particularly for children. Her career had been ignited by a personal childhood experience that involved her best friend. She was extremely committed to helping traumatized adults and children. Even though she shared the same ethnic and racial background as Tilda and Annette and understood intellectually, it was difficult for her to accept why a mother could suffer from domestic violence and still hit her own children.

Janet’s family had emigrated from the same country as Annette’s, but Janet’s family had moved to the U.S. years earlier. In contrast, Annette’s mother and grandmother had arrived in the past few years and were still adapting to their new country. Janet had become acculturated, adopting and integrating Western social norms and rules into her worldview and daily life. She hadn’t given much thought to the fact that Annette and her family were still quietly engaged in their familiar and different cultural practices.

Janet was forced to examine her personal motivations and previous session interactions after Annette’s mother began to cancel their sessions. As Janet revisited her past discussions with Annette’s family, she recognized that she had not fully acknowledged Tilda’s courage when she left her abusive marital relationship.

In addition, Janet also recognized that Annette’s grandmother could potentially be a powerful ally and invited her to family sessions, asking for her help to better understand the grandmother’s culture. Janet also made a point of learning more about her own family’s country of origin, revisiting its cultural norms, especially as they revolved around women’s issues. Janet also translated trauma information into Tilda’s primary language so that Tilda and her mother were able to read the information on their own. She spent time in session facilitating a discussion between grandmother and mother about the role of women in their culture and how adjusting to another could be daunting. They even exchanged recipes.

Janet became more reflective with her clients and explained the Western perspective on corporal punishment more compassionately as a teacher and coach. And as trust grew between the women, she was able to help Tilda to redirect Annette’s behavior as they both worked on reprocessing and integrating both their traumatic experiences.

Common areas of cultural and social class differences

Dominant and non-dominant cultures, while often similar, can also be in conflict. Dominant culture often creates the overall set of rules, rituals and laws that override other cultural norms and routines within a larger society. It is important to distinguish the differences created by intervening factors that influence culture.

Miscommunication can occur when mental health practitioners, oriented to dominant culture norms, conduct mental health assessments and provide treatment for people oriented to a non-dominant culture. Miscommunication can occur with these issues:

- Concept of time.
- Relationship of individual to others.
- Role of their community.
- Religious or spiritual beliefs.
- Sex roles.
- Work ethic.
- Respect and deference.
- Worldview.
- View of helping relationships.
- Parenting practices, such as responsibility delegated to children, the degree of adult dominance and methods of discipline.
- Privacy and personal space.
- Communication such as direct or indirect style of language and conversational conventions.

Even while the dominant culture may share common physical traits, language or religious backgrounds there are still distinct factors that influence culture even within this larger population that also determine how people think and behave. Some of these factors include educational and income levels, geographic residence, identification with community groups such as political or religious membership, personal experiences, age, gender and length of residency in the U.S.

Mental health professionals need to ask themselves: As a culturally competent mental health practitioner, am I capable of interacting positively with people who do NOT:

- Look like me.
- Talk like me.
- Think like me.
- Believe like me.
- Act like me.
- Live like me.
Common cultural competence missteps

In general, the more common mental health cultural competence mistakes include:
- Unintentional racism.
- Miscommunication.
- Lack of personal awareness.
- Insensitivity to nonverbal cues.
- Lapse in discussion of racial/ethnic issues.
- Gender bias.
- Overemphasis on cultural explanations for psychological difficulties.
- Lapses including appropriate questions within the context of acquiring background information.
- Inability to appropriately present questions that elicit valuable information or feedback.

Cultural competence proficiency continuum

Understanding and practicing cultural competence is learned. The cultural competence proficiency continuum ranges from destructive to proficient and includes more subtle areas of demonstrating cultural proficiency in between. It generally goes like this:
1. Cultural destructiveness.
2. Cultural incapacity.
3. Cultural blindness.
4. Cultural pre-competence.
5. Cultural competence.
6. Cultural proficiency.

