

## Debate paper

# Cultural competence in the mental health treatment of immigrant and ethnic minority clients

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## ABSTRACT

The increasing presence of culturally different clients in European health services constitutes an important challenge for the effective delivery of care. Cultural competence has been proposed as a general approach for improving services, which requires changes at both institutional and clinical levels. The majority of cultural competence models have been developed in the United States and as such may require adaptation for use in Europe. The key constructs of culture, ethnicity and race underlie important philosophical perspectives in cultural competency models. How these constructs, particularly race, are understood to relate to health and healthcare is of considerable importance in both the development of the competency models and their application and acceptability, which are not always the same, in a given context. Clinical cultural competence consists of specific knowledge, skills, and attitudes that function together to

provide an individualised, culturally sensitive and appropriate treatment. Knowledge about cultural specifics is less important than awareness of the different ways in which culture, race, and the migratory process can affect psychosocial functioning and mental health treatment. Given the complex play of racial bias and ethnic discrimination, cultural self-awareness is the key to effectively overcoming barriers that are often unseen but which can severely limit the effectiveness of the therapeutic relationship. Although there has been a very promising start, cultural competence in mental health needs to be further defined, adapted, and researched for effective application in the European context.

**Keywords:** cultural competence, cultural self awareness, interculture psychotherapy, interculture therapeutic relationship

## Introduction

The general spectre of immigration and cultural difference increasingly represents important challenges to the delivery of quality mental healthcare. It is becoming clear that the majority of mental health services are not sufficiently equipped to respond to the specific needs of immigrant and ethnic minority populations (US Department of Health and Human Services, 2001). Research in the general field of transcultural mental health, although emergent, is still relatively recent, and the bulk of it has been carried out in the United States.

Cultural competency represents one approach to improving the quality of healthcare received by culturally different patients. Rather than determining training on the basis of hours of content, competency models identify skill sets that must be met as a means of ensuring rudimentary capabilities in the activity area in question. Cultural competence models seek to outline the basic components, institutionally and/or clinically, necessary and sufficient for the provision of adequate services to all patients (Betancourt *et al*, 2003).

There exist a bewildering array of cultural competence models, in most human service fields, including nursing, medicine (Health Resources and Services Administration US Department of Health and Human Services, 2001; Betancourt *et al*, 2002; Dunn, 2002; Genao *et al*, 2003), and psychology (Sue *et al*, 1992; Arredondo *et al*, 1996; Hansen *et al*, 2000; Sue, 2003). Although virtually all models define competencies in terms of knowledge, skills, and attitudes, medical models tend to focus on concrete content and structural issues, whereas mental health and nursing models tend to be more process oriented. Overall, the focus of the different fields would appear to reflect their respective professional activities.

Although institutional and organisational changes are key for effective service delivery to immigrant and ethnic minority service users, this paper will address clinical cultural competence. As the focus is on mental health, the discussion will centre on the dominant cultural competence model in North American psychology, the Multicultural Counselling Competencies (MCC), and draw upon relevant aspects of other models in the process. It will be suggested that, overall, the model is robust, as, indeed, is evidenced by the considerable interdisciplinary overlap. On the other hand, validation and outcome research is far from conclusive (Fuertes *et al*, 2001; Weinrach and Thomas, 2002; Patterson, 2004), a function, it would appear, of methodological and conceptual issues inherent in models that emphasise self-awareness. Furthermore, as the skill sets outlined by the competencies tend to be process oriented rather than concrete, the MCCs can appear to be rather vague, with excessive attention paid to attitudes, awareness, and beliefs, and insufficient detailing of concrete application to specific knowledge sets (Cunningham *et al*, 2002; Vega, 2005).

Competence training in general tends to consist of knowledge, skills, and attitudes, as is the case in the vast majority of the models in nursing, medicine, and psychology. Although arguably falling within the attitudes domain, motivation and awareness of limits are included as additional foci of cultural competence, and will be discussed below.

