Cultural Competence in Mental Health Practice Part 1: Principles, Preparation and Priorities for Practice

3 CE hours

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Learning objectives

- List and define five qualities required for effective mental health practice.
- Describe four components of multi-cultural competency in mental health practice.
- Identify four barriers to multi-cultural competence in mental health practice and discuss strategies to avoid or overcome them.
- Define five components of the HIPAA Privacy Rules that impact multicultural competence in mental health practice.
- Identify and describe four themes of cultural competence in effective practice.
- List and define eight socio-cultural areas that a culturally competent practitioner must be prepared to assess and address with clients.
- Compare and contrast a group-specific approach and a multidimensional approach as they inform cultural competence in mental health practice.

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, “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 “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 “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. **Empathetic 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. “The ability to convey empathy in a culturally
consistent and meaningful manner may be the crucial variable to engage the client” (Ibrahim, 1991). The only way mental health counselors can enter the world of the client is with the permission of the client, who communicates the nature of his or her world to the practitioner through self-disclosure. Plus, client self-disclosure is the essence of counseling. The mental health practitioner’s respect and genuineness facilitates client self-disclosure (Patterson, 2004).

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. Vontrass (1976) says:

“Oh 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 (Kiselica 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 heritage, history, values, language, tradition or parts as superior.

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 and 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 below).
- **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 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 students. When students affirm the validation process is working, counselors 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 including 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.

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, socioeconomic 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.
- Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. This includes promoting 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, 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. 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 awareness**

- 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 no one can know everything, so counselors are always engaged in becoming more competent. The counselor’s focus is to be 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 and encourage open discussion 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 by increasing communication and decreasing isolation to 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 clients and significant others in the therapeutic relationship. They must help clients engage their family, friends and colleagues in constructive conversations to build positive relationships.
- 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:

- Dual or multiple relationships 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.

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).

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).

Attitudes and beliefs

Counselors must be open to having leaders in their organizations who represent diverse political viewpoints that may definition 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 not try 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:

- **Awareness** refers to the counselor’s awareness of his or her own worldview and cultural biases.
- **Multicultural knowledge** requires counselors to be knowledgeable about various cultural factors that might influence the counseling process.
- **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 (CCCR-I), other competency measures use self-report (CCC 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...
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, socio-economic status and religion. In addition, counselors must understand the concept of saliency and intersectionality to conceptualize socio-culturally diverse clients.

**Statistics**

The need for multicultural competent counselors is increasing as the population of various ethnic groups grows. Current and projected 21st century demographic changes in the United States are a major factor. For example, immigration patterns and increases among racially, ethnically, culturally and linguistically diverse populations are rapidly changing. A 1997 Census Bureau survey reported that one in every 10 persons in the United States is foreign born. Currently, the U.S. foreign-born population comprises a larger segment than at any time in the past five decades. This trend is expected to continue.

The Children’s Defense Fund predicted that in the first decade following 2000, there would be 5.5 million more Latino children, 2.6 million more African-American children, 1.5 million more children of other races and 6.2 million fewer white, non-Latino children in the United States. (NCCC). Cultural competence can increase the overall quality of life for everyone and supports best practice in mental health as well as decreases the likelihood of liability and malpractice claims. (NCCC Policy Brief)

**Child discrimination reports**

Discrimination is the denial of equal treatment. Although improvements have occurred, serious problems still exist with children and discrimination. Racial injustice is particularly noted in juvenile justice systems. Youths of color are treated more harshly than white youths for the same detention processing in juvenile court, transfer to adult criminal court,
and sentencing and incarceration in juvenile and adult facilities. Courts commit African American youths with no prior drug offenses to state institutions 48 times as often as white youths with no prior drug offenses. African American youths are sentenced 90 days longer for violent offenses than white youths, and Latino youths are incarcerated 150 days longer. (Child Welfare League of America, CWLA, 2002)

In a Child Welfare League of America study in 2002, 48 percent of children ages 8 to 11 and 67 percent of children 12 to 15 stated that children at their schools were treated badly because they were “different,” and that discrimination was a big problem for their peers at school.

As reported in 1999, 7,876 hate crimes were reported in the United States. Nearly two-thirds of all known perpetrators were teenagers or young adults. (CWLA, 2002)

The National Center for Cultural Competence policy brief, Rationale for Cultural Competence in Primary Care, states that there are additional compelling reasons to become culturally and linguistically competent. They include:

- **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:
  1. Knowledge of beliefs, values, traditions and practices of a culture.
  2. Culturally defined health-related needs of individuals, families and communities.
  3. Culturally based belief systems of the etiology of illness and disease and those related to health and healing.
  4. 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. Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Health care organizations and programs must address linguistic competence – ensuring for accurate communication of information in languages other than English. (National Center for Cultural Competence).