Cultural awareness and cultural sensitivity

When mental health professionals demonstrate cultural proficiency, they’ve incorporated cultural and linguistic knowledge, awareness and sensitivity into their work. Cultural knowledge, cultural awareness and cultural sensitivity all convey the idea of improving cross-cultural capacity, but they are defined differently.
- **Cultural sensitivity** is defined as knowing that cultural differences as well as similarities exist, without assigning values such as better or worse, right or wrong to those cultural differences. (National Maternal and Child Health Center on Cultural competency, 1997)

STRATEGIES TO PROMOTE DIVERSITY AND CULTURAL COMPETENCE

Cultural competence self-assessment

Cultural competence begins with an awareness of one’s personal cultural beliefs and practices, and recognition that people from other cultures may not share them. Cultural competence travels well beyond speaking another language or recognizing cultural icons. It encompasses transforming prejudices or biases about beliefs and customs.

Cultural competence is rooted in respect and validation towards someone different. Mental health practitioners can benefit from a personal check-in while acquiring client background information. The following questions may appear deceptively simple, but can be surprisingly helpful:

**Ask yourself:**
- Am I open to working with other ethnic and cultural groups?
- Do I have personal biases, and can I challenge myself to understand and overcome them?
- Am I willing to take the time to learn about my clients’ culture?

- Cultural knowledge is familiarization with selected cultural characteristics, history, values, belief systems and behaviors of the members of another ethnic group (Adams, 1995).
- Cultural awareness is developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995).

- Do I have a strategy to monitor my reactions and feelings to avoid imposing my values on others?
- Am I able to give up control to empower my client?

Self-assessment sample

Different types of cultural competency self-assessments have been developed that address specific areas of cultural competence. The following example is an assessment developed by the Georgetown University Center for Child and Human Development, titled Self-Assessment Checklist for personnel providing services and supports to children with disabilities and special health needs and their families. The assessment was broken down into three areas that include physical environment, communication styles and values and attitudes. There is no answer key with correct responses. However, mental health practitioners who often respond with “C” may want to learn more about how to engage in more culturally sensitive service delivery.
Self-assessment checklist for personnel providing services and supports to children with disabilities and special health needs and their families
(Adapted from "Promoting Cultural Competence and Diversity in Early Intervention and Early Childhood Settings – Georgetown University Center for Child and Human Development University Center for Excellence in Developmental Disabilities Education, Research and Service.)

Directions: Please select A, B, or C for each item listed below.


Physical environment, materials and resources
_1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families within my practice.
_2. I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served.
_3. I ensure that toys and other play accessories in reception areas and those, used during assessment are representative of the various cultural and ethnic groups within my practice.
_4. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.
_5. When using food during an assessment, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by me.

Communication styles
_6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.
_7. I attempt to determine any familial colloquialisms used by children and families that may impact assessment, treatment or other interventions.
_8. I use visual aids, gestures and physical prompts with clients who have limited English proficiency.
_9. I utilize bilingual staff or trained/certified interpreters for assessment, treatment sessions, meetings and for other events for families who would require this level of assistance.
_10. I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English proficiency.
_11. When interacting with parents who have limitations in English proficiency I always keep in mind that:
    ___ *Limitations in English proficiency is in no way a reflection of their level of intellectual function.
    ___ *Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
    ___ *They may or may not be literate in their language of origin or English.
_12. When possible, I ensure that all notices and communiqués to parents are written in their language of origin.
_13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.
_14. I understand the principles and practices of linguistic competency and:
    ___ *Apply them within my program or agency.
    ___ *Advocate for them within my practice, program or agency.
_15. I understand the implications of health literacy within the context of my roles and responsibilities.
_16. I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.

Values and attitudes
_17. I avoid imposing values that may conflict or be inconsistent with clients.
_18. In group therapy or treatment situations, I discourage racial and ethnic slurs by helping them understand that certain words can hurt others.
_19. I screen books, movies, and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with children and their parents served by my agency or myself.
_20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.
_21. I understand and accept that “family” is defined differently by different cultures.
_22. I accept and respect that male-female roles in families may vary significantly among different cultures (i.e. who makes major decisions for the family, play and social interactions expected of the eldest male in families).
_23. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
_24. I understand that age and life cycle factors must be considered in interactions with individuals and families (i.e. high value placed on the decisions of elders or the role of the eldest male in families).
_25. Even though my professional or moral viewpoints may differ, I accept that family/parents are the ultimate decision makers for services and supports for their children.
_26. I recognize that the meaning or value of medical treatment, health care and health education may vary greatly among cultures.
_27. I recognize and understand that beliefs and concepts of emotional well-being vary from culture to culture.
_28. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
_29. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death.
_30. I recognize and accept that folk and religious beliefs may influence a family’s reaction and approach to a child born with a disability or later diagnosed with physical/emotional disability or special health care needs.
_31. I understand that traditional approaches to disciplining children are influenced by culture.
_32. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.
_33. I accept and respect that customs and beliefs about food, its value, preparation and use are different from culture to culture.
_34. Before visiting or providing in-home services I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my agency or me.
_35. I seek information from family members or other key community informants that assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.
_36. I advocate for the review of my program or agency’s mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.
Improving communication with clients