This paper presents a critical synthesis of existing North American cultural competence models as relevant to mental health in the hope of contributing to the overall debate on this topic in the European context. Attention to issues related to culture and race in mental healthcare is in its infancy, and is beset by a variety of theoretical and methodological problems. It will be argued, however, that despite social and demographic differences, with modifications, the incorporation of North American models of cultural competence could be of considerable value for improving mental healthcare in Europe.

## Multicultural Counselling Competencies

The initial version of the Multicultural Counselling Competencies (MCCs) (Sue *et al*, 1982) was developed in 1982 under the auspices of the Division of Counselling Psychology of the American Psychological Association (APA), and they were subsequently updated in 1992 (Sue *et al*, 1992) at the request of the president of the Association of Multicultural Counselling and Development. In 1996 the competencies were further elaborated (Arredondo *et al*, 1996), and they form the foundation of the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* published in 2003 by the APA (American Psychological Association, 2003). The MCCs have been endorsed by the Division of Counseling Psychology and the Division of Ethnic Minority Studies, as well as the Association of Counselor Education and Supervision, and six divisions of the American Counseling Association. In short, although not without detractors, the MCCs have been well received in American psychology.

In North America, licensing as a psychologist requires holding a doctorate in counselling, school, or clinical psychology (Committee on Accreditation, 2005). Counselling psychology is an applied specialisation, whose professionals practise in the same settings as do those with doctorates in clinical psychology. As a field, counselling psychology has placed considerable emphasis on the relationship of the person to their environment across the life-span, which has made it a fertile ground for the examination and exploration of the intersection of psychology and culture, race, gender, sexuality, and so on. Clinical psychology specifically (Hansen *et al*, 2000; Sue, 2003; Henderson *et al*, 2004) and the APA (American Psychological Association, 2003) in general have tended to follow the counselling psychologists' lead with regard to cultural competence and, as yet, have not, at an institutional level, sought to develop distinct competencies.

The MCCs, like most other competency models, are based on attitudes and beliefs, knowledge, and skills, each of which is applied to the competency domains of:

- counsellor awareness of own cultural values and biases
- counsellor awareness of the client's worldview
- culturally appropriate intervention strategies (Sue *et al*, 1982, 1992, 1998; Arredondo *et al*, 1996; Arredondo and Toporek, 2004).

The model is complex because of the application of its  $3 \times 3$  construction. However, this has been done in order to emphasise that the three competencies are

applicable to each of the domains, e.g. self-awareness is a skill that requires knowledge.

Central to the MCCs is the notion that racial or ethnic group membership, in and of itself, does not comprise a *psychological* variable. Rather, racial or ethnic identity is considered to provide a more useful perspective on an individual's relationship to her or his racial or ethnic group membership. Racial identity is understood to be a dialectical process; how one relates to one's own group is inseparable from how one relates to the *other* group (Sue *et al*, 1998; Helms and Cook, 1999). Although there are a variety of different models, all share more or less the same components (Helms, 1995; Sue *et al*, 1998; Helms and Cook, 1999). For minority group members, internalisation of the dominant discourse marks the early stages of racial development.

The first stage is one in which there is a general denial of the importance of race, consistent with the dominant position that race is irrelevant and merit is what determines success. 'We are all equal' is the operative notion, a notion that may be reinforced in an unconscious effort to avoid confronting the painful reality of racism and inequality. When this reality can no longer be avoided, one enters the second stage, which is marked by confusion and discomfort. In a sense, the walls of the hitherto relatively comfortable reality have come crumbling down, and the individual increasingly confronts the existence of racism. In response to the discomfort and confusion, the third stage is marked by an immersion into one's racial or ethnic group in an exaggerated manner and to some extent still following the parameters set forth by the dominant group. As one stabilises from the initial shock, a more self-determined identity is developed, in which one acknowledges and respects one's ethnic group identity, but does so on one's own terms, which means that there are no externally given restrictions (Helms, 1995; Sue *et al*, 1998; Helms and Cook, 1999). Helms rejected an epigenetic stage model in favour of what she terms 'statuses' to underline that although one status is dominant, movement is not necessarily progressive and is context dependent (Helms, 1995).

