



**Abstract** To date, descriptions of culturally sensitive therapies have insufficiently acknowledged the heterogeneity of perspectives on the role of culture in therapy. The generally homogeneous manner in which advocates of culturally sensitive therapies have described this work has likely contributed to the mainstream's slow acceptance of the importance of culture. In this article, I propose an organizing framework that may help recognize the diversity of viewpoints regarding what constitutes culturally sensitive therapy. It is my hope that this framework, along with critical self-evaluation of the strengths and weaknesses of the various perspectives, will lead to more rapid incorporation of culture across treatments.

**Key Words** cultural competence, culturally sensitive treatments, culture, empirically supported treatments

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## Culturally Sensitive Treatments: Need for an Organizing Framework

In their article, La Roche and Christopher (2008) nicely highlight various ways in which many of the assumptions underlying empirically supported treatments (ESTs) are at odds with current conceptions of culture and the efforts to create culturally sensitive treatments (CSTs) that are well positioned to work with an increasing diverse population of clients. Their article is a complement to the increasing attention that scholars have begun to devote to these issues (e.g., Atkinson, Bui, & Mori, 2001; Bernal & Scharrón-del-Río, 2001; Hall, 2001; Miranda et al., 2005; Whaley & Davis, 2007). By reminding readers of the historical context of the development of the EST movement, namely reactions to the twin pressures of the biomedical/pharmacological field and the managed care/insurance arenas, La Roche and Christopher undermine the commonly held belief that ESTs developed purely out of a desire to improve the quality of public health care through the application of 'objective scientific criteria'. The authors then provide an excellent summary of the ways in which the EST perspective overvalues the importance of specific treatment factors and the methodology of randomized

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controlled trials while ignoring the importance of patient and therapist relationship variables that influence outcome, and the ways in which 'treatment' could lead to contextual change.

That said, as other notable criticisms of the EST movement have done, La Roche and Christopher have limited their description of the CST perspective by placing it in response to the limitations of the EST movement. This positioning, while understandable, has resulted in a limited and incomplete description of CST that is more reactive than proactive and creative. One consequence of the emerging CST movement generally failing to define itself in the affirmative has been the confusing and occasionally contradictory views on exactly what constitutes 'culturally sensitive therapy'. Many clinical, counseling, and cultural scholars have discussed their visions of how best to integrate culture into therapy; what remains lacking, however, is a framework that organizes this diversity of perspectives. Moreover, such a framework should be introspective and self-critical, acknowledging both the strengths and limitations of each perspective.

In this commentary, I will expand on La Roche and Christopher's paper by proposing an initial framework that I believe organizes much of the heterogeneity in perspectives among CSTs. My review of the literature has led me to identify at least three different emphases posited by scholars who support the explicit consideration of culture in psychotherapy: (1) culturally sensitive therapy is primarily or solely the product of culturally sensitive therapists; (2) empirically supported therapies can be adapted into culturally sensitive therapies; and (3) culturally sensitive therapies are only those that make culture the central focus. Each of these perspectives has intuitive appeal and some empirical support, and each has its strengths and limitations. It is my hope that this organizing framework may help the field more clearly articulate the various ways in which treatments could incorporate issues of culture.

### **Perspective I: Culturally Sensitive Therapy is the Product of Culturally Sensitive Therapists**

The first set of perspectives focus less on the treatment itself and more on the cultural sensitivity displayed and practiced by the *therapist*. Advocates of this perspective tend to use the term 'cultural sensitivity,' or oftentimes 'cultural competence,' to describe particular therapist attitudes and behaviors when working with culturally diverse populations (e.g., Helms & Cook, 1999; S. Sue, 1998; Whaley & Davis, 2007). Different definitions of cultural competence exist, but the essential

elements triangulate around the ability to understand and develop a strong therapeutic relationship with individuals from different ethnic or cultural backgrounds. Generally, this ability includes knowledge about specific cultures, as well as a more general awareness and understanding of issues of difference, power, and marginalization (Hays, 2008; S. Sue, 1998). For example, there exist a number of articles and chapters that discuss counseling approaches with specific racial/ethnic groups in the United States (e.g., Arredondo & Perez, 2003; Hines & Boyd-Franklin, 1996), as well as some recent attention to addressing non-specific aspects of difference in therapeutic encounters (e.g., Cardemil & Battle, 2003; La Roche & Maxie, 2003).