It is helpful to keep this communication checklist in mind when building cultural competency:

- Build collaboration through reflective listening, inquiry and coaching.
- Invite your client to tell you what feels comfortable or uncomfortable, safe or unsafe, within your practice environment.
- Make no assumptions. Remember the old saying, “You can’t tell a book by its cover?” Try this exercise: When you’re introduced to someone new, before beginning a conversation imagine how the person speaks, based on his or her appearance. For example, one mental health practitioner remarked that because she and someone she’d just met shared the same ethnic background, she imagined they would speak with the same accent. She was surprised when her new friend spoke quite differently.
- Cultural differences are valid. Communication, beliefs and daily practices become imprinted in children and have been developed from input from caregivers living out their cultural experiences.
- Assess for style or substance communication patterns and then match behavior and communication with those patterns.
- Self-observe and self-assess before reacting to someone who might prompt an “affectively charged” response.
- Learning cultural competence is challenging, and people make unintentional mistakes. So remember the phrase, “All the saints I know are dead.” Keep trying.
- Expand your cultural horizons by eating at a different restaurant, taking a foreign language class, asking for some coaching from a friend who shares a different life experience, or spending time volunteering with a more diverse population.
- Understand the differences between individuals and their personalities, and their broader cultural traditions. For example, people will very often adjust their language and conversation based on with whom they are speaking.
- Appreciate diversity and multiculturalism by buying something beautiful from another country.

Current Issues in multicultural counseling

Bullying, a unique problem in the field of multicultural counseling, affects school-age children and adolescents within marginalized groups, such as students of diverse cultures or students new to the United States. Because their cultures and backgrounds fail to mirror mainstream American society, these diverse, marginalized students are innocent targets for bullies. Not only do the bullies victimize them, but adults who often ignore bullying also leave them to their own resources.

By illuminating factors that stress marginalized groups of students, research exposes the danger of such adult attitudes. The factors that are stressors include students’ socioeconomic status, identity development, language, physical characteristics, skin color and type of hair (Merrill-James, 2006).

They also include school and community factors, such as pervasive attitudes of denial, justification, avoidance, racism and other forms of prejudice. Together these factors affect students’ peer group affiliations through name-calling and ostracism, and their self-esteem through verbal bullying, all of which perpetuate negative stereotypes, lower academic performance and school attendance, and contribute to a climate of violence (Merrill-James, 2006).

Best practices for addressing and putting an end to bullying include professional development and training for students and staff, group and individual counseling, and zero tolerance policies for verbal and other forms of bullying in schools. Additional research is needed about stressors that ensue from lower and middle class comparisons and intraracial bullying.

Future projections indicate that by the year 2020, a majority of school-age children attending public schools will be children of color or from diverse cultural, ethnic and linguistic backgrounds (Holcomb-McCoy and Moore-Thomas 2004). The current racial/ethnic distribution among students in public schools in the United States is about 1.2 percent native American, 4 percent Asian Pacific American, 15.6 percent Hispanic/Latino, 17.2 percent African-American, and 62.1 percent European/white American (National Center for Educational Statistics 2001).

Along with diversity are the increasing reports of bullying incidence among school-aged children and adolescents linked to cultural, ethnic, gender or linguistic differences. There are various definitions of bullying in the literature; however, a commonly cited definition is the repeated, aggressive, physical, psychological or sexual behavior a person directs toward another individual (Batsche and Knoff 1994; Olweus, 1993).