As members of the majority group, ethnic or racial discrimination is often thought to be the product of a few misguided individuals. The reality, it is argued, is that what really matters is the person, and that all people have the same opportunities in life, regardless of race or ethnic origin. Such a perspective defines the first stage of majority group development, which is characterised by colour blindness. This stage will remain in place until an event occurs that unequivocally demonstrates that equality exists, if at all, only on paper, and that in reality racial discrimination is the rule rather than the exception. This event, which could be a personal experience or a newsworthy item, forces the individual to confront the painful reality that

although all people *should* have equal opportunity, minority group members are discriminated against. The majority group member will often resolve this crisis by in essence blaming the victim, by adopting the view that in fact there would be equal opportunity if only *those people* would make an effort to integrate and play by the rules that everyone else abides by, and that whatever problems minority group members have are problems that they brought upon themselves. Time and reflection combined with new experiences can jolt the person from this stage into one that is ideologically anti-racist and pro-equality, but that lacks personal commitment. It often takes the form of consumerist pro-equality: one 'wears' one's anti-racism but does not live and breathe it. Such a perspective characterises the later stages, that of a true pluralism (Helms, 1995; Sue *et al*, 1998; Helms and Cook, 1999).

As will be seen in examining the domains of the model, knowledge of, facility with applying, and willingness to examine racial identity, of both therapist and patient, are cornerstones of the MCCs.

## Domain 1: counsellor awareness of own assumptions, values and biases

The emphasis on self-awareness distinguishes the MCCs, along with many of the nursing models (see, for example, Kim-Godwin *et al*, 2001; Campinha-Bacote, 2002; Purnell, 2002), that differentiate them from medical cultural competency models. Self-awareness about racial and cultural identity, prejudice, and values are the cornerstones of this domain. The self-transparency involved requires that the therapist actively engages in understanding her or his cultural situatedness and racial identity, and how this influences her or his engagement with the world. The *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* published by the APA in 2003 summarise this point well in Guideline 1:

Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves. (American Psychological Association, 2003, p. 382)

The detailed examination of one's racial and cultural heritage, attitudes and beliefs about race, culture, and immigration required by this competency may demand confrontation with socially and ideologically undesired attitudes. For the majority of group members, this requires exploration of the privilege that accrues simply by virtue of belonging to the majority group, privileges that are a function of individual and institutional racism. The biggest challenge of this competency is the complexity not of the material,

but of the capacity to identify and correct racist and ethnocentric attitudes and beliefs.

The cultural and racial self-exploration required by this competency domain tends to be difficult for majority group members both because attention to themselves as racial and cultural beings is not habitual and because of the unpleasantness of having to confront implicit attitudes that run counter to the desired explicit attitudes. Whereas minority group members are accustomed to contemplating racial and cultural differences by virtue of being excluded, directly or indirectly, from the majority group and suffering the concordant discrimination, majority group members are rarely in situations in which their cultural or racial group membership is problematised. As majority group members' views are privileged and normative, they are simply taken as representative of reality, in contrast to minority group perspectives, which are taken as representative of cultural beliefs. The very notion that racial and cultural self-exploration could be relevant in clinical work is difficult to accept, because racial and cultural difference is rarely personally salient for the majority group member. Key to this competency is confronting the presence of racist and ethnocentric views, which tend to run counter to the humanistic values that are generally shared by almost every mental health professional. This means that cultural competence requires a sort of self-confrontation that can be very painful.

## Domain 2: counsellor understanding of client's worldview

The culturally competent therapist attempts to understand and respect the cultural and racial perspective of the service user. The attitudes and beliefs competency involves an application of the previously discussed self-transparency and concordant skills to monitor and control negative judgements and emotional reactions towards the clients and their cultures. It also requires incorporating the notion that the worldviews and explanatory paradigms of the culturally different client are neither less valid nor more 'cultural' than those of the scientifically based practitioner.