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**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, defining individuals and informing their identity. Everyone has culture influences that affect how they see others. Organizations or systems have distinct cultures that are developed and communicated by mission and goal statements. Communities represent diverse cultures influenced by their members, the environment and socioeconomic conditions. Culture is a framework for making human connections, as individuals see things from their 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:
- Education.
- Marital status.
- Employment.
- Geographic background.
- Cultural values, beliefs and practices.

**Cultural competence** – In general, the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientation, and faiths or religions in a manner that recognizes, affirms and values the worth of individuals, families, tribes and communities and protects and preserves the dignity of each.

Demonstrating cultural competence is an ongoing process that emphasizes cultural strengths of others and integrates their unique abilities and perspectives into our lives. It is a vehicle that can be used to broaden our understanding of individuals and communities, and is reflected in how people in a community relate to and interact with mental health providers. Cultural competence addresses how to understand cultural implication issues and then integrate this knowledge into an optimal therapeutic interaction. (CWLA)

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**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 or 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:
   a. Revisiting policies and procedures that are no longer relevant and, in fact, could be counterintuitive to providing culturally competent mental health services.
   b. Restructuring systems and methodologies to more appropriately meet the needs of the people served.
   c. Enhancing and adopting different values with the commitment to provide culturally competent, evidence-based practice.
   d. Revising service practice to incorporate culturally sensitive mental health protocols.
   e. Applying cultural competence to mental health practice.

The majority of mental health practitioners are culturally sensitive. When missteps 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.” The following case study provides an 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 mother 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 1,000 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 springtime. 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 afternoons 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 incident, I noticed
people looking doubtfully at me. I came here with my family and we all became American citizens. I don’t know why people don’t trust my loyalty to this country. I love America.

**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.

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’s not 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 was similar 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 us. 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.

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 who speak English as 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 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 competence is critical to address disparities in mental health services that have been documented throughout the United States. Practitioners and clients must be able to communicate and develop trust despite cultural differences. For mental health services to be effective the practitioner must be aware of all socio-cultural influences that impact the diverse needs of their clients. Organizations and systems for mental health care must be attuned and responsive to the needs of the multi-cultural communities they serve in order to conduct outreach services to increase access to quality care for all.

References


- ARCH National Resource Center for Respite and Crisis Care Services Fact Sheet. Department of Health and Human Services, Chapel Hill, NC 27514.


CULTURAL COMPETENCE IN MENTAL HEALTH PRACTICE PART 1: PRINCIPLES, PREPARATION AND PRIORITIES FOR PRACTICE

Final examination questions

Select the best answer for each question and proceed to Psychology.EliteCME.com to complete your final examination.

1. Recommendations for knowledge of culture are necessary but not sufficient for effective treatment. Knowledge must be____________________.
   b. Can be achieved by specific academic courses.
   c. Must be transformed into concrete operations and strategies.
   d. Acquired in the language and customs of every client.

2. Two of the five basic counselor qualities in Roger’s system include which of the following?
   a. Respect for the client and genuineness.
   b. Knowledge and non-judgment.
   c. Listening and experience.
   d. Competence and linguistics.

3. The definition of multicultural competence means in part to____________________.
   a. Approach the counseling process from your competency base.
   b. Approach the counseling process from the context of the personal culture of the client.
   c. Use an approach acceptable to the community.
   d. Create an approach that follows organizational guidelines regardless of client culture.

4. Professional ethics compel counselors to ensure that their cultural values and biases___________.
   a. Are totally removed from the process.
   b. Do not override those of the client.
   c. Are similar to those of the client.
   d. Are understood by all parties in the process.

5. Which of the following could hinder counselors in their ability to form helpful and effective relationships with culturally different groups?
   a. Ethnicity, educational background.
   b. Nationality, language, lack of skill.
   c. Knowledge, skill, ethnicity.
   d. Stereotypes, perceptions and beliefs.

6. Which of the qualities below have a particular focus on recognition of aspects of multiculturalism?
   a. Cultural similarity and gender.
   b. Ability to handle dual relationships.
   c. Credibility, trustworthiness and integrity.
   d. Advanced, specialized education.

7. Studies of multicultural competency are often grouped into several identified themes. These themes are____________________.
   a. Discrimination, validation, multicultural competence, and the sharing of knowledge.
   b. Language, ethics, education, and ethnicity.
   c. Gender, sexual orientation, age, and race.
   d. Privacy, advocacy, competency, and trust.

8. Which of the following protect the well-being of clients when the mental health practitioner assumes two or more roles, either concurrently or sequentially, with the help-seeker?
   a. Confidentiality.
   b. Boundaries.
   c. Consent.
   d. Ethics.

9. The ability to incorporate values, knowledge, attributes and skill sets in order to work effectively cross-culturally refers to the term?
   a. Multi tasking.
   b. Competence.
   c. Effectiveness.
   d. Credentialed.

10. Being “affectively charged” leads the 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 for effective solutions.