Some statistics on bullying indicate that 60 percent of students report bullying on the basis of appearance or body size, 57 percent on the basis of gender expression, 53 percent on ability, 52 percent on real or perceived sexual orientation, 40 percent on race/ethnicity, and 33 percent on religion or family income (Gordon 2001; Scott, 2002).

Reports indicated that 45 percent of all students said they feel unsafe at school because of some real or perceived personal characteristic, 9 percent of all students have skipped a class in the past month because they felt unsafe in school, 7 percent skipped an entire day of school, 29 percent of gay students skipped a day of school in the past month because of feeling unsafe (four times greater than in the general population) and 60 percent of all students who have been harassed or assaulted did not report the incident to faculty or staff (Gordon; Scott, 2002).

Addressing diversity as a bullying issue is one of the challenges facing school and mental health counselors. The counseling process must validate and affirm children from marginalized groups and recognize the contextual dimension of race, culture, class, gender, religion,
sexual orientation and geography. A marginalized group includes children and adolescents whose cultures and backgrounds do not necessarily mirror the cultural dictates of mainstream American society (Holcomb-McCoy and Moore-Thomas, 2004). Culturally responsive counseling practices require an ethic of caring and understanding in an effort to build bridges between different ethnic groups.

Although all forms of bullying are of significance when addressing the concerns of students, school-aged children, adolescents and adults, counselors must develop techniques to address bullying within marginalized groups, including intraracial bullying (Merrell-James, 2006).

**Suggested best practices to address bullying**

The following list contains suggested strategies that multicultural counselors can use to address bullying in the school and community:

- Be aware of the various forms of bullying.
- Develop a zero-tolerance policy for bullying.
- Be prepared to host professional development workshops for parents, students, staff and the community on the issue of bullying. The workshops will focus on defining the problem and working on suggestions for addressing the behavior in the school and the community.
- Include bullying intervention strategies in all work plans against bullying and violence in schools and community organizations.
- Multicultural counselors should encourage students to research their ethnic heritage by reading selected literature, attending cultural events, and interacting with experts on the history and culture of their heritage.
- Form multicultural groups for students to address ethnic identity, exploration, and to develop awareness and understanding of ethnic groups other than their own.
- Help students manage the impact of others' negative perceptions. Coping with others' faulty perceptions based on stereotypes is an ongoing and difficult path that will likely impact the adolescents' lives (Holcombe–McCoy and Moore–Thomas, 2001).

**Multicultural competent supervision**

Supervision is a primary method of clinical training, and clinicians rely on their supervisors to guide them as they seek to become culturally competent in providing treatment. A study conducted at Lehigh University investigated the direct and indirect impact of marriage and family therapy trainees' perceptions of their supervisors' multicultural competence on the supervisory working alliance and two outcome variables, trainees' multicultural competence and perceived supervision satisfaction. Trainees who are able to differentiate cultural information, identify multiple hypotheses and integrate this information about clients are considered more proficient at their work (Blocher, 1983).

Research evidence supports the positive relationship between supervisor multicultural competence and the supervisory relationship. Factors such as the supervisors' openness and attention to cultural factors and guidance on culture-specific issues have been deemed important to a culturally responsive supervisory relationship.

In the Lehigh study, a supervisory working alliance served as a significant positive mediator in the relationship between supervisor multicultural competence and supervision satisfaction. In addition, a supervisory relationship that involves an implementation of cultural competence through a mutual agreement on goals and tasks with a focus on multicultural issues may provide for greater supervision satisfaction.

Although trainee satisfaction is crucial to achieving their goals (Heppner & Hadley) little attention has been given in the past to the issues of supervisor multicultural competence in building a working alliance. Another study (Constantine) on multicultural differences in supervisory relationships at 22 internship programs revealed that many participants reported that supervision would have been greatly enhanced if they had spent more time processing issues surrounding cultural differences in supervision.

Supervisors should have the capacity to model behavior that is culturally responsive; facilitate cross-cultural communications; and identify and bridge cultural gaps in both staff development and client service delivery. In their supervisory role, they have opportunities to develop and present culturally enriching activities that stimulate cultural awareness. Assertiveness and direction guide appropriate behavior among staff.