Understanding the client's worldview clearly involves cultural knowledge, and this competency consists of different components. The first requires in-depth knowledge of the client's culture, which includes awareness of cultural heritage and historical background. Because cultural knowledge is nomothetic, and because ethnic and racial group membership is demographic but not psychological, the MCCs strongly endorse the use of the identity models as a means to individualise cultural knowledge and to render it more behaviourally and psychologically meaningful.

Cultural knowledge, in the MCCs, also involves awareness of how race and culture influence people, not only general concepts like psychosocial development, but also specific concerns about mental health such as representations of distress, help-seeking behaviour, and expectations regarding the therapeutic process. Finally, the knowledge competency involves an understanding of the influence of sociopolitical and economic factors on the lives of ethnic minority group members.

The skill competency of this domain essentially entails seeking out the education and experiences needed to develop such cultural empathy. It would appear, however, that many practitioners who would like to be multiculturally competent have difficulties in being culturally empathic. Accepting the sometimes contradictory and challenging worldviews held by culturally different clients can challenge even well-meaning therapists because of their discomfort with cultural and racial difference. The understanding of client worldviews requires that clinicians be sufficiently aware and knowledgeable to be able to seek out the sort of training that will enable them to understand their clients' worldviews.

## Domain 3: culturally appropriate intervention strategies

This domain is the most concrete of the three, and perhaps that which most commonly is of interest to helping professionals, as it concerns what one must do in working with service users from different cultures. At the same time, this domain does not provide a cook-book of recipes for interventions with different ethnic groups. In fact, this domain consists of the attitudes, beliefs, and skills needed for effective interventions, but does not describe the interventions as such, which leaves the model open to criticism.

Effective intervention requires as a starting point that the professional respects the client, which implies respect for the beliefs about the distress or problem, as well as the possible solutions to this problem. The knowledge competency of this domain entails general understanding of mainstream helping approaches and institutions, and the ways in which they are culturally biased and may prevent effective work either by impeding access or by providing a culturally inappropriate service.

Flexibility is the basis of the skills competence, which requires the therapist to be adaptive, as appropriate and ethical, in meeting the needs and desires of the patient. The culturally competent therapist can easily apply her or his knowledge of different communication styles, is adept at correctly interpreting the verbal and non-verbal cues and messages sent out by the patient, and can respond in a way that is comprehensible

to the client. The therapeutic intervention should be responsive to the needs of the patient rather than to the philosophy of the professional, although flexibility has its limits. In this respect the service user must be made aware of the limits of psychotherapy, and when a referral is indicated. In addition, the competent professional can discern when a more social or institutional intervention is required, and will take the steps necessary to ensure that this occurs. Flexible and effective interventions also mean knowing not only when to refer, but also when to consult with traditional healers or community and religious leaders in an effort to make treatment more responsive to the client's needs. In the same way, the service provider should take responsibility for making available services in the client's language of preference. This could mean making appropriate referrals, or it could mean ensuring the availability of cultural mediators.

It is important to underline that although flexibility is important, services should be consistent with the competencies of the therapist, and the services provided, although done so flexibly, should still be counselling or psychotherapy. It is essential that the service provider informs and educates the client about the nature of the work to be done and what it involves. Many people have no experience with psychotherapists, and as such have no idea what to expect; effective treatment and communication require that the understanding of what is being done is mutual.