From this perspective, cultural competency (and, by extension, culturally sensitive therapy) is conceptualized as a therapist skill, much like other therapist skills. In support of this perspective, researchers have begun to develop scales that can measure cultural competence (e.g., Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sheu & Lent, 2007). However, the generally unstated assumption is that therapists who skillfully practice cultural competence will have better outcomes with their diverse clients than will therapists who do not. And with regard to this assumption, there is a notable absence of empirical support.

Nevertheless, this perspective has several strengths. First, because cultural competence is a therapist skill, it can be taught and learned through participation in coursework, conference workshops and seminars, independent reading, and introspection. A second strength is its flexibility. Cultural competence can be achieved by therapists from different theoretical orientations, in different mental health settings, and with clients of different racial, ethnic, and cultural backgrounds. Taken together, these two strengths raise considerable hope that the numbers of culturally competent therapists, and by extension the practice of CST, will increase. That is, insofar as CST is defined solely as the product of culturally competent therapists, then any existing therapeutic approach could be deemed culturally sensitive if conducted by a culturally competent therapist. From this perspective, the various traditional therapeutic approaches could easily incorporate cultural competency, much as has already happened with the incorporation of humanistic principles (i.e., therapy alliance) by the cognitive, behavioral, and psychodynamic schools.

There are several important limitations to this perspective, however, that go beyond the general lack of empirical support for the relationship between cultural competence and treatment outcome. Most critical is the dearth of consideration of the congruence, or theoretical

fit, between those therapist behaviors that are encouraged by considerations of cultural competence and those therapist behaviors that are prescribed, or proscribed, by the particular therapeutic orientation (see Helms & Cook, 1999, as one exception to this lack of attention). While the fit between these two sets of behaviors is likely to be high for some therapy orientations (e.g., humanistic therapy, cognitive-behavioral therapies), there are other therapies that proscribe the very behaviors that are recommended by some advocates of cultural competency (e.g., informality between therapist and patient, increased self-disclosure on the part of the therapist). Thus, before considerations of culture can be effectively integrated into all therapy orientations, the field must stop to consider and resolve some of the inconsistent recommendations that can emerge.

In sum, then, while there is much to value in a perspective that places the location of cultural sensitivity in the therapist, the ways in which this perspective is limited have led some scholars to push for a different approach, which I describe next.

## **Perspective 2: Empirically Supported Therapies Can Be Adapted into Culturally Sensitive Therapies**

The second perspective on culture and therapy argues that existing ESTs can be adapted in ways that make them more culturally relevant and attractive to individuals from different cultures (e.g., Muñoz & Mendelsohn, 2005; Otto & Hinton, 2006). Contained under the broad category of *cultural adaptations*, these include both efforts to take established manual-based treatments and adapt them for particular cultural groups, as well as novel treatments that have been developed for specific cultural groups, but that adhere to theoretical principles of change that have been developed in Western cultures. For example, in their recent article discussing adapting cognitive-behavioral therapy for Native Americans with anxiety disorders, De Coteau, Anderson, and Hope (2006) describe the importance of attending to the worldview of the clients, the use of culture-specific assessment instruments and rituals, and the consideration of socioeconomic contextual factors, all while working within a cognitive-behavioral framework. Thus, cultural sensitivity includes both cultural competence on the part of the therapist and explicit attention in the intervention to culturally relevant issues, such as discussion of immigration-related stress (see Cardemil, Kim, Pinedo, & Miller, 2005).

From this perspective, cultural sensitivity plays a critical role in making the intervention more attractive to participants and making it

more likely that participants stay engaged throughout the course of therapy. Importantly, however, cultural sensitivity is not generally viewed as an active ingredient that will directly contribute to improvement in the functioning of the client. Although the literature is limited, the emerging evidence suggests that these approaches can be efficacious in treating some mental disorders (Miranda et al., 2005). An excellent example of this approach can be found in Roselló and Bernal's (1999) randomized controlled study examining cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) with Puerto Rican adolescents. The authors adapted both therapies in a variety of ways to make them culturally sensitive, including the delivery of the intervention in the native language (Spanish), attention to the similarities and differences between client and therapist, and the use of culturally relevant metaphors and concepts, like traditional cultural values of *familismo* and *respeto* (Bernal & Saéz-Sanchez, 2006; Rosselló & Bernal, 1996). Results were positive: adolescents in both the IPT and the CBT conditions reported significantly fewer depressive symptoms than those adolescents randomized to the wait-list condition. Other researchers have begun to find support for the efficacy of cultural adaptations of EST across a variety of disorders, including anxiety, substance use, and disruptive disorders in children (Miranda et al., 2005).