**Cultural responsiveness in mental health systems of care**

A paradigm shift from ethnocentrism to multiculturalism in mental health systems is accomplished when cultural competence is seen as one of the primary goals of the entire system. In addition, on-going evaluation of internal bias in policies, practices and personal philosophies is necessary to implement and sustain effective treatment protocols.

Three main components of program design for a mental health system that can facilitate the development of culturally responsive services are:

1. Organizational structures, policies and procedures.
2. Training curricula.
3. Supervisory and staff roles and responsibilities.

Cultural responsiveness can be enhanced when:

- Non-dominant-culture staffers are used as consultants and coaches.
- Clear expectations and guidelines for staff exist regarding cultural responsiveness as a job requirement.
• Forms and processes pertaining to cultural bias, stereotypes and stigmatizing are regularly reviewed, monitored and revised.
• Cultural responsiveness training is required for all employees.
• Job expectations and supervisory responsibilities are established on service delivery and workplace interactions.

Overall, training on cultural competence should be presented as an enriching activity. Training in cultural responsiveness (competence) should include first, listing cultural responsiveness as an expectation and providing more details and practice opportunities for cross-cultural communication and ethnographic interviewing techniques. In addition, training should also include stressing cultural self-assessment for trainees as a cultural responsiveness tool.

Conclusion

Cultural competence in mental health practice incorporates culture, competence and diversity as well as language. Five elements of cultural competence include valuing diversity, conducting cultural self-assessments, managing the dynamics of difference, acquiring and integrating cultural knowledge, and adapting to diversity and cultural contexts that include policy, structure, values and services.

Linguistic competence is the ability to communicate effectively, in a manner easily understood by diverse clients, including clients of limited English proficiency, those who are not literate or have low literacy skills, and individuals with disabilities.

There are a variety of cultural competence strategies available to mental health practitioners that promote cultural competence in the workplace, and they all build on the five elements of cultural competence. Mental health practitioners have a responsibility to incorporate the five cultural competencies into their work, and according to social researchers, self-awareness is a prerequisite for multicultural competence.

When working with diverse populations, mental health practitioners should keep in mind dominant and non-dominant culture practices and expectations, and avoid unintentional error through various cultural competence missteps that include unintentional racism.

A supervisory relationship that involves an implementation of cultural competence through a mutual agreement on goals and tasks with a focus on multicultural issues may provide for greater supervision satisfaction. (Inman, 2006)

Paradigm shifts from ethnocentrism to multiculturalism can occur in larger mental health systems when cultural competence is seen as one of the primary goals of the entire system.

Training on cultural competence should also be presented as an enriching experience for staff in mental health organizations and include stressing cultural self-assessment as a cultural responsiveness tool.

The most important work for every counselor and mental health professionals is to become more culturally responsive and respectful.

Cultural competence is first and foremost a commitment to take the next step, and the next, and the next toward offering accessible and appropriate services for the diverse clients and communities being served. Counselors need to learn to ask questions sensitively and to show respect for different cultures (Ahmed, 2011).

Looking forward

Multiculturalism has been referred to as the “fourth force” in counseling alongside the traditional psychodynamic, cognitive-behavioral, and humanistic approaches (Ivey, Ivey, & Simek–Morgan, 1997; Pederson, 1991). Given the data suggesting the continuing disparities in mental health services for diverse socio-cultural populations, organizational efforts to enhance multiculturalism in multicultural counseling competency need to be continued in the counseling field.

At the close of the 2010 Multicultural Social Justice Leadership Development Academy, a number of strategies were developed as listed below (Zalaquett, 2011):

The first strategy was to develop a support system for counselors and counselor educators who might feel they are “lone wolves” in their working environments. This support might help counselor educators feel empowered to stand strong and move forward in their work as advocates for social multicultural justice. This would help counseling professionals find and use their own voices, and help them balance the “I” with the “we.” Empowering activities should be implemented to help individuals feel connected.

The second strategy was to provide more “bottom-up” rather than “top-down” training. Training should be more participatory, integrating experiential components into workshops. Promoting group dialogue and reducing lecture-style presentations will help participants become more aware of the problems within society. Assistance should be provided to aid the development of groups that work as a collective unit to bring about social justice.