## Additional aspects of the MCCs

### *The multicultural therapeutic relationship*

Although not identified as a separate competency domain, the multicultural therapeutic relationship constitutes an important component of cultural competence (Fuertes *et al*, 2001; Roysircar *et al*, 2003; Qureshi, 2005). Sodowsky considers what she calls 'ethnotherapeutic empathy' 'to be the human element in counsellor–client interactions ...' (Roysircar *et al*, 2003), of sufficient importance that she includes it as a subscale of her instrument used to measure multicultural counselling competence. Researchers have found, however, that therapist cultural and/or racial responsiveness, or overt openness to racial and cultural material, appears to be directly related to improvements in various aspects of the therapeutic relationship, including self-disclosure (Thompson *et al*, 1994), the working alliance (Zhang and Burkard, 1999), therapist rating (Fuertes *et al*, 2001; Want *et al*, 2004), empathy (Fuertes *et al*, 2001; Burkard and Knox, 2004), and client satisfaction (Constantine, 2002). The MCCs' focus on process-related aspects of racial and cultural identity and issues would, then,

appear to contribute to the development of a strong intercultural therapeutic relationship.

### *Motivation and recognition of limitations*

Although arguably falling within the domain of therapist attitude and belief, the motivation to develop cultural competence, on the one hand, and awareness of the limits of said competence, on the other, have been identified as additional key elements. That a person has the ability to effectively apply relevant knowledge, along with self-awareness concerning racial and cultural issues, does not necessarily mean that he or she is sufficiently motivated to engage with a high degree of commitment to multiculturalism, with regard to either treatment of patients or ongoing competence development. To this end, Campinha-Bacote (2002) adds cultural desire, along with cultural encounters, to the standard tripartite group. This motivation or indeed commitment is identified within the overall MCC approach by a variety of authors; however, its explicit identification is of considerable value.

The clear objective of competence models is the achievement of mastery over the subject matter in question. This can, in the context of intercultural work, lead to the erroneous belief that the correct application of the MCCs will result in accurate assessment and effective treatment (Gailly, 2003 unpublished observation). As many of the MCCs are process oriented and involve constructs that are at once elusive, complex, and contested, mastery over any or all of them is highly unlikely. Marie Tervalon introduced the notion of cultural humility as a corrective, that serves to remind multicultural practitioners of the very real limits present in their work. The notion of cultural humility calls upon clinicians to refrain from automatically assuming that their competence is in fact complete, and as such should always give the issue at hand a second look.

## Discussion of the multicultural competencies

It is important to note that the specific approach to be used with a client is left up to the individual clinician, and that competencies are neither a replacement nor a substitute for existing counselling skills. Although the competencies are critical of existing western-based models, they do not provide concrete suggestions for alternative therapeutic approaches, beyond expanding the role of the therapist. Indeed, it remains uncertain to what extent this is feasible given the nature of the criticisms leveled at conventional approaches. MCCs do not propose discarding conventional psychology treatments; indeed, the operating system remains firmly embedded in conventional approaches, albeit with modifications. What the multicultural counselling

competencies offer above all is an orienting paradigm that can sensitise therapists to issues that, when effectively responded to, can make services more responsive to ethnic minority group members. Some studies (Coleman, 1998; Constantine, 2002) have found a correlation between measures of general therapeutic competence and cultural competence, which raises the question as to whether or not they are distinct constructs. This remains an important issue. One study indicated that they are indeed distinct constructs, in that a patient reported effective therapy for certain key issues, but ineffective for other, race-related ones (Qureshi, 1999).

Despite their widespread acceptance, as evidenced by the tremendous volume of publications and conference presentations that draw upon the MCCs, as well as their incorporation into the APA's *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (2003), there is a dearth of conclusive validation research (Worthington *et al*, 2000; Nagayama Hall, 2001; Pope-Davis *et al*, 2001; Sue, 2003). In part this would appear to be a function of the nature of the competencies, which, being highly process oriented, are difficult to measure. Although there do exist instruments designed to measure the competencies (D'Andrea *et al*, 1991; Sadowsky *et al*, 1994; Ponterotto *et al*, 2002), these instruments are predicated on the MCC model itself, thus, primarily through self-report, the degree to which the individual in question demonstrates proficiency with the MCCs. Psychometric evaluations of the instruments have been far from conclusive, with questions remaining about their validity (Constantine and Ladany, 2000; Constantine *et al*, 2002a). There has been minimal research that seeks to identify, empirically, what specifically contributes to or detracts from effective therapeutic work (Bolling, 2002; Sue, 2003). As Sue noted in his Distinguished Professional Contributions to Applied Research Award address (2003), much work remains to be done to build upon the foundations that have thus far been developed

## Application of the MCCs in the European context

In this section different aspects of the MCCs are reflected upon, in an effort to comment on the applicability of the American approach to the European context.