A strength of this approach has been the explicit attention to quantitative empirical evaluation of both outcome and process variables. While La Roche and Christopher and others have cogently argued for the importance of qualitative methods for evaluating the efficacy of treatments, it remains true that the majority of the field of clinical psychology and psychiatry value traditional quantitative methods. As such, approaches that work within this framework have the potential to effect more change within the field. Moreover, as with the first perspective discussed, aspects of cultural sensitivity are theoretically teachable, increasing the likelihood of broad dissemination.

However, an important limitation is the fact that none of the existing cultural adaptations has adequately assessed culture sensitivity, either on the part of the therapist or in the ways in which the adaptation incorporates cultural elements into the treatment. Instead of actually measuring cultural sensitivity, the most common approach has been to rhetorically describe the ways in which the adaptation is culturally sensitive. This neglect of empirical assessment is puzzling, given the explicit valuation of quantitative assessment of outcome championed by the advocates of this perspective.

A second important limitation has been the absence of empirical evidence demonstrating that the provision of adapted ESTs produces

better outcomes than the standard versions of the ESTs with individuals from the targeted cultural groups (Lakes, López, & Garro, 2006). The state of the literature is still very much in its infancy, however, and so the careful comparisons have not yet been conducted. It is plausible that the adapted ESTs will demonstrate their benefit in the domains of treatment acceptability, retention, and adherence, rather than in alleviation of symptoms, but the field needs to attend more closely to this issue.

### **Perspective 3: Culturally Sensitive Therapies Are Those That Make Culture the Central Focus**

The third perspective regarding the integration of cultural considerations into therapy is by far the most comprehensive, and has been termed *culturally-centered therapies* by some scholars (Bernal & Saéz-Santiago, 2006; Pedersen, 1997). According to this perspective, any attempt to impose a Western-based therapy upon individuals from non-Western cultures is built upon the faulty assumptions of universality and essentialism (Atkinson et al., 2001; Bernal & Scharrón-del-Río, 2001). Moreover, because Western-based therapies are part and parcel of the societal status quo, they are inherently limited in the ways in which they can empower individuals to overcome the societal structural obstacles that exist for racial and ethnic minorities. Thus, while ESTs can produce positive results with racial and ethnic minorities, it is likely that therapies that are not constrained by Western perspectives will produce better results. For these reasons, adherents of this perspective suggest that clinical psychology would do better to expend its resources in the support and development of novel therapy approaches that centralize culture in the treatment process, by working from particular cultural conceptions and idioms of distress, utilizing culture-specific traditions of pathways to health and sickness, and explicitly addressing societal structure issues in treatment (e.g., race, gender, class, sexual orientation).

From this perspective, cultural sensitivity is not simply a means to increase the attractiveness of therapy, nor is it limited to specific therapist behaviors, as in the previous two perspectives. Rather, cultural sensitivity is the central guiding principle underlying the development of an entire new therapeutic approach. La Roche and Christopher cite the example of *cuento* therapy, an approach that uses cultural folktales to increase children's connection both with their parents and with their Puerto Rican culture and heritage (Costantino, Malgady, & Rogler, 1986; Malgady, Rogler, & Costantino, 1990). *Cuento* therapy, then, uses

culturally salient techniques (i.e., folktales) in the service of a culturally salient goal (i.e., increased connection to family and culture). Other examples of this perspective can be found in the counseling psychology tradition, which has historically focused less on resolving pathology and more on promoting developmental well-being. The scholars who have developed therapies that centralize multiculturalism in both mental health and treatment have tended to give attention to the relationship between the client and therapist, as well as a variety of sociocultural developmental issues, including racial and ethnic identity, spirituality and religion, and social class struggles (e.g., Atkinson, Morton, & Sue, 1998; D.W. Sue, Ivey, & Pedersen, 1996).