Additional strategies included promoting change that is based on kindness and consideration, being less politically correct, and offering more authenticity in communication. Individuals should listen before engaging, be more patient, and embrace differences. All states should participate in the development of multicultural social justice, and this should include the provision of workshops focused on meeting the social justice needs in schools and communities.

The development of programs to provide more time to participate should be encouraged. Training programs should be expanded to include a wide variety of presenters who are not primarily ethnic/racial minorities and should include more participants from the dominant racial/ethnic group.

Training activities could include self-discovery activities, reacting to cultural values that differ from their own, and role-playing. Workshops could also be developed for teachers, children and parents and could be provided in the schools when possible.

Mentoring for graduate students should also be provided, and as a long-term goal, multicultural social justice training should become a requirement for licensing or certification.

At the close of the session, participants in the conference felt that work was needed to encourage more therapists and counselors to become open-minded, and validated the need for social justice. Speaking out against injustice is about affirming and confirming action – not about being right or wrong (Zalaquett, 2011).

If we look to this future of counseling from a multicultural and social justice perspective, it is important that we open our eyes to the many different perspectives held by diverse people in our society. We must all be willing to see the world from the view of those who are different and have insight into how we view the world from our own
phenomenological perspective. Using the multicultural counseling competencies (Sue et al., 1994), counselors can look at themselves and begin to see and conceptualize multicultural counseling competencies and learn about themselves and diverse clients their attitudes and beliefs, knowledge and skills. Applying this knowledge is essential if we are to develop counselors who are multicultural, competent and oriented towards social justice (Zalaquett, 2011).

References

- ARCH National Resource Center for Respite and Crisis Care Services Fact Sheet, Department of Health and Human Services, Chapel Hill, NC 27514.
1. Knowledge of the culture of a client:
   b. Can be achieved by specific academic courses.
   c. Must be transformed into concrete operations and strategies.
   d. All of the above.

2. Practitioners of a universal system of counseling need all of the following qualities EXCEPT:
   a. A respect for the client.
   b. Genuineness.
   c. Empathy.
   d. The ability to work without structure.

3. The validation process by a counselor means all of the following EXCEPT:
   a. Helping a client to see that his or her view is wrong.
   b. Confirming what the client is saying.
   c. Acknowledging that the client’s experiences, opinions and thoughts are legitimate.
   d. Helping the counselor to gain confidence and growth through clients’ communication of “a job well-done.”

4. Bartering between a therapist and client:
   a. Can enhance the professional nature of the therapeutic bond.
   b. Is specifically permitted by the state of California.
   c. Is not ethically prohibited by the ACA Code of Ethics but is not recommended as a customary practice.
   d. Is covered by most professional liability insurance policies.

5. Being “affectively charged” leads therapists to:
   a. Stick to a message that at the moment cannot be heard.
   b. Commit to a message that is more strength-based.
   c. Be objective and focus on the goals of therapy.
   d. Increase their cultural awareness of diverse populations.

6. A counselor’s own culture and worldview:
   a. Have little or no effect on their counseling.
   b. May limit the success of counseling if they lead to adherence to a specific counseling theory or method.
   c. At their basic level are seldom different from their clients’.
   d. If shared, can lead clients to accept the counselor’s definitions of what are appropriate treatment options.

7. Miscommunication can occur because of cultural differences in:
   b. Respect and deference.
   c. Parenting practices.
   d. All of the above.

8. All of the following are common cultural competence missteps EXCEPT:
   a. Unintentional racism.
   b. A too-familiar relationship between a counselor and client.
   c. An overemphasizion on cultural explanations for psychological difficulties.
   d. An inability to appropriately present questions that elicit valuable information or feedback.

9. The main components of program design for a mental health system that can facilitate culturally responsive services include all of the following EXCEPT?
   a. Organizational structures, policies and procedures.
   b. Training curricula
   c. Suitable physical space that will reflect a multicultural focus.
   d. Supervisory and staff roles and responsibilities.

10. Assimilation is defined as:
    a. Adoption of another culture’s values and way of life.
    b. The belief that everyone within a culture is exactly alike, shares the same values, beliefs and attitudes.
    c. A social group within a cultural social system that is based on variable traits, including religious, linguistic, ancestral or physical characteristics.
    d. The dynamics of difference in which one group regards another group as subhuman and seeks to destroy that group or their culture.