### Cultural knowledge

Cultural knowledge remains an important cornerstone of most cultural competence models, the MCCs

being no exception. Cultural knowledge, however, presents some important difficulties for clinicians. To begin with, cultural knowledge itself is a tricky proposition, and any cultural explanation is inevitably subjective – it is the interlocutor's interpretation of the role of culture in a particular situation. The cultural knowledge of a service provider will have come from a source that may or may not be in direct contact with the culture in question, thus leading to Geertz's (1973) notion that cultural knowledge is the clinician's interpretation of the anthropologist's interpretation, and so forth. Specific cultural explanations, then, are not unequivocal, but depend in large part on the person who is attempting to provide the explanation; the same phenomenon can be accounted for by any number of different cultural explanations.

Cultural knowledge is all the more complex because of difficulties in applying it to particular cases. As some experts have pointed out, when seated next to a service user, the cultural knowledge remains very far away from the actual helping relationship (Sue and Zane, 1987). Applying cultural knowledge is complicated, and is all the more so because of the many different ways in which a person can live their culture. One common application of cultural knowledge to psychological treatment is culturally specific treatment approaches, such as directive therapies for Asians (Li and Kim, 2004) or Afrocentric-based therapy for African Americans (Phillips, 1990; Robinson and Howard-Hamilton, 1994). Although showing some promise, any efforts at culturally specific treatment assume a degree of homogeneity within cultures, which the MCCs themselves disavow. Research on various measures of cultural difference, for example, locus of control, individualism/sociocentrism or time orientation, have shown inconsistent results across and within cultures (Carter, 1991). This is hardly surprising given the incredible richness of intragroup variation. Cultural knowledge is general, but the client is specific, and to what degree any particular common cultural feature may characterise a particular individual is variable and changing. This is so to such an extent that some commentators contend that a little bit of cultural knowledge is worse than none at all, because of the ease with which stereotypes are applied. Finally, cultural knowledge may be overly applied, such that all behaviour is explained 'culturally'; the service user is reduced to a cultural being who has no unique personality characteristics.

An alternative to specific cultural knowledge is the elaboration of specific domains in which culture, immigration, and ethnic minority group membership can impact on psychosocial development and therapeutic transactions. The Purnell Model of Cultural Competence (Purnell, 2002) provides a comprehensive overview of many of the different demographic,

social, economic, and other factors that can have an impact on patients, and thus can be of relevance in the treatment process. Indeed, the MCCs also require attention to the multiple aspects of human life, but they remain focused on issues of difference. In this respect, another conceptual difficulty of the MCCs is that they at once tend to focus rather exclusively on race while at the same time asserting that all differences are cultural differences, to the extent that sexual orientation, age, and ability would be included as distinct cultures. Carter and Qureshi (1995) noted there are a variety of philosophical typologies that identify the basis of what exactly constitutes 'multicultural', and it would appear that this issue requires clarification, particularly for use in the European context.

### Race, culture, and immigration

Despite the long history of immigration in the US, and the recent influx of refugees and immigrants from the Balkans, Iraq, and other regions affected by regional strife, the thematic perspective in the MCCs tends to remain fixed on the categories that were initially set forth for bureaucratic reasons. Referred to as 'racial' or 'ethnic' groups, they are an odd mixture of linguistic (Hispanic) or cultural (Latino), geographic (Asian American), and socioracial (black, white) elements. Typically research focuses on ethnic minority status, with minimal attention to the immigration process. One of the stronger criticisms of the MCCs is that the model gives excessive importance to race and difference, to the extent that common humanity (Weinrach and Thomas, 2002; Patterson, 2004) and issues related to culture and immigration are neglected.