The most apparent strength of this perspective is the coherence between the conceptualization of the problem, which is located in society or in the disconnection with one's culture, and the resultant treatment approach. There are fewer inconsistencies than exist in the other two perspectives, as cultural sensitivity is not being added as a separate component onto existing treatment paradigms. Moreover, the central attention given to culture allows these treatment approaches to be well positioned to work within an ever-changing global community.

Despite this strength, this perspective has several notable weaknesses beyond the general lack of evidence demonstrating its effectiveness. From a pragmatic point of view, this perspective is the most difficult to disseminate. Because treatments are developed for particular groups, their development is necessarily slow. Moreover, the education and training of practitioners are likely more labor-intensive than the other perspectives, which will also contribute to the slow growth of this paradigm. A second limitation is the general lack of attention to heterogeneity within cultural groups, despite the centrality that culture is given in all of these models. For instance, it is plausible that culturally centered therapies would work less well with more assimilated individuals, who may not resonate with approaches that utilize traditional healing pathways. Very little guidance is given to help with these determinations. Similarly, although the multicultural counseling perspectives tend to explicitly prioritize assessment of the client's sociocultural location, there has been less attention given to providing guidance for working with clients who may prefer standard therapeutic approaches.

## **Where Should the Field Go from Here?**

Advocates of the CST movement have correctly critiqued the EST movement for its disregard of culture and its role in therapy. These

critiques have appeared rather steadily over the past ten years, by a variety of different authors, and in a variety of publication outlets. And there has been some evidence that the larger clinical psychology field has taken notice of these critiques. For example, as La Roche and Christopher note, the National Institutes of Mental Health now require all funded investigators to document the expected numbers of research participants from different racial and ethnic backgrounds. And yet, the overall change could best be described as incremental. Why is the inclusion of culture not being more readily embraced by advocates of the EST movement?

There are many reasons for the slow pace of change, and La Roche and Christopher highlight a number of them. However, I believe that one of the impediments to more rapid change has been the generally muddled state of the field with regard to cultural sensitivity and the development of CSTs. Concretely, EST scholars who agree with the importance of incorporating culture into their research programs might receive contradictory information from the literature regarding how to proceed. For example, if an EST researcher were to approach me for recommendations, I might encourage the consideration of cultural adaptation research. However, in their article, LaRoche and Christopher devalue the cultural adaptation approach, and instead argue for more culturally centered approaches. Both of these approaches have merit, but because the CST perspective lacks an organizing framework, it is likely unclear to EST advocates where to begin when attempting to incorporate cultural considerations into their research.

Let me be clear: I believe that the variability in perspectives regarding how to incorporate culture into therapy is a *strength* of the CST movement, as each of the perspectives that I described in this commentary has its strengths that merit attention. At the same time, however, I recognize that without some clarity and organization, this variability can be an impediment to increasing the number of scholars and clinicians who attempt to expand their research programs to include culture. Moreover, without an honest appraisal of the weaknesses of the various perspectives, we risk the possibility that scholars who attempt to incorporate culture will encounter unanticipated difficulties and complications which may lead them to be less likely to embrace the CST movement.

Perhaps the organizing framework that I propose can provide some clarity and promote some critical self-reflection on the heterogeneity that exists in perspectives on culture and therapy. It is my hope that by refining our thinking around culture and the therapy process, we can then position ourselves to make affirmative judgments and

recommendations about the efforts that ESTs and other standard approaches have taken and can take to consider culture. This affirmative position may help us step out of a reactionary mode of self-description, so that we may create models of action that have concrete guidelines like the ones articulated by La Roche and Christopher, and, it is to be hoped, lead to more tangible change than is evident to date.

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## **Biography**

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# Cultural competence and master therapists: an inextricable relationship.

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Striving for cultural competence and developing expertise are both highly desirable objectives in the field of mental health counseling. That the two concepts have been investigated rather independently of each other is surprising. The importance of and rationale for combining two scientific knowledge bases of cultural competence and research about expertise in mental health counseling are the focus of this article. The case for a more deliberate juxtaposing of the two research areas of cultural competence and expertise in mental health counseling is made by highlighting the interrelatedness of cultural competence and master therapist research, the diversity of mental health consumers, the requirements of ethical practice, and the need to reduce bias in how mental health research is conducted.