European approaches to cultural competence tend to divide along the English Channel in their attention to race and difference, with those models and commentaries originating in the UK providing considerable attention to the issue (Papadopolous *et al*, 2004; Quickfall, 2004), whereas on the continent race and difference are either entirely ignored (Schultz, 2004; Stier, 2004) or treated as another aspect but without particular priority to the issue (Thomas, 2000). The Anglo-American focus on race is problematic because it ignores or downplays the stressors related to immigration as a potential source of psychological distress. The MCCs, as they currently exist, tend not to attend in any great detail to the immigration process and, as such, lose some relevance for application in countries such as Spain or Italy, that are relative newcomers as multicultural societies.

The identity models endorsed by the MCCs appear to be heuristically and clinically useful for a variety of reasons. They facilitate self-examination, and examination of how the professional's race-related attitudes and identity can impact on the therapeutic process. In

effect, the model can counter the trend, identified by Papadopolous *et al*. (2004, p. 113), for trainees to '... identify knowledge deficits about particular cultural groups rather than examine beliefs and attitudes towards clients or reflect on professional practice'. At the same time, it is clear that the racial identity model, as it stands, is inappropriate for use in Europe, and requires adaptation to the European reality.

One of the principal difficulties with the race construct, however applied, is that the demarcations of groupings are far from clear. Whereas in the US and the UK there is a history of specification of racial and group difference, this is not the case in many continental European nations which are currently undergoing a surge in immigration or have a policy of downplaying racial and group difference (Kirmayer and Minas, 2000), or both. On the continent, the demarcation of the different groups is not always clear, although this would also appear to be the case for those 'new' immigrant and refugee groups which defy the received categories. Thus immigrants and refugees from the former Soviet Union, for example, are by definition, both white and European and yet do not enjoy the same privilege accorded to white western Europeans. What this means is that the categories are not so neat, and require work to be coherent in the local context, for research, clinical, and training purposes.

### Attitudes and beliefs: ideology or social activism

A philosophical assumption implicit in the MCCs and many other process-related cultural competence models is that differences in race and power are of paramount importance in minority mental health and psychotherapy. Much of the focus of the MCCs is on the importance of race for mental health and psychotherapy, particularly in response to white racism. The MCCs suggest that, by virtue of being white, a therapist is necessarily racist and must attend to his/her racism as a prerequisite for effective psychotherapy. The MCCs have been criticised for being overly ideological, for demanding that a particular political stance is adopted by practitioners, to the extent that the MCCs have been referred to as a manifesto (Weinrach and Thomas, 2004). Criticism of the MCCs, particularly when at the hands of whites, is often met with charges of racism (Sue *et al*, 1998; Weinrach and Thomas, 2004), which demonstrates the extent to which the MCCs have become highly politicised and which may serve to impede their growth and effective analysis. This stance would appear to be nominally present in some of the UK nursing models, which also seek to thematise the importance of race. It is not

entirely clear that such politicisation is necessarily problematic. Clearly, if indeed racism is as ubiquitous as is suggested by the MCC and other competency models, then social activism and political change are indicated.

### MCCs and treatment effectiveness

One of the curious aspects of the MCCs is that, despite their widespread acceptance, it has yet to be unequivocally demonstrated that they are both necessary and sufficient for effective intercultural treatment. A number of researchers have begun such a process (Ladany *et al*, 1997; Sodowsky *et al*, 1998; Constantine and Ladany, 2000; Fuertes *et al*, 2001; Constantine *et al*, 2002b; Fuertes and Brobst, 2002) but a large-scale research project that even begins to approach the rigours required of evidence-based treatments has yet to be initiated. Interestingly, one of the key stumbling blocks is serious difficulties in recruiting a sufficient number of study participants from the different cultural groups in question (Bolling, 2002), which itself may be related to a lack of perceived cultural competence on the part of existing therapies (Nagayama Hall, 2001; Sue, 2003). Thus, although the MCCs have face validity and would appear to be highly relevant for effective mental health treatment (the authors of this article endorse them), continued promulgation of this model without empirical validation is of questionable value.