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Skovholt and Jennings (2004) have provided a rich, insightful, and illuminating portrait of master therapists and the development of expertise in mental health counseling that is, I believe, cutting-edge. However, I am recommending that more attention be given toward investigating the role of cultural competence in the research on expertise. In an earlier report of their findings, Jennings and Skovholt (1999) were aptly self-critical about the lack of diversity in the sampling for their landmark study on the cognitive, emotional, and relational characteristics of master therapists. Jennings, Goh, Skovholt, Hanson, and Banerjee-Stevens (2003), in addressing the multiple factors that contribute to the development of expertise in counselors and therapists, also noted that the literature on expertise in mental health counseling fails to give sufficient attention to the role of cultural competence. I understand that the methodology used in the studies mentioned in Skovholt and Jennings' book did not intentionally seek to leave culture out of the equation. Other studies on expertise in counseling similarly did not fully capture or address cultural competence aspects of expertise (e.g., Goldfried, 2001; Goldfried, Raue, & Castonguay, 1998; Orlinsky et al., 1999). Methodological constraints notwithstanding, I believe that more can and needs to be done to address issues of cultural competence in studies of expertise in mental health counseling.

In this article, I will argue the case for a more deliberate juxtaposing of cultural competence

with expertise in mental health counseling by outlining the following reasons: (a) Cultural competence and expertise in mental health counseling are conceptually similar and intertwined, (b) counselors and therapists need to be trained to work with the increasing cultural diversity in our communities, (c) developing cultural competence is required for ethical practice, and (d) meaningful research on expertise in mental health counseling must include and involve cultural diversity.

## CONCEPTUAL SIMILARITIES BETWEEN CULTURAL COMPETENCE AND MASTER THERAPISTS

Two concepts frequently used in mental health counseling that address cultural expertise are cultural competence and multicultural counseling competence. S. Sue (1998) defined cultural competence as "the belief that people should not only appreciate and recognize other cultural groups but also be able to work effectively with them" (p. 440). The term multicultural counseling competence has been defined as a counselor's beliefs/attitudes, knowledge, and skills that relate to working with culturally diverse clients (D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1998). Another definition describes multicultural counseling as "preparation and practices that integrate multicultural and culture-specific awareness, knowledge and skills into counseling interaction" (Arredondo et al., 1996, p. 43). The most comprehensive definition of cultural competence is perhaps provided by the Substance Abuse and Mental Health Services Administration (1997):

A set of congruent practice skills, behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. It is the ability to demonstrate skills and knowledge which enable a person to work effectively across cultures: the ability to provide mental health treatment within the cultural framework of the consumer; the ability to provide effective services to people of a specific cultural background, including one different from the provider. (p. 27)

In this article, I use the term cultural competence as also representing multicultural counseling competence. It also should be noted that definitions of culture in these instances often are inclusive of gender, ability/disability, and sexual orientation and deal with a broader diversity than just purely race and ethnicity (D. W. Sue, 2001a).

Jennings and Skovholt (1999) stated that the term master therapist "is used frequently in the mental health lexicon to describe therapists considered to be 'the best of the best' among fellow practitioners" (p. 4). Orlinsky et al. (1999) defined mastery through their perceived mastery scale in a more traditional sense of a master craftsman. Orlinsky et al. defined therapeutic expertise in terms of knowing "what happens moment-by-moment during therapy sessions ... precision, subtlety, and finesse in therapeutic work ... ability to guide the development of other therapists" (p. 211). Orlinsky (1999) elaborated on potential meanings in the use of the word master that could refer to "one who teaches or someone who practices with exemplary proficiency" (p. 13) and described mastery in practice to be "an encompassing, inventive, procedural kind of knowledge that can be modeled impressively for

others or used as a basis for supervisory shaping of the practice of others" (p. 13).

Conceptually, both cultural competence and the more general expertise in counseling and therapy try to capture the essence and characteristics of high functioning counselors in therapeutic situations. Both attempt to describe competencies required to perform well in mental health counseling. In an attempt to differentiate the two concepts, expertise in master therapist research has been called general or traditional competence and the other, multicultural counseling competence. Pedersen (1991) was the first to suggest that all counseling that is effective must be responsive to the cultural nuances present in every counseling relationship. Fuertes, Bartolomeo, and Nichols (2001) believe that multicultural competence goes beyond traditional counseling, but the two are related "because one may need basic competence and even expertise in traditional counseling methods and techniques (such as the use of empathy and paraphrasing skills) to meaningfully engage and use multicultural competencies" (p. 10). Two studies have found general and multicultural competence to be highly correlated (Coleman, 1998; Fuertes & Brobst, 2002). Coleman actually questioned the assumption that general and multicultural counseling competence are separate constructs and suggested that the terms may be inseparable. More recently, it has been argued that multicultural counseling competence is a superordinate (D. W. Sue, 2001b; D. W. Sue & D. Sue, 2003) and higher order (Weaver, 2005) competency to achieve.

Another striking similarity between expertise in counseling and multicultural counseling competency is how difficult it is to arrive at a satisfactory definition of each and how attempts to do so are fraught with challenges. Ridley, Baker, and Hill (2001) concluded that "what remains elusive is a collectively agreed upon operationalization that comprehensively and accurately captures the quintessence of the construct cultural competence" (p. 823). In addition, concerns about how to translate cultural competence theory into training and practice, and consequently how to measure and assess such competencies, have been raised in the literature (e.g., Constantine & Ladany, 2000, 2001; S. Sue, 1999). Orlinsky's (1999) comments and questions in his reaction article to Jennings and Skovholt (1999) echo many definitional difficulties that also are faced in defining master therapists.

The similarities between cultural competence and master therapists further extend to the way in which both concepts are theorized and modeled. For example, in comparing D. W. Sue (2001a) and Skovholt and Jennings (2004), one can observe the following similarities:

1. Capturing the essence of cultural competence and expertise is elusive.
2. Cultural competence and mastery in therapy are complex and multifaceted.
3. Both concepts are described as developmental processes.
4. Both concepts are portrayed as developmental characteristics, and these characteristics can be taught or trained.
5. There is a positive goal orientation for both concepts in the sense that developing each set of characteristics is highly desirable.

6. Multiple diagrams of all shapes, forms, and dimensions--such as cubes, circles, layers, and radial diagrams--have been attempted to portray each concept.

7. Both concepts represent ideal or exemplary role models for maximizing effectiveness in mental health counseling.

8. Both concepts are difficult to operationalize and translate into training goals.

The apparent similarities between cultural competence and expertise, therefore, suggest that we need to do a better job, even with naturalistic or phenomenological research designs, to inquire about the role of and relationship with cultural competence.

## CULTURAL COMPETENCE FOR CULTURALLY DIVERSE COMMUNITIES

The rapidly growing diversification of the United States and the changing demographic complexion in many communities (D. W. Sue & D. Sue, 2003) demand a serious review of access and efficacy issues in mental health counseling. What is unclear with many studies on expertise is the ethnic or diversity makeup of the participants who were surveyed or interviewed and whether they reflect society's growing diversity. The surgeon general's report *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services, 2001) noted discrepancies in the delivery of mental health services to ethnic minority populations in the United States. Culture, it was concluded, matters in how ethnic minorities fail to access or confront barriers when trying to obtain help. The report found that "major disparities exist in the access, utility and quality of mental health services for racial minorities" (p. 163). Training culturally competent counselors is essential in bridging this gap by making their work more relevant to diverse populations (Pedersen, Draguns, Lonner, & Trimble, 2002; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). Even though Orlinsky, Botersman, Ronnestad, and the SPR Collaborative Research Network's (2001) remarkable study of 4,000 participants has strong international representation, the findings do not necessarily translate to ethnic minority mental health issues in the United States.

It is increasingly recognized that cultural factors such as race, gender, sexual orientation, national origin, and ability/disability play some role in the therapist-client relationship and the effectiveness of therapy (Atkinson, Morten, & D. W. Sue, 1998; Pope-Davis et al., 2002; Pope-Davis & Coleman, 1997; Ridley, 1995). Ridley, Baker, and Hill (2001) considered cultural competence to be of critical consideration for all mental health professionals.