### Process/metatheory versus specific techniques and interventions

The general multicultural counselling approach upon which the MCCs are based is posited as a metatheory (Sue *et al*, 1996) and, as such, with few exceptions as noted above, does not propose specific interventions or techniques to be used with culturally different service users. The MCCs do a relatively good job at identifying the Eurocentric or culturally encapsulated aspects of dominant psychotherapeutic interventions, but do not offer alternatives beyond adaptation of existing approaches. This renders efficacy research problematic for two reasons. The first has to do with difficulties in accurately measuring the degree of competence, given that self-reported MCCs tend to be influenced by social desirability (Sodowsky *et al*, 1998). The other is that determination of the specific relationship between process-type competencies and outcome is not easily amenable to more objective forms of psychotherapy research, particularly the clinical trial. It could well be argued that the cultural competencies are a glorified sort of navel gazing, in which therapists focus the attention on themselves and not on the treatment needs of the patient. What is

needed is not so much attitudinal and process-type adaptations, but specific interventions and techniques that will bring about a relief of patient distress (Cunningham *et al*, 2002; Vega, 2005). In this respect, the debate as to the utility of empirically validated treatments is quite relevant (Chambless and Ollendick, 2001; Wampold and Bhati, 2004; Westen *et al*, 2004) because it demonstrates that in the general psychotherapy literature the importance of process, that is the therapeutic relationship, versus technical issues, such as psychological treatments, has yet to be resolved. Put differently, the criticism that the MCCs do not specify concrete treatment strategies may be unfounded, precisely because it is not so much the strategy that makes for good treatment but rather the way in which the treatment is carried out that makes the difference. It may well be the case that the MCCs, directed at professional psychologists, assume that practitioners are proficient therapists, and as such do not need to be taken through the detailed process of choosing an intervention.

### Conclusions

Cultural competence represents, above all, a response to the barriers that impede the provision of quality mental healthcare to immigrant and ethnic minority patients. Clinical cultural competence, as outlined in this paper, is predicated on the notion that the most serious impediments faced by immigrants and ethnic minority patients are related to the therapist's capacity to effectively process issues related to race and culture. Although knowledge and skills related to cultural differences are considered important, the clinician's capacity to process her or his own racial and cultural identity comprises the key to cultural competence. Concrete intervention strategies are not included in the MCCs; these are left to the therapist's discretion based on a culturally competent analysis of the situation. The two major criticisms of the MCC model are the emphasis on race and power relations, and the lack of concrete intervention strategies. It has been suggested that the MCCs are a response to a North American demographic and historical context distinct from that of Europe, and as such a European cultural competence model would need to pay greater attention to immigration and cultural difference. The process-related focus, although challenging, would appear to provide the basis for effective mental health treatment. The North American cultural competency approach presented here, although clearly not without problems, particularly in the context of transportability, provides a useful point of departure. It is notable that with the exception of nursing, cultural competency as such has not made institutional inroads in healthcare

in general, and mental health in particular. At the same time, there is no shortage of initiatives concerning models of culturally appropriate care. Such initiatives, in contradistinction to cultural competence models, generally pertain to specific therapeutic approaches rather than an ordered, coherent model by which to approach the therapeutic process, regardless of the specific orientation of the therapist. It is hoped that a European-wide effort can be deployed that would incorporate the experiences and realities of different countries in the development of a cultural competency model that could be applied at the educational, clinical, and organisational levels.

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#### CONFLICTS OF INTEREST

None.

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