S. Sue (1998) noted that it is as yet inconclusive why ethnic minorities do not utilize mental health services in the same manner as Whites. Sue found that at least three critical variables influence cultural competence: (a) ethnic match (i.e., ethnically similar client and therapist); (b) service match (i.e., utilization of ethnic-specific services); and (c) cognitive match (i.e., when clients and therapists think in the same manner). Although ethnic match and ethnic-specific services studies reflect more favorable outcomes for ethnic minority clients, Sue concluded that the reasons why remain unclear. Cognitive match studies, however, reveal that when therapists and clients share conceptions and expectations about the therapeutic process, better outcomes emerge. Sue concluded by describing three culturally competent characteristics that mental health professionals should possess: (a) scientific mindedness,

testing hypotheses when uncertain about cultural meanings; (b) the ability to "dynamic-size," a term borrowed from computer science and applied to mental health practice as knowing when to individualize and generalize about clients; and (c) the development of culture-specific expertise. It would be interesting for research on expertise to explore or test Sue's thesis.

Fourteen years ago, Ponterotto and Casas (1991) had already noted an increase in the number of publications that address cultural competence. The continuing interest in training counselors and therapists to be culturally competent is reflected in the burgeoning number of studies that investigate the processes for culturally competent practice. Examples of the increasing emphasis on the training and effect of multicultural counseling competence may be found in special issues of journals, such as the *Journal of Mental Health Counseling*, 26(1); *The Counseling Psychologist*, 26(1), 26(4), 29(6), and 30(3); and the *Journal of Multicultural Counseling and Development*, 29(1). Two other journals, *Cultural Diversity and Ethnic Minority Psychology* and the *Journal of Counseling and Development*, are also frequent publishers of articles related to culture and mental health practice.

Even as scientific knowledge grows and our practice evolves to more effectively address the mental health needs of the culturally diverse, it is clear that cultural competence needs to be at the forefront of discussions around expertise in mental health counseling. Training culturally competent counselors to work effectively with the increasing diversity in schools, higher education, the workplace, families, and communities is an urgent need now more than ever (D. W. Sue & D. Sue, 2003). To do any less is unethical (S. Sue, 1998), racist (Ridley, 1995), and cultural malpractice (Hall, 1997).

## CULTURAL COMPETENCE FOR ETHICAL PRACTICE

Multicultural counseling competence stands for ethical practice (Arredondo, 2004). The development of cultural competence as ethical practice recently was highlighted when the American Psychological Association (APA, 2002) approved the Guidelines for Multicultural Education and Training, Research, and Practice for Psychologists. The APA Guidelines mirrors the codes of ethics of the American Mental Health Counselors Association (2000) and the American Counseling Association (1995) in emphasizing the need for mental health professionals to understand the diverse backgrounds and cultures of the clients with whom they work. Furthermore, the Council for the Accreditation of Counseling and Related Educational Programs in its Standards (CACREP, 2001) requires that all CACREP-accredited counselor education programs provide students with training and knowledge in working with culturally diverse clients.

Pack-Brown and Williams (2003) in their textbook illustrated with many cases studies and anecdotes how culturally complex situations can pose ethical dilemmas for counselors and therapists. They emphasized both the importance of making ethical decisions within the cultural framework of clients and the critical expectation that supervisors be effective in a multicultural context. In turn, the unique roles that culture and cultural competence play in supervision were addressed at length in an entire section of a book by Pope-Davis and Coleman (1997). Ridley, Liddle, Hill, and Li (2001) argued that ethical decision-making in multicultural counseling situations "requires more critical reflection and creative problem

solving than is facilitated by ethical codes" (p. 166).

There is almost verbatim consensus, in every definition of ethical practice by professional mental health associations, that culturally competent practice equals ethical practice. It is therefore incumbent that mental health researchers who study expertise in counseling reflect this basic assumption.

## CULTURAL COMPETENCE AND MENTAL HEALTH COUNSELING RESEARCH

S. Sue (1999) put it pointedly:

I believe that there is a lack of psychological research on ethnic minority populations; that research on ethnic minority groups is uneven, with much of it at a relatively low level; and that funding for ethnic minority research has been woefully inadequate. (p. 1070)

Sue elaborated that an overemphasis on internal validity and a lack of attention to external validity has led to an overgeneralization of findings based on studies that utilize only small subsets of people. S. Sue and L. Sue (2003) believe that conducting ethnic research is good science and good for science.

The APA (2002) Guidelines, mentioned earlier, were based on the premise that the United States is becoming more racially and ethnically diverse. Therefore, scientists who conduct mental health research should reflect that diversity in their research sampling and methodology. Guideline 4 in the APA Guidelines encourages mental health researchers to be culture-centered and ethical when conducting research with ethnic, linguistic, and racial minorities.

Citing Heppner, Kivlighan, and Wampold's (1999) listing of five types of research validity (i.e., internal, external, construct, hypothesis, and statistical conclusion), Quintana, Troyano, and Taylor (2001) suggested that cultural validity be added to the list. The authors defined cultural validity as the following:

The authentic representation of the cultural nature of the research in terms of how constructs are operationalized, participants are recruited, hypotheses are formulated, study procedures are adapted, responses are analyzed, and results are interpreted for a particular cultural group as well as the usefulness of the research for its instructional utility in educating readers about the cultural group being investigated, its practical utility in yielding practice as well as theoretical implications about the cultural group, and its service utility in "giving back" to the community in important ways. (p. 617)

These authors went on to outline ways in which researchers can maximize cultural validity during various phases of research. Their ideal is best captured in this opening statement: "Someday, we hope, all research will be multicultural and we will not need the qualifier 'multicultural' when referring to research" (p. 604).

Skovholt and Jennings (2004) in their qualitative study utilized a research methodology that is well suited for culture-centered studies. Ponterotto (2002) and Ponterotto, Costa, and Werner-Lin (2002) described qualitative research methods as the fifth force in psychology. Ponterotto and associates noted that qualitative or multimethod approaches are ideal for understanding the complex juxtaposition of culture and mental health counseling and that qualitative methods may be even more effective in tapping the complex interacting forces such as cultural competence and expertise in counseling. S. Sue (1999) noted the need for more qualitative studies to understand old and new constructs from different cultural perspectives. An inductive analysis allows the researcher to understand the data without imposing preexisting expectations on the topic of study within cross-cultural contexts. Marsella (1998) and S. Sue (1999) claimed that cross-cultural research has not been as conclusive or useful because of the bias in value-laden assumptions and hypotheses of previous research methodologies and because of viewing results from Western lenses. S. Sue recommended a variety of research methods for our knowledge about culture's role in mental health counseling to grow substantially. Marsella believes that the increased use of qualitative research methods will expand our boundaries in understanding culture and mental health counseling as well as reduce the way research is viewed predominantly from a Western ethnocentric bias.

At the time of this writing, I am pleased to note that I have secured grant funding to replicate the Jennings and Skovholt (1999) study, in collaboration with the original authors, with a focus on multicultural counseling competence. We hope that deliberate attempts to elicit cultural dimensions in expertise in our research questions and through our interviews will help to shed light on the role and relationship of cultural competence vis-a-vis general expertise in mental health counseling.

## CONCLUSION

In this brief article, I have tried to paint, in very broad brush strokes, what I consider to be the essential and obvious reasons why research on expertise in mental health counseling needs to be juxtaposed with its conceptual twin of cultural competence. In doing so, I hope that I have not underrepresented the vast body of knowledge on cultural competence and multicultural counseling nor undermined the bold positive steps that have been taken in master therapist research (Orlinsky et al., 2001; Skovholt & Jennings, 2004). I gave more attention to the two constructs' similarities because I believe the similarity forms the theoretical basis for why the two are inextricably related. I then made the case for their juxtaposition based on the more pragmatic realities of the changing national demographics, clinical and ethical prudence, and, finally, research responsibility.

Research about cultural competence and expertise in mental health counseling continues to grow and will undoubtedly make significant contributions to the scientific knowledge as well as to the training, education, and practice of mental health counseling. Even as I write, I am mindful of the recent work by Earley and Ang (2003) on cultural intelligence and Sternberg's (2004) thinking about culture and intelligence that shed new light on how culture potentially manifests itself in what we consider to be expertise, indeed, cultural competence is very much a vibrant topic that is evolving every day. I am confident, therefore, that when we

include it in our study of master therapists, our understanding will be enhanced, and the mental health professions will be the better for it.

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